Annual Performance Report: Working and Planning Together

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Strategic Commissioning Framework

The Dundee Integration Joint Board (IJB) is the group of people responsible for planning, agreeing and monitoring community-based health, social work and social care services for adults. They must agree a plan that sets out the IJB's ambition and priorities for health, social work and social care services in Dundee and how they plan to use the resources they have to make this ambition a reality. The plan also describes how health and social care services will be delivered and improved; these are the services delivered by Dundee Health and Social Care Partnership. The Health and Social Care Partnership is the place where Dundee City Council, NHS Tayside and some organisations in the third and independent sector work together to deliver the services and supports the IJB has planned and agreed.

A full copy of the plan can be found here

In April 2023 the IJB approved its new Strategic Commissioning Framework 2023-2033. 'The plan for excellence in health and social care in Dundee' builds on the previous framework and reflects the outcome of considerable engagement with communities and stakeholders. Work has started to develop companion documents including: an Annual Delivery Plan, Performance Framework and Resources Framework but has been delayed by staffing pressures and the prioritisation of a response to the Joint Inspection of Adult Support and Protection in Dundee.

The new Strategic Commissioning Framework will help the IJB reach their ambition:

People in Dundee will have the best possible health and wellbeing. They will be supported by health and social care services that:

- Help to reduce inequalities in health and wellbeing that exist between different groups of people
- Are easy to find out about and get when they need them
- Focus on helping people in the way that they need and want
- Support people and communities to be healthy and stay healthy throughout their life through prevention and early intervention

There are six strategic priorities in the framework as follows:

- Inequalities (support where and when it is needed the most)
- Self-care (supporting people to look after their wellbeing)
- Open door (improving ways to access services and supports)
- Planning together (planning services to meet local need)
- Workforce (valuing the workforce)
- Working together (working together to support families)

These priorities are consistent with and support the Scottish Government's nine National Health and Wellbeing Outcomes which apply across all health and social care services.

Engagement

In the production of the Strategic Commissioning Plan 2023-33: The Plan for Excellence in Health and Social Care in Dundee, there was a significant focus on stakeholder engagement, with priority given to engagement with people who use health and social care services and supports, unpaid carers and the health and social care workforce. Building on learning from previous engagement work this has taken a flexible and tailored approach with a range of different tools and opportunities being developed. This has facilitated Partnership staff to engage people in places and ways that best suit them as individuals and groups, creating spaces for the Partnership to listen to what is most important to them. Opportunities have also been taken to reflect back to stakeholders' contributions made in early engagement activities and to further refine thinking, particularly in relation to the IJB's vision and wording of strategic priorities.

From Late October 2022 there was a 'Call for Views' from people who access care and support or may access care and support in future; carers of people living in Dundee and young carers in Dundee; colleagues and volunteers across services and supports (including the workforce from NHS, Council, Third Sector and Independent Sector.) A mixed method approach was applied including face-to-face meetings and going to where people were already meeting, phone calls and one-to-one meetings, online survey and focus groups. From January, due to the low number of responses, it was agreed to combine (where appropriate) this engagement activity with engagement about GP premises.

Proactive contact was made with people and groups who had contributed to earlier consultation activities that had informed the development of the consultation draft.

Alternative routes for providing feedback, by non-digital means, were also identified and promoted to the public. Flyers highlighting the consultation and how to get involved, both digitally and non-digitally, were issued to libraries, community centres and sports venues (via Leisure and Culture Dundee) for display in public areas. This

included the offer for a printed copy of the consultation draft and summary version to be provided to people via post or other means.

From late April 2023 until the end of May 2023 information on how to access the consultation draft was circulated (on-line) with an electronic feedback form. There was also a further offer to hear views about the consultation draft in other ways and to print and post copies for discussion.

As part of the Engagement Strategy, contributions made during the development of the Carers Strategy and the Learning Disability and Autism Strategy plus engagement relating to GP Premises Strategy was also used. This approach has helped to ensure that we make best use of the valuable time and effort people have given in contributing their views, as well as ensuring consistency as we develop the overarching strategic commissioning plan.

People told the Dundee Partnership they want to have more say in improving things in their communities.

They said that the IJB need to think more about how best to work with other organisations, including the Dundee Partnership, to improve all services and supports that make a difference to people's health and wellbeing. People said this is most important when working on ways to prevent poor health and wellbeing and making sure people get the help they need sooner. They also said that the IJB needs to think more about the help required to reduce the impact of the cost-of-living crisis on people's health and wellbeing.

They also said that the IJB should make sure that the Health and Social Care Partnership spend more time working with people and communities to understand the help they need to stay healthy and well. They also said the Partnership should then work with people to design services that will deliver the help they need. People said health and social care services should stop talking about models and pathways because these words don't mean anything to people who need services. It would be more helpful to talk about how services can give them the specific help they need and help them to look after themselves and one another rather than doing everything for them.

Learning Disability Services have hosted several events aimed at sharing information and hearing from people in their local communities. In 2023, information events were held in the North East, Broughty Ferry, Maryfield and the West End, and 4 more events will be held during 2024 and 2025. These are part of an ongoing dialogue between the Partnership and people with a Learning Disability as well as the workforce and family members/carers and help the Multi-Agency Strategic Planning Group shape plans for the future. Partner agencies and community groups also have an opportunity to listen to their potential customers and develop services that meet their needs. Unpaid carers and family members of this group of people expressed an interest in having a formal mechanism to learn about developments

and share their views. An initial discussion meeting took place with carers in December 2023 to explore and make plans for how this might best be achieved.

The Independent Review of Adult Social Care in Scotland

The Independent Review of Adult Social Care in Scotland (2021) found that there needs to be more focus on involving people in planning their own care, deciding what needs to change in their communities, and planning, designing and developing health and social care services.

The Value of Co-Production within Health and Social Care

In 2022 the Scottish Government began the process of developing a new National Care Service for Scotland. This will impact the way that adult social care, social work and community-based health services are delivered in the future. It might also affect the way that adult and children's services work together. The planned changes will be the biggest change to the health and social care system in recent years. The IJB will have an important role in helping to plan these changes.

Click here to learn more about the National Care Service in Scotland

Click the image to view the Scottish's Government's vision for the National Care Service in Scotland

Care Homes

The Dundee Activity Network and the Benefits of Being Involved

The aim is to improve the quality of life and physical and mental health and wellbeing of care home residents through offering person-centred meaningful activity which is focused on the needs, interests and hobbies of residents.

Activity Networks in other areas have been the catalyst for new innovative initiatives, including national pilots and can help facilitate inter-care home interaction, community involvement and intergenerational working.

Benefits of being involved in an activity network:

- Sharing of good practice, activity ideas and how to adapt, materials and resources
- Networking and support
- Training opportunities for care home staff
- Bring information from network back to the care home
- Facilitates collaborative working and inter-care home activities such as Go4Gold
- Opportunities to be involved in national initiatives

Since September 2023, there have been get togethers, events and some friendly competitions. More events, competitions and a Going4Gold event are planned for September 2024

"I just want to say a big thankyou to the residents and staff who put lots of effort into what they all made for the competitions and the judges who had the difficult task of choosing the winners. It was lovely to see everyone enjoying themselves and getting involved in a singsong. A big thankyou to Janet Brougham, Menzieshill House and Mackinnon Centre for being the hosts who put on lovely spreads of food and drink on the day. This was the first of many events, competitions, and a chance for residents to come together and socialise."

Carole Brunton, Independent Sector Lead, DHSCP, Scottish Care

Photos from the Janet Brougham Easter Card Making Competition held March 2024

Photos from the Menzieshill House East Bonnet Competition held March 2024

Photos from the Picture Making Competition at Mackinnon Centre


ONE
DAY
AT A
TIME

For a short time, the residents in Harestane enjoyed their very own Easter 'extravaganza' where they nurtured, named and documented the birth of chicks and ducks, from hatching to holding and feeding to farewell.

The residents named all the ducks and chicks and went in every day to handle and feed them. Doreen welcomed “John” (named after her beloved late husband), born 1400hrs on 21st March and thereafter, Edith welcomed “Chick” at 14.30. The following day kept everyone busy with the birth of Matilda, Michael, and Ralph. Meanwhile, the ducks started hatching that same morning with Franco named by their very own Franco, followed by Summer, Donald, and Georgie Porgie.

Shirley, Tweet, and Lucas (chicks) all arrived on the 23rd and finally, duckling number 5, Tarka.

Maggie, Manager stated

“This lifted everyone’s spirits, the residents loved them and really took part in the activity. The ducks and chicks were in Harestane for 10 days and it was magical seeing the ducks take to the paddling pool 24 hours after hatching”.

Staff at Janet Brougham House and one of their resident’s family have been participating in the AIR project which is run by St Andrews University. This focusses on different ways of communicating with residents who have limited verbal communication. This is proving to be very effective in their interactions with the residents and in support of a resident who was experiencing severe agitation. Stacy, Manager stated *“It has also been rewarding in the sense that we have supported a family member to ‘find his wife again’ by offering him the opportunity to attend the training. His wife who is one of our residents has advanced dementia, and this has helped with their communication.*”

Turriff House were looking to have their main corridor redecorated and the staff wanted to get the service users involved to give it a more personal touch. They

collectively came up with the idea of a photography project with the service users taking the pictures and getting them put on canvas to hang on the walls. Stuart Laverick (Activities Co-ordinator) said

"We have had the perfect opportunity to get some beautiful pictures as we go out on a bus tour every Wednesday to places like the Botanical Gardens, Forfar Loch, and the Japanese Gardens to name a few, as well as places that have got significant individual memories for the service users. As this was so successful, we are continuing with the project over the summer months this year."

There are so many great pictures, which meant the service users and staff had a hard choice of picking the ones that are now proudly on show in Turriff House.

Benvie Care Home - Project Smile

At Benvie Care Home, they have made it their mission for 2023 to investigate new ways of stimulating their residents' minds, providing reminiscent therapy, and keeping a smile on their faces.

In April, they had a friendly visit from Annie the Alpaca. Annie naturally had a gentle and affectionate manner due to her upbringing on a farm. Many of the residents adored Annie and it brought smiles to the residents, staff and relatives faces.

The latest project which includes the resident, relative and staff members all getting involved, is to find out the hopes, wishes and dreams of our residents. The job of Benvie is to then make those hopes wishes and dreams come true.

Their resident Ron has been a keen golfer his whole life and was a regular at Rosemount Golf Club where he was a member for 70 years. (There is even a bench in his father's name). His dream was to take a trip down memory lane and see the course one more time. Staff were thrilled to hear all about Ron's stories and the many memories he had created over the years. Ron's family also joined on the trip and were over the moon to see he could still putt a few balls. Ron still speaks about the golf club today, and we are in the process of arranging another visit for him.

Another project recently completed was the Welcome to Benvie Care Home Board. They wanted to make something which was bright, welcoming, and personalised. There were sixty-five residents and staff members who participated. Having classic music on in the background, residents,' and staff both dancing, and getting involved in the activity, created a lovely experience and great atmosphere in our Home.

They have been looking into new technologies to help stimulate our resident's memories. They have incorporated sensory boards, blankets and cushions which offer a variety of sensory functions created to stimulate cognition. Phyllis, one of their residents, uses one of the cushions daily and enjoys playing with all the different elements on the cushion.

Menzieshill House team, residents, young volunteers, and children were recognised by Generations Working Together Excellence Award 2023, for their hard work towards tackling age discrimination.

Promoting intergenerational practice in care homes in turn tackles age discrimination and stereotypes, thus creating inclusive communities for people of all ages. The award recognised Menzieshill's activity programme for promoting quality outcomes for all involved. The activities are organised carefully with the focus of making a difference in breaking down barriers and building understanding between generations. The work has been seen as progress towards enabling inclusive communities and is particularly notable because of progress made to re-establish links to the local community after the Covid-19 pandemic. Intergenerational activities involved pupils from Tayview Primary School, Menzieshill Nursery, as well as the local high school and Helms college.

The activity programme is run throughout the year, which focusses on boosting resident's wellbeing and reducing social isolation. Menzieshill's intergeneration approach plays a crucial role in achieving outcomes for residents whilst also benefitting younger people involved. Activities included most recently: 'The journey of the duck egg hatch,' storytelling, singing, sports days, gardening, arts, and crafts. Primary school and nursery children get to know the residents individually and learn how games, toys and technology have changed over the years. Young volunteers provide 1-1 social sessions with the residents and form social bonds.

One of the care home residents said of the young people;' They are lovely. They all have their own idiosyncrasies and personalities- I love getting to know them. They take me right back to when I was that age.

Balcarres Care Come won the Scottish Care, Care Home Service of the Year Award

Lynn McLean, Manager stated

"It was an amazing achievement for everyone at Balcarres when we won the Scottish Care, Care Home Service of The Year Award then a regional and a national award from HC-One all in the space of a few months, I am one proud home manager."

One of the judges quoted

"*Balcarres is a very person-centred organisation and what really stood out was the mutual respect between Lynn and her team and residents alike. It is no surprise that word of mouth is so positive. We were particularly impressed with Lynn's unique approach to managing funerals and making residents dreams a reality."*

Examples of why Balcarres won their awards:

Funerals - When a resident dies, they may have a reduced amount of family, so the care home holds the wake with a buffet and beverages to celebrate their loved one's life and experiences with the staff and residents at Balcarres.

Wishes - A couple had a wish to have lunch in Forgan's, St Andrews as this had been one of their favourite places to go – Balcarres booked a table for them and arranged the whole day - they both had an amazing afternoon.

On another occasion, a resident wanted a surprise for when his wife visited the home to see him on Valentine's night. Balcarres purchased chocolates and roses and set a table for them both where they were served an a la carte menu. The wife was absolutely delighted and was a huge success that Balcarres continue to offer.

Supporting Tayside Excellence Programme (STEP) for Tayside Care Homes

The STEP was designed to improve and enhance care to residents collaboratively within Tayside; created as a supportive tool that provides the ability to self-assess against the healthcare framework for adults living in care homes, making reference to the health and social care standards.

The STEP is collaborative and looks at a whole system approach to the delivery of care to residents and allows us to identify where there is a need for improvement, where support and resources can be provided to enable this to happen.

Following an initial pilot phase, the full programme was rolled out to all care homes across Tayside from July 2023.

Urgent Care Home Visiting Team

The Urgent Care Home Visiting Team of Advanced Nurse Practitioners provides a same day response, on behalf of the GP to care home residents who are deteriorating or are acutely unwell.

The Team supports care home staff to identify people approaching end of life, supporting symptom management and end of life care.

The Team works closely with multidisciplinary colleagues to support residents, their relatives and care staff to prepare for, and deal effectively with the transition to end of life.

The use of evidence-based assessment tools including Supportive and Palliative Care Indicators Tool (SPICT) and the Gold Standards Framework Proactive Identification Guidance were used to identify care home residents who would benefit from a palliative approach based on their individual need.

GP appointments data from January 2022 to December 2023 was reviewed and 18 people were identified as living with potential palliative end of life situations and therefore the working relationship between GPs and Care home staff was developed. Through training and support from the palliative care team, care home residents were able to be assessed to ensure they were receiving the best approach of care to meet their needs.

"ANPs work extremely hard.....this is an excellent service.....enhanced my home through support and care...GPs pass a lot to them" GP

"I was struck this year by how many patients identified as having cancer or long-term health conditions had been care for at the end of their lives by your colleagues. Thank you" Care Home Manager

"This team is now and integral part of the MDT for staff in care homes to feel supported and valued. Really good therapeutic relationships have been established" Senior Carer

"We appreciate the single point of contact and the consistency of having support from one team rather than a large number of GPs" Care Home Staff

Feedback regarding Kingsway Care Centre

"Each time I have visited I have witnessed such tender, kind considerate specialised care. I genuinely feel that every time my dad sneezes someone will wipe his nose for him! The nurses persevered as best they could to trim his moustache. His nails are always clean and trimmed and whichever clothes he has on they are always clean and coordinated.

My Dad loves his food and I know that he eats a well-balanced diet every day and that he enjoys plenty of varied treats !!

He engages with staff and residents as they play Dominoes and Bingo. He is accompanied on walks or in a wheelchair regularly to the local restaurant/pub where he enjoys a half pint and a new environment. The staff play his favourite music for him, and he still has a wee dance with them when he is able.

His bedroom is always clean and tidy and personalised with photos and I know the staff relate to these photos with him daily and encourage him to listen to their understanding of the photos and the good memories they recall for him.

Sadly, my Dad is unable to communicate with appropriate words now but staff sensitively guide him and remind him of the stories behind the photos. That is a truly precious act in itself and one that my Dad and I hugely appreciate.

My Dad cycled all his life and the staff have had him on the Ward exercise bike as often as he would engage ant tolerate. They read his books with him and point out

the window to the Birdlife in the Garden and encourage him to participate with any other ward activities he may enjoy.

Every phone-call I have made has been answered quickly, professionally and with minute detail of care given which gives me great peace of mind especially as I cannot visit as often as I want to.

Each member of Staff are remarkable and utterly dedicated people. They are a tribute to each and every person in the caring profession".

Step Down Care

There are 3 Step Down properties in Dundee which support discharge from hospital.

- A total of 614 bed days were saved during 2023-24. In addition to better outcomes for people than if they were in a hospital setting, there was a financial saving of £196,490.

Services for People Affected by Cancer

Tayside Cancer Support Service

Tayside Cancer Support Service is a Dundee based charity that cover the whole of Tayside and North East Fife and offer vital support to those affected by cancer;

- 121 counselling +/- complimentary therapies (short waiting list)
- befriending
- monthly drop-in cafe at St Aidan's Centre Broughty Ferry

MacMillan Cancer Support

The Cancer Strategy for Scotland 2023-33 person-centred care for all objective requires all cancer care pathways to include a TMICJ service providing key workers, holistic needs assessment, triage and help with navigating complex cancer care systems. Tayside has TMICJ services with local link workers in Angus, Perth & Kinross and Dundee City hosted by multiple organisations. Macmillan and Scottish Government fund 5wte link workers and one administrator.

The Tayside MacMillan Improving the Cancer Journey Service supports the national cancer strategy by enabling access to person -centred care for all:

✓ TMICJ is an essential listen, assess, plan, triage and coordination service for people who need/want non -clinical community -based support and care during their cancer experience.

✓ TMICJ takes up referrals at every phase of a person's cancer journey and facilitates access to prehabilitation, rehabilitation, reablement and palliative interventions.

1,419 care plans were provided across Tayside, of which link workers performed an average of 3.7 actions to support individuals reduce their concerns and access supportive care.

There was 100% increase in activity between March 2023 and March 2024, evidencing investment in additional 2.5 link workers plus promotion and engagement has improved access and use of this service.

People mostly want supportive care during treatment (34% 2023-2024, slightly up on 30% 2019-2024). More people are using the service at the point of diagnosis (increase 9% to 13%) and started to use ICJ to access prehabilitation (1%), with work planned to increase this access point. 16% of people in palliative care used ICJ, up from previous periods (12%), again due to targeted professional engagement.

Practical concerns – just under a half (47%) of all people wanted to talk about and explore help with practical concerns, dominated by money worries, social support, transport and housing.

Physical concerns – Just over a third of people wanted help with physical concerns with moving about the top issue, followed by eating and fatigue. Leads facilitated learning about moving more interventions and link workers participated in move more sessions to help shape effective conversations and enable take up of local interventions.

Emotional and family concerns – accounted for 15% of concerns raised with link workers. 6% of people wanted to discuss family concerns.

Referral to partner agencies – along with the increase in referral activity, service offer improvements and partner agency engagement has led to a significant increase in referral and signposting activity during 2023, up from 2022 by 68% and 830%, respectively.

The intended outcome is to connect people to tangible interventions that impact positively on their health and wellbeing AND specifically to help people take up the intervention at a time when they cannot or may not feel like doing something to help themselves.

This has been achieved by enabling access via referral to over 69 referral partners and signposting/ sharing information to over 100 available supportive care services.

Post Diagnostic Support

The Post Diagnostic Service in Dundee has grown within the last 5 years, developing from a team of 5 to 11 this introduced an additional Mental Health Nurse, Occupational Therapist and a further 3 link support workers. The expansion in the team ensured staff were undertaking educational opportunities - taking part in group facilitation training, confident conversations, playlist for life, POA and Capacity training and so many more which now enables staff to deliver groups such as CST, supporting people living with young onset dementia, carers groups, post diagnostic groups that enriched the lives of people living with dementia and their carers.

As the team grew the service needed to ensure they continued to develop effectively as a service. We needed to create a more cohesive strategy for a continued gold standard service and were delighted to be selected as an improvement site for a Care Co-ordination project with Healthcare Improvement Scotland.

Four main areas we focused on were:

1) Closer working relations with primary care

2) Closer working relations with AHP, Particularly Speech and Language Therapy

3) Improving our care co-ordination, planning and delivery

4) More confidence in promoting our service

The team now have a better understanding of our role in the wider context of improving outcomes for the people of Dundee and more confident to put ourselves forward and take on challenges for the improvement of the service. PDS staff feel more confident about going into communities and raising awareness of dementia and also now looking to adopt tools like the RESPECT document that is being promoted throughout Tayside as a tool that we can use to continue to push the boundaries of our service to incorporate a more holistic approach ensuring we can discuss Advanced Care Planning in a more confident and self-assured manner.

The service also made an appearance on BBC Scotland highlighting the high-quality service they provide.

How gadgets are helping a couple live with dementia

Community COPD Service

Our service continues to provide care and support, including palliative care to all housebound patients via a designated practice link nurse. They are also available to provide remote clinical advice and support for GPN/GP, as requested, for patients with severe and complex health needs.

From 1st July to 29th February 375 referrals were received from 21 of the 23 GP practices.

The COPD team has developed a community-based patient assessment (NPA) clinic for patients with suspected COPD for all Dundee practices. This service provides holistic assessment including spirometry, diagnosis, initial treatment planning and any onward referral/referral advice for those with suspected COPD. This provides continuity of care in the diagnosis of COPD in the City.

4 additional pathways have been added to the COPD discharge service to help to identify patients with worsening of their COPD and offering Specialist Nurse assessment including medication concordance, patient/carer education and referral onto other support services if required. These help to reduce unnecessary admission through the earlier identification of vulnerable people and working with them to assist them to manage their disease with specialist education and support. These pathways are with Scottish Ambulance Service, Out of Hours via a 3-month trial, A&E and Community Advanced Nurse Practitioners (ANPs).

Patients who historically would have been conveyed to hospital by ambulance when they become breathless can now be referred from Scottish Ambulance Service. This pathway facilitates direct communication between ambulance clinicians and the COPD team. The COPD Clinicians then follow up patients at home and undertake appropriate interventions including non-pharmaceutical evidence-based interventions to help manage breathlessness in the home.

We continue to review the service and look for new ways of identifying and engaging with COPD patients. We have formalised a pathway between DECAT and Community Nursing ANPs that will ensure patients have access to COPD Specialist Nurse follow up at home following an acute exacerbation of their COPD which was treated at home by these services.

Pulmonary Rehabilitation classes, led by Physiotherapy colleagues, at Kings Cross Health and Community Care Centre are supported by the COPD team.

COPD Practice Link Nurses support practice facilitation discussions with the Respiratory GPN +/- GP in each Practice.

In September 2023 we reintroduced the COPD annual educational event to which Practice-based staff with an interest in COPD were invited. This year's event has also been opened to Community ANPs and Secondary Care Respiratory Liaison Nurses.

District Nursing

The introduction of the Clinical team Leader (Advanced Practice) in Dundee District Nursing Service has resulted in many positive outcomes for patients and reduced workload for GPs.

This service was designed by engaging in collaboration with other services, such as DECAHT, engaging with District Nursing teams and GPs to promote the role and build professional relationships.

Case Study: Supporting Advanced Decision Making

Referral from District Nursing team to an age 60+ female due to a suspected chest infection and urinary retention.

Past medical history of COPD suspected upper GI cancer which patient does not wish to investigate, low mood with previous self-neglect and very poor mobility and requirement for a stand aid to mobilise from bed to wheelchair.

A package of care was also being provided.

Consultation and clinical examination was undertaken which determined an infective exasperation of COPD (IECOPD). Clinical supervision was provided during this assessment to develop competence around clinical and prescribing decision making.

CTLAP were able to prescribe treatment for this. During the assessment, it was also discovered that this person had excoriated, irritated skin to her arms and legs. An appropriate emollient was prescribed to treat this and relieve discomfort. Bloods were also obtained for differential diagnosis as well as bladder scanned to avoid unnecessary catheterisation. This person was added to the caseload for a review following treatment of IECOPD.

Case Study: Autonomous Advanced Decision Making

District Nursing Team were attending daily to an age 90+ female with a leg wound.

District Nurse requested a visit by CTLAP as they felt that this person needed more antibiotics as they thought her leg was still infected.

Past medical history of atrial fibrillation, dementia and heart failure.

After conducting a full assessment and consultation, it was determined that she had a prevalent cellulites and bilateral oedema in her legs and sacral oedema indicating fluid overload secondary to her diagnosis of heart failure. This was in turn affecting her mobility resulting in an increase in falls. She also didn't have the most appropriate dressing choices on her leg wound.

Prevention of leg wound healing dur to oedema and infection. A wound swab was sent, antibiotics were prescribed for cellulites whilst awaiting swab results. Her diuretic was also increased. Her wound care plan was also updated to a more appropriate choice according to the wound formulary, including the addition of Prontosan soaks to reduce microbe / bio film of wound. Bloods were requested in 7-10 days for review following increase in diuretic. A physio referral was also submitted as a request for the District Nursing Team to continue wound care with the updated wound care plan, obtained repeat blood pressure on next visit following an increase in diuretics and to complete falls assessment on next visit.

Feedback:

"I've found you approachable and relatively easy to access, you call back promptly if you're not able to answer your phone. You've been great for discussing patients and ideas with. You are decisive if you think it's an appropriate request that we're making, if not point us in the right direction of who can help" Community Charge Nurse

"I can speak on behalf of all the Drs here at the practice when we say that we really appreciate your help and support to our DNs with regards to patients. You have been very helpful and logical in your approach to patient care" GP

Dundee Community Treatment and Care Services (CTACS)

CTACS offers treatment room care to non-housebound patients across Dundee. We offer phlebotomy, biometrics including BP measuring, chronic disease monitoring, wound care including removal of clips or staples, assessment and management of leg ulcers and Warfarin monitoring for non-housebound and housebound patients. We also have a catheter clinic 1 session per week for routine catheter changes for non-housebound patients.

Key achievements:

- Leg Ulcer Clinic waiting list reduced to 4 - 6 weeks
- Additional Phlebotomy clinics reduced waiting lists for routine blood appointments same week availability for some locations
- No waiting lists for ear irrigation
- Additional non-medical prescriber for service will improve patient care and reduce GP workload
- Leg Ulcer Clinic commenced new bandaging system benefits to patients less bulky and lighter easier to tolerate, quicker to apply

- Reducing phlebotomy appointment slots to 10 mins has increased capacity which offers more availability to patients
- Wound healing rates increasing patients satisfied wounds cared for and healing well

Care at Home

The Care at Home Team has been involved in many projects where they worked and planned with others to improve pathways and services for the people they support

- Thematic Fire Review which included Risk Recognition and Hoarding and Clutter Risk Training and also changes to paperwork and assessments to incorporate fire safety discussions and evacuation plans
- Technology Enabled Care 'Try Before you Buy' scheme
- Falls Prevention and Education Training which includes co-working with SAS, Falls Team and Social Care Response Service

Reduction of 428 falls through this joint project so far

Case Study

Mrs A is an age 90+ female who is a frequent faller (3+ occasions), has osteoarthritis, angina and reduced mobility. After falling at home, she was initially supported by the Social Care Response 'Community Alarm' Team. An assessment was undertaken, focussing on the key areas and was supported with pieces of equipment from Occupational Therapy, provided with advice and referred to a 6-week strength and balance programme and she has had no falls since.

Case Study

Mrs B has advanced dementia and she has been receiving support from the Social Care Response service for approximately 1 year. In that time Mrs B's health and wellbeing has deteriorated and she has been prone to wandering and falling, resulting in admissions to hospital as she was injured. Once home this pattern continued and the social care response team referred Mrs B to the falls screening and assessment team for support. Mrs B was also assessed for a care package to help her in the morning and evening. The Resource Matching Unit sourced this package of care for Mrs B to allow her to be supported at home. The Social Care Response service also deployed a Technology Assessor to meet with Mrs B and her daughter and they took a person-centred review and along with Mrs B's daughter decided to install a bed sensor and door sensor linked to Community Alarm to safeguard Mrs B if she left the property. Mrs B and her daughter were also provided with a GPS tracker on loan, for if in the event she did leave the property Mrs B's daughter could locate her. An Mrs B's dementia was advancing, the Technology

Assessor also installed a Community Alarm and a heat sensor, in the event of a fire a rapid response could be given as the Community Alarm team would alert the Fire Service. With the support of SCRS Mrs B and her daughter were kept safe an informed, regular reviews were held to confirm the technology was still meeting the needs of Mrs B. Mrs B's daughter fed back that this was a 'lifeline' for her and her mother.

Discharge Planning

Work has continued to improve existing discharge planning processes and pathways as a means of reducing inpatient length of stay, as well as optimising outcomes for people by supporting discharge and provision of care closer to home as soon as appropriate. An enhanced flow coordinator role has been introduced within the Discharge Team which further strengthens the communication and management of capacity and flow across patient pathways.

Performance in relation to delayed discharge has continued to improve throughout the year despite a sustained increase in unscheduled admissions. Since a peak of delayed discharge in mid-August 2022 of 18 acute delays, and a total of 55 delays across all sites, performance in relation to the locally agreed RAG (Red, Amber, Green) matrix has consistently been in amber status since the beginning of May 2023 and continues to reduce. This demonstrates a specific improvement in relation to the management of non-complex delays, the reason for which had predominantly been the ongoing increased demand for social care.

Additionally, within Community Urgent Care and the Medicine for the Elderly medical workforce, all staff have now aligned around GP cluster teams with the aim of creating more effective and efficient virtual teams who communicate across the whole system to promote intervention on the basis of ‘right place, right person, right time’. This is a further step in the strategic plan to move to a whole system pathway approach which promotes early intervention and prevention of admission wherever possible by providing enhanced care and treatment closer to people’s own homes.

98.5% of all discharges were without delay

96.7% of all 65+ emergency discharges were without delay

91.5% of all Medicine for the Elderly discharges were without delay

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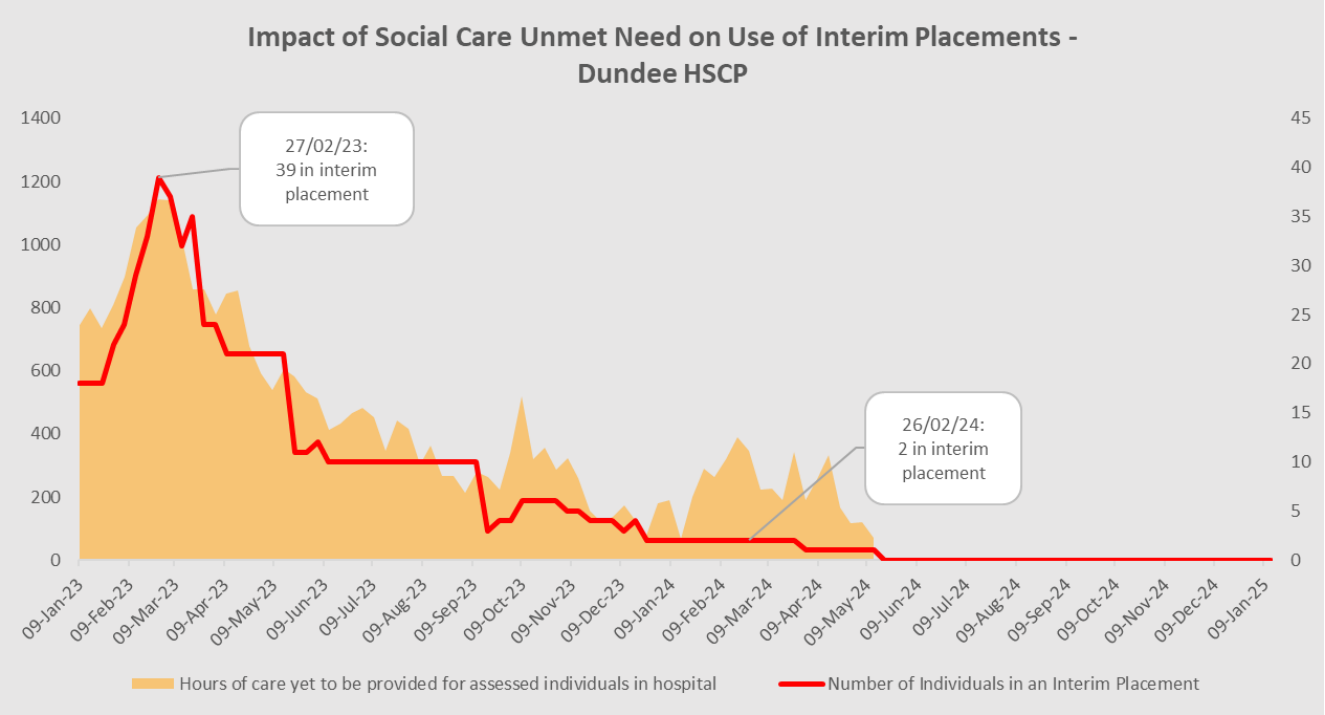
To view more data about discharge management please click here

As a result of the improvements relating to social care, the bed days lost has gradually dropped over the year. In April 2023, 604 bed days were lost as a result of reportable delays in acute, compared to 94 in April 2024.



Use of interim placement as an alternative to being delayed in hospital awaiting services has gradually reduced in line with the reduction of social care unmet need. Social care is now more readily available, meaning patients can go home with services rather than an interim move to 24-hour care to await.

The cost of an interim placement during 2023-2024 was circa £800-£900 per week – in line with Care Home Weekly Rates for residential and nursing care. The cost of a standard 4 x daily care package (15.75 hours per week) is around £328pp/pw based on the 2023/24 hourly rate of £20.82.

In February 2024, there were a total of 39 patients in interim awaiting services. If we assume all patients are placed in a residential setting, the cost to the HSCP per week would be around £31,200. If we assume all those in interim were awaiting a 4 times daily package of care, the cost to the HSCP would have been £11,700 – a difference of £19,500 per week.

First Contact Physiotherapy and Musculoskeletal Service Dundee

Musculoskeletal problems frequently cause repeat appointments and are a significant cause of sickness absence in Scotland. The majority of a GP's musculoskeletal caseload can be seen safely and effectively by a physiotherapist without a GP referral. However, the existing patient pathway often includes an unnecessary delay while initial non-physiotherapeutic solutions are attempted prior to access to a musculoskeletal physiotherapy service. There are variable waiting times across the country for access to face-to-face physiotherapy. Physiotherapists are already well situated to work collaboratively with primary care multi-disciplinary teams and support the GP role as a senior clinical leader. Physiotherapists are an expert professional group. They have a high safety record and are trained to spot serious pathologies and act on them. Physiotherapists utilise their wider knowledge and skills as part of their assessment. A first point of contact service could also be seen in the context of the wider musculoskeletal pathway. Under the new contract, HSCPs will develop models to embed a musculoskeletal service within practice teams to support practice workload. In order to provide a realistic alternative for patients, access times must be comparable to those of general practice.

The FCP service operates a hub-based model with four locations spread across Dundee City - MacKinnon in Broughty Ferry, Maryfield, Ryehill and Lochee Medical Practices. The FCP service aims to deliver efficient, high-quality management of MSK patients evidenced through achievement of clinical outcomes and feedback from patients and clinicians. It is accessible to all Dundee GP practices and although delivered primarily via in-person appointments, can be accessed via telephone or video consultations (NearMe) when required.

The main deliverables of the service include

- Release of GP appointment capacity
- Timely access to specialist assessment and advice
- Early promotion of self-management strategies
- Coordinated pathways of care
- Reduction in onward referrals e.g. imaging, secondary care
- Right person, right time, right place

Last 12 months

FCP appointments are currently released daily (one week in advance) to ensure those appointed are seen in a timely manner. Individuals are offered an appointment within one of the four Hub locations on a day and time that is suitable to them.

Over the last year, FCP capacity has improved following successful recruitment. Development roles have also been recruited with a view to increasing capacity further following a period of training.

In order to truly ease the burden on GP practices, up-skilling physiotherapy staff to be able to function independently of the GP where safe and appropriate to do so is essential for both streamlined patient care and to reduce the number of patients being re-referred to the GP for further review. Previous research has highlighted that up to 2% of patients attending physiotherapy services will require blood investigations as part of their assessment or ongoing management and the Chartered Society of Physiotherapy (CSP) also recommends access to these investigations is organised as part of implementing an effective FCP service. The FCP Clinical Lead has worked in partnership with the GP Sub Committee to ensure blood investigations can be requested and acted upon safely within Dundee. The aim is to roll this out in July/August 2024.

Following a legislative change in July 2022, Physiotherapists are now legally permitted to certify FIT notes. The FCP staff group have therefore also completed the necessary training (agreed nationally) to offer this to appropriate patients and reduce the need for signposting back to their GP.

During Covid, the MATS service, accessed via NHS24, was stepped down. Patients no longer had the option of completing a self-referral for MSK Physiotherapy services. Whilst the national direction to replace MATS is discussed and designed, the Dundee MSK service has introduced (April 2024) a guided self-referral option that can be completed and returned to the MSK service electronically or via the post. Early indications suggest this has been received well by GP practices and patients and has created capacity across the pathway of care.

" The difference in my physical and mental health is immense and I am very grateful."

"....my symptoms were complex and the physiotherapist helped me understand that even though not curable that there were certain exercises that I could do to help my situation. I am still in pain but the physiotherapist helped me cope with this pain and helped me enormously, I thank her greatly"

".... I got a prompt appointment with an excellent physiotherapist. I was reassured and my confidence was boosted"

"I go to physiotherapy at Kings Cross and I feel more confident after it. Really makes a difference and the staff I've seen have been great"

".... very professional service. Thank you..."

"The physiotherapist has been so helpful, with appropriate exercises and has given me confidence"

"I talked about something related to my physiotherapy which was very personal and sensitive during the consultation and the physiotherapist was genuine, kind, empathetic and positive about it. This helped me feel comfortable and confident..."

Violence Against Women

Women's Hub Dundee Violence Against Women Partnership have worked alongside a wide range of partners to develop Dundee Women's Hub, which opened in 2023. Practitioners working and engaging with local women recognised the need and desire for a women's only space for 1:1 support appointments, drop-in support, groups and activities. The Hub is a multi-agency support hub for women impacted by substance use and other disadvantage such as gender-based violence, homelessness, poor mental health, isolation and trauma. It provides gender-specific, trauma-informed support for women to make informed decisions regarding their support options, reduces barriers to accessing support and helps to improve their overall health and wellbeing. The Hub will continue to evolve and adapt their support based on listening to the voices of women.

The Corner

The Corner is a service which aims to enable and empower young people to look after and improve their health and wellbeing. The service continues to offer a wide range of initiatives in response to feedback from users, for example:

• Young People's Involvement Group - service users and interested young people get involved in supporting the work of the Corner and contribute to service improvement.

• The substance use support service STRIVE, in partnership with Hillcrest Futures, has expanded to support people aged 12-21 who are affected directly or indirectly by substance use and are homeless or at risk of homelessness, or struggling with school, family or friends. The service offers holistic health and well-being checks and provides 1:1 emotional support alongside harm reduction education. The service provides a whole family approach and has a dedicated family project worker. The Housing Education for Youth (HEY) project continues to deliver awareness and housing support information to all S4 pupils, in partnership with stakeholders from housing, homeless and young people's services (Action for Children, Angus Housing, HELM).

• The Corner continues to support the Early Years & Young People Team within NHS Tayside with their annual drama tour addressing young people's emotional wellbeing. All S3 pupils across Dundee watch a live performance of the Drama tour identifying health issues facing young people, such as substances, mental wellbeing, and sexual health. The Corner and other services are involved in a Q&A panel afterwards to answer any questions regarding health and wellbeing.

• The Corner delivers targeted outreach services to improve awareness of Corner services and offer tailored sessions on a range of issues faced by young people. Joint programmes with DCC Community Learning and Development teams are being developed to co- deliver certain aspects of health interventions to identified groups.

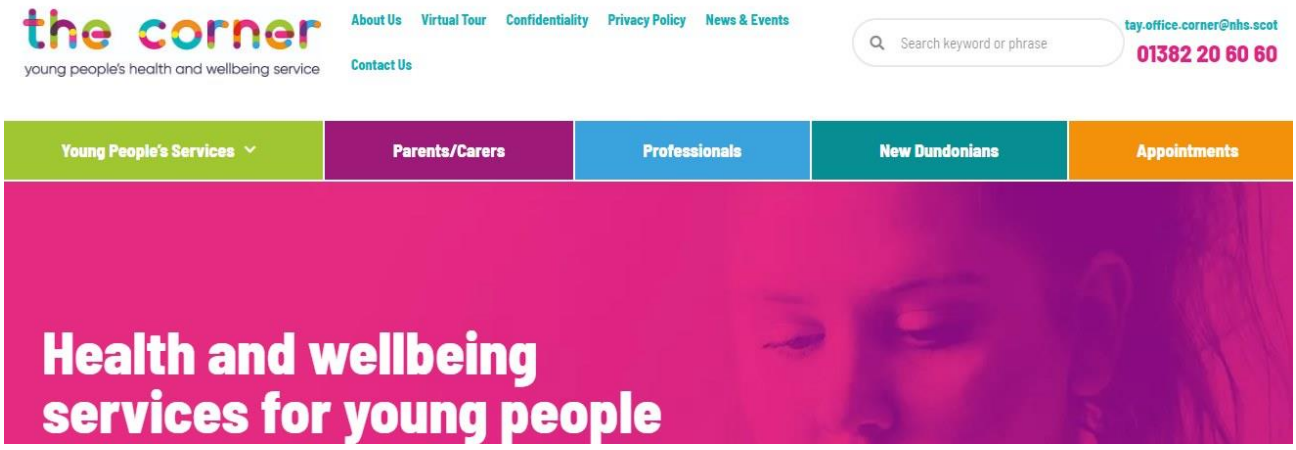
Detached Outreach continues to be delivered in partnership with Hot Chocolate and DCC Community Learning and Development team.

• The counselling service continues to provide one-to-one counselling to young people with mild to moderate emotional wellbeing issues. The counselling service offers up to eight sessions in a flexible and accessible way. Options include receiving support in-person, online, telephone and walk and talk.

• The Corner continues to work in partnership with Dundee Carers Centre, secondary schools and wider partners across the city to offer and deliver Health and Wellbeing checks to identified Young Carers aged 12-25. The checks also identify and address any unmet need by offering one to one support for identified Young Carers or linking them in with the Carers centre or identified services.

• Monthly attendance at local LGBT Young People's group with agreed session plans based on young people's feedback.

• The Corner drop in continues to provide health and wellbeing support to young people across the city. Open Monday to Friday 1-6pm, the drop in offers a range of service to young people. Every young person is offered a holistic health and wellbeing assessment, which identifies and addresses any unmet needs. Sexual health provision offers contraception (pill, patch, injection, implant insertion and removal), emergency contraception, pregnancy testing, sexually transmitted infection screening, free condoms, condom demonstrations, free sanitary products and support for termination of pregnancy.



Click here to view The Corner's website

Positive Steps

Positive Steps has been funded to provide a Crisis Response Outreach Service (CROS) to individuals who are in high level of crisis. CROS will provide a responsive, proactive, and personalised approach to supporting individuals. Dundee has a wide variety of specialised support agencies both statutory and third sector and often the barrier to engagement with these services is attendance and proactive engagement. Many of the most vulnerable within our communities find it difficult to coordinate and attend their support needs. CROS will contact individuals with 72 hours of the referral. Contact will be made by a variety of means and this will be dependent on the individual. CROS will call, text, visit homes, properties, know addresses, pharmacies, begging spots etc to make contact and will continue to try various methods until these are exhausted to engage the individual.

CROS will provide the catalyst to engagement with specialised services and support individuals to engage with the right support at the right time for them. CROS will coordinate support appointments and services, support individuals to attend, signpost to expert services, support individuals to understand their options, provide a “sticky” approach to support and complete welfare checks for those most at risk of harm.

CROS will follow the “Lead Professional Model” and can be the main point of contact in the early stages of the support journey. A needs assessment will be completed, and support needs identified will be prioritised with the individual. An action plan will be compiled with the individual and with consent, can be shared with support partners. CROS will discuss support options, source, and attend the chosen support with the individual to ensure engagement. This could take many sessions dependent on the needs of the individual and the issues they are facing. Time spent with individuals will be used to gain trust, cultivate relationships, and identify their needs.

Click here to find out more about Positive Steps

Tayside Adult Autism Consultancy Team (TAACT)

Tayside Adult Autism Consultancy Team (TAACT) works across the whole of Tayside and has its main base in Dundee. The Team includes a range of different professionals who have skills and experience in working with people with Autism Spectrum Conditions (ASC). This includes psychologists, occupational therapists, psychiatrists and speech and language therapists. The number of people coming forward asking to be assessed for ASC has increased markedly and the level of demand has resulted in significant waiting times. To make sure that we can better meet demand, a new Consultant Clinical Psychologist is leading the team and building up increased numbers of staff. A Partner organisation has also been commissioned to see people who have been waiting to be seen. This will result in waiting times decreasing and mean that TAACT staff can offer more direct work to people with complex needs and more consultancy to staff in other services already helping people with ASCs.

CONNECT

CONNECT is a new service for people experiencing psychosis for the first time. Around 43 new people experience psychosis for the first time every year and well-established research from around the world demonstrates that a particular approach - Early Intervention in Psychosis (EIP) - results in fewer people needing to go into hospital, shorter hospital stays for those who do and better longer-term wellbeing (including fewer relapses in the future). A key element of EIP services is early assessment and engagement with people and their families/supporters to build strong therapeutic relationships. CONNECT provides people with a compassionate safe haven when they can be at their most distressed and people can remain with the team for up to 2 years. It provides an encouraging, secure base to help people understand their experiences, develop and test out new skills as they recover. Importantly CONNECT enables people to access evidence-based care and treatment with a particular focus given to psychological and occupational recovery in addition to the use of medication if a person wants to take this.

The CONNECT team are now well established and work closely with other mental health services to ensure that everyone who may be suitable is found and seen quickly. Around 8 people a month are identified as possibly having a first episode of psychosis and around half-of these are confirmed as this being the case. Most people wait only 4 days from point of referral to being seen and everyone who has been engaged in treatment has stayed in treatment. CONNECT are already demonstrating that people they work with are going into hospital less than people who don't receive an EIP approach and a high number of people are returning to education/employment as they recover. Whilst at the moment CONNECT is only funded for three years and available only in Dundee, it is hoped that the model will be used across Tayside (keeping Dundee as the main hub) and will be continued in the longer term.

Image of some of the CONNECT team during a Ministerial Visit

Adult Support and Protection

A Joint Inspection of Adult Support and Protection took place between August 2023 and November 2023 with the report published in December 2023. This was a second phase inspection conducted by the Care Inspectorate at the request of Scottish Ministers with the focus on whether adults at risk of harm in the Dundee partnership area were safe, protected and supported. The joint inspection team found that key processes and leadership for adult support and protection are 'effective' with 'clear strengths supporting positive experiences and outcomes for adults at risk of harm, which collectively outweighs for improvement'. An improvement plan was submitted for the priority areas identified including consistent application and quality of investigations.

The inspection team identified six key strengths within the Dundee Partnership:

The way in which the Partnership responded to concerns about an adult at risk, including how quickly initial inquiries were carried out and the role of Council Officers in supporting investigations.

Attendance at case conferences by multi-agency partners and good collaborative working to support and protect adults at risk of harm.

How partners worked together though review case conferences and care groups to continuing to address risks to adults through protection plans.

Dedicated support from NHS Tayside Adult Support and Protection Team to members of the workforce involved in adult support and protection work.

The commitment of senior staff to including the voice and experience of adults at risk to influence strategic planning, including the voice of lived experience at the Adult Support and Protection Committee.

"There has been a good measure of success, built on strong engagement strategies inclusive of staff and people with lived experience"

The shared vision on senior staff, including innovative and ambitious plans to meet complex needs of adults at risk of harm in Dundee.

The inspection team also found six areas for partners to continue to work together to improve services and supports. This included: improving the quality of investigations, chronologies and risk assessments; completing ongoing work to update guidance and procedures; improving systems for quality assurance; improving the pace of improvement; and, making sure that improvement work is resourced and supported. Through the Adult Support and Protection Committee the Health and Social Care Partnership has agreed improvement plans to address these areas for improvement.

Click here to read the full inspection report

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

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