



Introduction

Welcome to the August Integration newsletter, and thank you very much for all your feedback and comments on the last edition. We hope we've covered some of the main topics you told us you'd like to hear about in this issue. One of them included what the 'big themes' are for how we'll be working together as a partnership to achieve our goals, and how partnership working is making a difference for the people who use our services. As ever, keep [letting us know](#) about anything else you'd like to hear about.

Some of you have also told us that you're finding the newsletter useful to share with people you work with, so if there's anyone you know of who doesn't already get the newsletter, but would like to, you can [email us](#) to find out about adding them to the mailing list.

Chief Officer's message

In the Spotlight

What integration
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Chief Officer's message



I hope this month's newsletter will show you how we're moving ahead at a pace on our integration journey while we work towards having an approved Integration Scheme - the document that enables the establishment of our Integration Joint Board (IJB). The IJB will then effectively run health and social care in Glasgow city.

The main function of the Integration Joint Board (IJB) is to establish the strategic direction for the delivery of services and to this end, we held a large scale event in the City Chambers at the end of July to complete the initial drafting of the City's health and social care Strategic Plan. The draft plan will be published around late September. I will be keen to hear your views on our draft plan, and information on how to give me your thoughts will be made available when we publish the draft.

The consultation on the Strategic Plan will run up to the end of the year. The primary theme that comes through the draft plan is about how we deliver much more early intervention and preventative care at a very local level across the city in the future. You can read more about the key themes later on in the newsletter.

This is what I mean when I talk about the development of the Partnership. It really is about so much more than the bringing together of two budgets and two workforces, and it really does reinforce for me the fact that whilst those of us who work in Social Work Services or the Health Board will continue to be employed by those organisations, and what we do will broadly remain the same, how we do our work will necessarily have to change if we are to deliver success within the Glasgow City Health and Social Care Partnership.

I will repeat what I've said before, how we are with each other is more important in the integration agenda than what the structure is or who is going to be based where. And that is not just about how the health staff and the social work staff are with each other, it's also about how those two groups of staff are with colleagues from the third and independent sector, carers, patients and service users, and communities. But this change of expectation and being relates to those groups as much as it does to health and social work staff.

And hopefully, through the examples of things that I have seen in practice across the city on some of my visits last month you will begin to get a flavour of how genuine multi-layered partnership working is already happening in places across Glasgow to very great effect in terms of early intervention and prevention.

For example, I hope you are inspired by what you read about what we're doing in reablement with older people in this newsletter. I hope you will be reassured by our rolling out of the community respiratory team's Home Support for People with Chronic Obstructive Pulmonary Disease (COPD) across the city that we are serious in our intention to provide increased early intervention and preventative services and support people to live longer at home.

Our Strategic Plan 2016- 2019

As a new Partnership, one of the first things we need to do is to agree what our general direction of travel and our priorities will be and articulate this in a Strategic Plan. We are committed to developing our Strategic Plan in collaboration with the people and organisations who we work with and for - our 'stakeholders'.



Image provided by www.careimages.com

By law we are required to establish a Strategic Planning Group, however given the size of Glasgow City, we have actually set up six groups each focussing on one specific area of adult services, but making links across the groups so they work in a joined up way. The groups are focussing on: older people, mental health, disabilities, addictions, homelessness and carers. Strategic Planning Groups contain a number of stakeholders from social work, health, the third and independent sectors, service users, patients and carers. Our planning structures for Children's Services and Criminal Justice remain in place, but with a clear link to the wider planning structure of the Partnership.

As you'll have seen in David's message, a Strategic Planning Group event took place in late July, to bring all the Strategic Planning Groups together to review our working draft Plan. Following this event the Plan is being further developed and it is our intention to publish the draft Strategic Plan in September 2015 and invite comments from all stakeholders, before beginning the more formal consultation process, which can only begin once the Integration Joint Board has been established, later in the year.

When the draft Strategic Plan is published, and when the formal consultation process begins, you will have the opportunity to have your say on the priorities and vision outlined in our draft Plan. All comments will be welcomed and considered in the development of the final draft Plan which will be presented to the Integration Joint Board early next year.

The overall priority for the Glasgow City Health and Social Care Partnership is delivering transformational change in the way health and care services are planned, delivered and accessed in the city.

We believe that more of the same is not the answer to the challenges facing Glasgow, so we are focussing on:

- **Shifting the balance of care**

Services have transformed over recent years to shift the balance of care away from institutional, hospital-led services towards services that are better able to support people in the community and promote recovery and greater independence wherever possible. Glasgow has made significant progress in this area in recent years, and we will continue to build on our successes in future years.

- **Enabling independent living for longer**

As a priority, we will work across our all care groups to support people to continue to live healthy, meaningful lives as active members of their community for as long as possible.

- **Providing greater self-determination and choice**

We are committed to ensuring that service users and their carers are given the opportunity to make their own choices about how they will live their lives and what outcomes they wish to achieve.

- **Early intervention, prevention and harm reduction**

We are committed to working with a broad range of city partners to improve the overall health and well-being of the Glasgow population. We will continue to promote positive health and well-being, early intervention, prevention and harm reduction, ensuring that people get the right level of advice and support to maintain their independence, and minimise the number of times that they need health and social services at a point of crisis in their life.

In the spotlight: Glasgow City Reablement service

There are lots of great examples of successful partnership working already across Glasgow City. This month, we profile two of them - the City's **Reablement Service** which aims to build people's confidence in their ability to help themselves, increase their independence, and potentially reduce dependency on long term mainstream home care provision, and the **community respiratory team's Home Support for People with Chronic Obstructive Pulmonary Disease (COPD)**

The reablement process involves:

- **Screening the person**, which is carried out by the reablement homecare team
- **Assessing** what they can do for themselves; what they would like to be able to do, or what they used to be able to do before they were admitted to hospital.
- Developing a **care plan** for the person.
- **A weekly review** to meet changing needs and promote their regained independence.
- **A final review** at the end of reablement, to log the progress and to see if any changes should be made to their care plan.



Reablement contributes to the key policy objective of supporting people to live healthy and independent lives at home for as long as possible. Reablement is also a way to help vulnerable people to live safely at home. The increasing number of people requiring support and the reality of limited resources requires public services to be innovative in how they deliver support.

The project was launched in October 2011, following consultation with the people who use our services, carers, staff, managers, trade unions and other stakeholders. It was first introduced to service users in the north east of the city, then the south and more recently in the north west.

The first group of people to benefit from the service were older people discharged from a hospital environment. The service was then developed to include other adults, community referrals and other people we cared for who were likely to benefit from reablement. The team have produced [this animated story](#) to show how reablement helps people.

Approximately 660 people are screened through reablement every four weeks in Glasgow, and currently 38% of the people who use our services require no on-going care. And the 62% of people who do transfer to mainstream home care, require typically 16% fewer care hours.

The reablement service is a partnership project developed by Social Work Services, Cordia, NHS Greater Glasgow and Clyde and supported by the Home Care Direct team in Customer and Business Services (CBS). You can see [an illustrated version of what reablement is all about](#) at:

In the spotlight: Help at home for people with Chronic Obstructive Pulmonary Disease (COPD)

A successful pilot partnership project in the north west of Glasgow has shown such promising results in helping people who have Chronic Obstructive Pulmonary Disease (COPD) to manage their condition and prevent them from having to be admitted to hospital, that it is now being rolled out across the city.



The service will expand to become a Glasgow City multidisciplinary team including respiratory nurses and dieticians. And for the first time in the city, Health Promotion colleagues will work with the team within people's homes to help housebound patients stop smoking.

COPD is a progressive disease which makes breathing difficult and can mean that people have to be admitted to hospital if symptoms worsen, and the north west area of the city was chosen because more than 40 per cent of people with COPD in the Glasgow and Clyde area live in that area

Since the pilot began in 2013, the north west Community Respiratory Team have supported more than 400 people with COPD to develop a number of ways to live at home and even improve their condition. And following a successful evaluation in March this year, the team is expanding its service across Glasgow City from the autumn.

The team works closely with specialist respiratory nurses, consultant physicians, community nurses and GPs and is made up of health care professionals from Physiotherapy, Occupational Therapy, Pharmacy and Rehabilitation Support. They work closely together and visit patients in their own home to provide:

- Support to prevent unnecessary and unscheduled hospital admissions of COPD patients by the treatment of exacerbations, disease management, and improved education
- Support for the patient to allow early discharge from hospital, working closely with the Early Supported Discharge team

In the spotlight: Help at home for people with Chronic Obstructive Pulmonary Disease (COPD)

- Home based personalised pulmonary rehabilitation for housebound patients and provision of equipment to help people stay independent
- Advice for patients on self management strategies (including inhaler technique)
- Comprehensive medication review for patients with COPD
- Regular home contact by the team to supply advice, reassurance and guidance in self-care
- Ways of identifying and monitoring patients at high risk of exacerbations and undertake activities to avoid emergency admissions
- Direct access for patients to the team to optimise self-management and early response to treatment

Since the pilot began, evaluation has shown that 90 per cent of those who were at risk of being admitted to hospital were seen by the team within one day, and two weeks following an assessment, 80 per cent of patients avoided being admitted to hospital. And results are showing significant improvements in patients' ability to cope with their symptoms and improve their quality of life.

Help is also available through a telephone helpline where people can discuss any concerns, symptoms or changes in their condition or in their ability to carry out their usual activities. The team will talk to the caller about how they feel, then either give advice over the phone, go out and do a home visit or advise the caller to contact their GP, depending on the circumstances.

Suzanne Marshall, NW Rehabilitation Manager explained "Our team aims to help people living with COPD to have a better understanding of their condition and how to manage it, including how to manage flare-ups when they happen. We also help people to learn how to control their breathing, and to become more confident in managing their medication and overall, in managing their everyday activities. The provision of a 'hospital at home' scheme provides GPs with an alternative option to hospital admission particularly for patients with certain symptoms, which reduces hospital admissions and the length of time that people need to stay in hospital."

Patients who have been part of this project have said:

"They saved me going to the hospital. They showed me my medication I had been taking I was taking wrong. They fixed all that out. I wouldn't have known what to do without the staff. The

physiotherapist arranged for me to get a delta and went over my nebulisers. The occupational therapist arranged for a bath thing for my daughter to help me get a bath."

"I did discover how important it is to keep my wits about me with my breathing and stay calm. I could be at absolute panic stations before so the physio was really good at getting it into my head that I need to control this. I can't just turn up at hospital every time. She was essential at getting my confidence up but it's not only that I could control it but that I could have gone on floundering."

"The staff were nice, really helpful, they said you make a goal. I aimed for 6 weeks and I did it in 3. I wasn't in control of it before and now I'm good. I'm not so hemmed in with it. I've got a bit of my life back. I can get out even without my inhaler always on the go now."

If you would like more info about Home Support for People with COPD, please contact 0141 800 0790.

Joined-up leadership



A range of events have been taking place over the summer to develop an integrated approach to leadership across our Partnership. These include ‘**Leadership Conversation Events**’, attended by senior managers, shadow Integration Joint Board members and supported by several service managers across the city within each care group topic. The events will run through until December and aim to:

- Improve our knowledge and understanding of the broad range of services provided, the challenges and problems they face
- Ensure senior managers are equipped to challenge each other, think differently, while working constructively and effectively
- Improve partnership working to prepare for the challenges that lie ahead.

A series of Engagement and Information Events are also taking place to support Band 9 Social Work Managers and AFC Band 8/ Service Managers in Health to:

- Get an update on Integration and how the Partnership is developing
- Match thoughts about our vision with ways to implement services
- Understand the whole system approach being developed.

Look out for more information on [events on the website](#).

What integration means to me

By local community activist Ann Souter from Easterhouse, Chair of the North East Public Partnership Forum (PPF) and a member of the Shadow Integration Joint Board.



“ I strongly believe that the main priority for integration is to develop strong locality planning arrangements that offer a real opportunity for local people to become much more involved in designing and developing services that meet the needs and requirements of their own communities. ”

For more information on integration...

Our people

[Health Website](#)

[Council Website](#)

Our places

The Glasgow City Health and Social Care Partnership's (GCHSCP) headquarters is now located at Commonwealth House, in the heart of Glasgow's Merchant City. Around 180 staff in total - including fixed and mobile (office and field) staff – moved this month from William Street, City Chambers East, Granite House and other locations across the city to 32 Albion Street, G1 1LH, (phone: 0141 287 0499).

The headquarters will bring together:

- Executive and Senior Management Team
- Secretariat
- Business Development
- Commissioning
- Adult Services
- Practice Audit
- Health Improvement
- Planning and Strategy
- Organisational Development
- Business Admin and
- Customer and Business Services (CBS) staff.

Please note that not all team members of these teams will be moving to Commonwealth House. Some team members may be based within the City Chambers Complex or other locations.

In addition, the Partnership's three 'locality' (area) offices have been confirmed as:

- South – Clutha House, 120 Cornwall Street, Glasgow, G41 1AF
- North West – William Street Clinic, 120-130 William Street, Glasgow G3 8UR
- North East – Templeton Business Centre, 62 Templeton Street, Glasgow, G40 1DA

Our papers

You can read our Shadow Integration Joint Board papers at [Glasgow City Council](#) or [NHSGGC](#).

Keep up to date...

Health staff – visit [Staffnet](#)

Council staff – visit [Connect](#)

Partners and stakeholders - visit

[Health website](#)

[Council Website](#)