Glasgow City HSCP
Health and Social Care Partnership

Performance Report 2016/17

NHS Greater Glasgow and Clyde

Glasgow City Council

CONTENTS

1. INTRODUCTION

1.1 Purpose of Report

The Public Bodies (Joint Working) (Scotland) Act 2014 requires Integration Joint Boards to publish an Annual Performance Report, setting out an assessment of performance in planning and carrying out those functions for which they are responsible. This is the first report for the Glasgow Integration Joint Board and within it we look back upon the last year and reflect upon what has been achieved since we became established.

Within this report, we review our performance against agreed local and national performance indicators and against the commitments within our first Strategic Plan. This Plan covered the period 2016-19 and through the planning and performance arrangements described in sections 1.3 to 1.5 below, we have been continuing to oversee its implementation and ensure its ongoing relevance.

1.2. Partnership Overview

i. Organisational Profile

Glasgow Integration Joint Board is a distinct legal entity created by Scottish Ministers and became operational from February 2016. In responding to the Public Bodies (Joint Working) (Scotland) Act 2014, Glasgow City Council and NHS Greater Glasgow and Clyde agreed to integrate children and families, criminal justice and homelessness services, as well as those functions required by the Act, delegating these to the Integration Joint Board. The IJB is, therefore, responsible for the strategic planning and/or delivery of a wide range of health and social care services in the city. These include the following:

- School nursing and health visiting services
- Social care services for adults and older people
- Carers support services
- Social care services provided to children and families
- Homelessness services
- Criminal justice services
- Palliative care services
- District nursing services
- Services provided by allied health professionals
- Dental services
- Primary care medical services (including out of hours)
- Ophthalmic services
- Pharmaceutical services
- Sexual health services
- Mental health services
- Alcohol and drug services
- Services to promote public health and improvement
- Strategic planning for accident and emergency services in a hospital
- Strategic planning for inpatient hospital services relating to general medicine; geriatric medicine; rehabilitation medicine; and respiratory medicine.

Across these services, the Health and Social Care Partnership directly employs approximately 9,000 staff and has a total budget in the region of £1.1 billion (see chapter 4). Within the Partnership's area, there are 150 GP practices (over 430 GPs) providing general medical services to their practice populations, of whom approximately 100,000 live outside the city boundary. There are also 145 dental practices and five orthodontic practices, 163 community pharmacies and 113 optometry practices.

ii. Locality Management Arrangements

Glasgow is divided into three areas, known as localities, to support operational service delivery and enable planning to be responsive to local needs. To ensure consistency in local service delivery with key partners, the Glasgow City Health and Social Care Partnership has adopted the same strategic areas as the Glasgow Community Planning Partnership. These are described in more detail in chapter 3 of this report, which also sets out the key priorities within their individual locality plans.

iii. Performance Management Arrangements

Routine performance management arrangements are in place within the Partnership, with regular performance reports produced for internal scrutiny by citywide management teams. Performance is also scrutinised by locality management teams, with locality variation reports produced to facilitate this. Localities share good practice in areas in which they are performing well and have drawn up performance improvement plans in response to identified areas of underperformance, with progress in delivering these regularly reviewed.

In addition to the above, the Integration Joint Board's Finance and Audit Sub-Committee scrutinises performance, receiving a full performance report each quarter. They have introduced arrangements whereby they focus on specific services at each meeting, in order to enable then to undertake a more in-depth review of performance, with relevant strategic leads invited to attend and discuss the performance of their respective areas.

A strategic overview of performance is also maintained by the Integration Joint Board which receives a quarterly performance report that focuses upon a smaller set of more strategic performance indicators. The Integration Joint Board also received a Performance Baseline report at the start of 2016/17, against which performance throughout the last 12 months is reported upon in chapter 5 of this report.

There are, therefore, a range of mechanisms in place to scrutinise performance at city wide and locality levels, as well as by the Integration Joint Board. This enables areas for improvement to be identified and actions taken forward and monitored on an ongoing basis.

In addition to service performance, the health improvement team, in partnership with the wider public health intelligence community, also undertakes periodic population surveys, analyses and tailored needs assessments, in order to compare population health and well-being trends and inform future planning.

1.3. Area Profile

A full profile of the city was set out in the Strategic Plan. Some of the key characteristics include the following:

i. Population

The latest population of Glasgow City is 615,070, 11.4% of the total population of Scotland (Source: National Records of Scotland for 2016). In Glasgow City, 24.0% of the population are aged 16 to 29 years, compared to 18.2% in Scotland. Persons aged 60 and over make up 18.4% of Glasgow City, compared to 24.4% nationally. Although the population fell towards the end of the 20th century, it has been increasing again since 2004 and has risen from 593,245 in 2011 (Source: National Census). This growth is expected to continue over the next 20 years, with the biggest increase expected in the over 75s, followed by 65-74 year olds, in line with national projections.

ii. Deprivation

Glasgow City contains 3 in 10 of the 15% most deprived data zones in Scotland, the highest proportion for any local authority. 116 of these most deprived data zones are in the North East of the city, while the North West has 83 and South 89. Around 40% of Glasgow's entire population live in one of these 288 data zones, with around 54% of these people living in the North East of the City.

iii. Health and Social Care Needs

- Although increasing, life expectancy at birth in Glasgow is currently 73.4 years for males and 78.8 years for females (compared to the Scottish averages of 77.1 and 81.1).
- Healthy Life Expectancy for males in Glasgow is 56 years and for females 59 years.
- Around 8.7% of the Glasgow population live in 'bad' or 'very bad' health, with 31% of Glasgow's population- around 184,000 people - suffering from one or more long term health conditions.
- Around 9.3% of people in the City carry out unpaid caring duties.
- It is estimated that up to 75,000 people in Glasgow experience common mental health problems such as depression or anxiety, with around 6,000 people experiencing a more severe and enduring mental illness.
- Glasgow has over 69,000 residents estimated to be problem alcohol drinkers, and has the highest rate of alcohol related hospital admissions in Scotland.
- Glasgow has an estimated 13,000 problem drug users, most of whom also consume alcohol on a daily basis.

Further information upon the city's population and needs are available from a number of sources including some of which our Health Improvement function either lead, commission, or support. These include the Health and Wellbeing profiles for the city. One profile covers the adult population and is presented at city and locality levels, as well as for three of the 'Thriving Places' areas in the city. Staff also supported Glasgow Centre for Population Health in the production of Child Health profiles last year, which were produced for each of the 56 neighbourhoods in Glasgow. These are both available and can be accessed on the Understanding Glasgow website.

Information is also available from the Glasgow City Schools Health and Wellbeing Survey and the adult Health and Wellbeing Survey, which we funded and assisted in the production of. These are described in more detail in chapter 5, where links to these reports are made available.

1.4 Strategic Vision and Priorities

i. Strategic Plan

In accordance with the Public Bodies (Joint Working) (Scotland) Act 2014, we prepared a Strategic Plan for the delivery of those functions which have been delegated to the Integration Joint Board by Glasgow City Council and NHS Greater Glasgow and Clyde. This plan, which covers the period from 2016-19, sets out our agreed vision, priorities and the future direction for health and social care services in Glasgow. These are set out below.

The vision and priorities within the Strategic Plan remain relevant. Progress in taking forward this plan continues to be monitored through the range of Strategic Planning Groups which have been established in the city, each of whom have implementation plans in place. Within this report, we capture progress made in relation to this Strategic Plan over the last 12 months, highlighting some of our key achievements in delivering against our agreed priorities and the nine National Health and Wellbeing outcomes (Appendix A). We will begin the process to develop the new Strategic Plan for 2019 - 2022 in mid-2018.

ii. Our Vision

We believe that the City's people can flourish, with access to health and social care support when they need it. This will be done by transforming health and social care services for better lives. We believe that stronger communities make healthier lives and we will seek to achieve these by:

- Being responsive to Glasgow's population where health is poorest
- Supporting vulnerable people and promoting social well being
- Working with others to improve health
- Designing and delivering services around the needs of individuals, carers and communities
- Showing transparency, equity and fairness in the allocation of resources
- Developing a competent, confident and valued workforce
- Striving for innovation
- Developing a strong identity
- Focussing on continuous improvement

iii. Our Priorities

The biggest priority for the Glasgow City Health and Social Care Partnership is delivering transformational change in the way health and social 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, and will strive to deliver on our vision through the following strategic priorities:

- Early intervention, prevention and harm reduction
- Providing greater self-determination and choice
- Shifting the balance of care
- Enabling independent living for longer
- Public protection

iv. Equalities

As a Partnership, we aim to remove discrimination in accessing all of our services and ensure that our services are provided in an equalities sensitive way. We also seek to work with partners to contribute to reducing the health gap generated by discrimination and to make Glasgow a fairer city.

We have worked to establish strong working arrangements with equalities networks within and beyond the city. We have established an Equality Group consisting of representatives from across health and social work services, as well as from Glasgow City Council, the Health Board Corporate Inequality team, and the Glasgow Equality Forum.

This Group has developed and published its Mainstreaming and Equality Plan during the last year for the period 2016-18, consulting with a wide range of groups and individuals city wide. In accordance with the Equalities Act (2010), this Plan sets out our agreed Equalities Outcomes, against which we will report upon progress going forward.

During the course of the year, a range of equalities training has been delivered across the partnership including autism, LGBT (Lesbian, Gay, Bisexual, and Transgender) and disability diversity training. Equality and diversity e-modules have also been made available to health and social work staff with over 900 staff completing these. The Sandyford service has published an analysis of the health and well-being of LGBT young people across Greater Glsagow and Clyde and the partnership is now working towards the LGBT Youth Charter Mark. Partnership staff have also undertaken a variety of work with partner agencies and third sector organisations to promote awareness and action around key equalities themes.

1.5 Structure of the Report

In chapter 2, we describe progress which we have made over the course of the last 12 months. For each of the agreed strategic priorities described in section 1.4 above, we highlight some of the key developments and service improvements which we have delivered. Relevant performance indicators and trends affected by these developments are also highlighted, along with user/carer feedback and individual case studies which seek to demonstrate our impact upon the nine national Health and Wellbeing Outcomes

In chapter 3, we provide an overview of our three localities. We describe their management arrangements, along with the engagement mechanisms they have established with primary care, community planning partners, and the wider community. We then describe the locality planning processes and provide links to the plans they have developed, within which they set out their key priorities and highlight their key achievements over the last year.

In chapter 4, we set out the Partnership Budget for 2016/17 and provide a summary of our financial performance over the course of the year. We also describe the transformation programme we have been taking forward and the key capital investments progressed, before considering the financial outlook for 2017/18.

Finally, in chapter 5, we provide a more comprehensive overview of performance, drawing upon a range of sources including our agreed local key performance indicators, national integration indicators, results of inspections undertaken of our services during the last 12 months, and key survey findings. Where available, performance in relation to our local performance indicators is shown both for the end of 2016/17, and the baseline position at the end of 2015/16, with reference made to the National Health and Wellbeing outcomes to which each indicator most closely relates.

2. DELIVERING OUR KEY PRIORITIES

2.1 Introduction

This chapter is structured primarily around our 5 Strategic Priorities as set out below:

- Early intervention, prevention and harm reduction
- Providing greater self-determination and choice
- Shifting the balance of care
- Enabling independent living for longer
- Public Protection

In the following sections we highlight some of the key service developments and improvements undertaken in relation to our Strategic Priorities over the last year. We also describe any associated activity or performance trends and where relevant, draw upon some of the local Key Performance Indicators which are reported quarterly to the Integration Joint Board, adopting the RED/AMBER/GREEN classification system used within these reports.

Under each of the Strategic Priorities, we have also included any relevant user/carer feedback and case studies which help to demonstrate the impact being made by our services upon the nine national Health and Wellbeing Outcomes. In section 2.6 we then focus upon our staff and how we have engaged with and supported them over the last 12 months.

A comprehensive overview of performance in relation to all local Key Performance Indicators is provided in chapter 5 where this classification system is described in more detail. Please note that end of year data is not yet available for all of the indicators that feature here and in chapter 5. These will be incorporated into the ongoing performance management reports once available.

2.1 EARLY INTERVENTION, PREVENTION AND HARM REDUCTION

Within this chapter, we profile some of the key developments progressed in relation to our strategic priority of Early Intervention and Prevention. These activities have contributed to a range of the 9 national Health and Wellbeing Outcomes, most notably the following:

Outcome 1	People are able to look after and improve their own health and wellbeing and live in good health for longer
Outcome 2	People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
Outcome 5	Health and social care services contribute to reducing health inequalities

I. EARLY YEARS

Family Nurse Partnership

Family Nurse Partnership (FNP) is a voluntary programme for first time mums aged 19 and under. It is an intensive, structured home visiting programme which is delivered by specially trained nurses to pregnant women from under 28 weeks gestation through to their child's second birthday. The programme aims to improve maternal health and pregnancy outcomes, child health and development and parents' economic self-sufficiency. A first cohort of 167 clients have already graduated from the programme and a second cohort of 202 clients have now been recruited. Uptake to the programme is very good with over 75% of those offered the service accepting it.

Case Study

Client A was a 19 year old asylum seeker from an area of conflict. She could not read or write and her parents, who had not left their country, previously made all decisions for her. She was taken by soldiers to fight and her 'rescuer' raped her. She was subsequently rejected by her family for being pregnant and got passage to the UK with a lorry driver and was abandoned in the Glasgow area at 28 weeks gestation. Someone called an ambulance for her and she was taken to hospital and referred to the Family Nurse Partnership programme. She has received assistance with a range of day to day activities including working showers and washing machines, taking medicines and attending appointments, all with the support of an interpreter. She now has her baby and is breastfeeding with the baby developing well and attachment strong. She has a new partner and both are making safe choices for themselves and the baby. She is becoming more assertive and confident, her spoken English has been improving and she is now keen to attend formal English classes.

Nine multi-agency Early Years' Joint Support Teams (EYJST) have been established across the City aligned to the Community Planning Partnership's "Thriving Places" neighbourhoods. These meet to discuss and respond to the needs of families and children referred to them. The main partners in this approach are early years' education services, health visitors, third sector organisations, housing and, when required, addiction and other community services. Third sector organisations are crucial to this approach, as they are able to offer a wide range of assistance, such as parenting programmes, family support, child minding, and pathways into financial, housing and employment advice and support. Through this work, we aim to secure positive outcomes for children by increasing the self-efficacy and resilience of families. There is a rolling programme of validated self-evaluation due to conclude in summer 2017, which has been undertaken to evidence the impact of the EYJST model. Over the course of 2016/17, 219 families have been referred to and supported by these teams.

Breastfeeding

Mechanisms are in place in each locality to ensure that relevant staff are trained and mentored in supporting infant feeding. Work has been undertaken in the last year to achieve reaccreditation of the UNICEF Baby Friendly Standards and all localities were successful and received positive feedback from assessors in relation to infant feeding, relationship building and attachment support. There are currently 8 breastfeeding support groups across the city which had approximately 1,800 attendances during 2016/17. In addition, a 'baby café' 'drop-in' approach has been introduced in South Glasgow, where breastfeeding mothers are given the opportunity to come along and access help and support, and meet other breastfeeding women to share experiences and to socialise.

The table below indicates that between 2015/16 and 2016/17 Glasgow has seen an upward trend in rates of exclusive breastfeeding at 6-8 weeks amongst both the general and most deprived sectors of the population. This increase has not been has not been reflected elsewhere in the Health Board or across Scotland. Although performance within the 15% most deprived data zones are the highest within the Health Board area, they remain below target and work is ongoing to achieve further improvement.

Breastfeeding: % babies at 6 week review recorded as exclusively breastfed			
Population	**TARGET**	**Actual 2015-16**	**Actual 2016-17**
General	24.0%	**25.5%** 	**26.5%** 
15% most deprived data zones	20.1%	**18.2%** 	**19%** 

User Feedback

As part of the ongoing audit cycle and assessment process for UNICEF accreditation women are asked about the care and support they receive in relation to feeding and caring for their baby. Assessors for the recent award noted that the majority of mothers questioned reported that they found the care and support they received beneficial. Feedback included the following comments:

"I was on the point of stopping breastfeeding and my Health Visitor encouraged me to think about mixed feeding rather than stopping completely. I am still exclusively breastfeeding! I am very grateful"

"*I initially had big problems latching on and associated pain – I visited at week 1 and found the support from the health visitor and peers gradually made feeding easier and gave reassurance. I felt better knowing I could go each week."*

"It has been useful speaking to others who have had similar problems and reassuring to hear that things get better. It has also given me confidence to breastfeed in public"

II. HEALTHY LIVING

Our strategy for improving health focuses on:

- Reduce exposure and use of tobacco
- Rebalance our relationship with alcohol and reduce drug use
- Enable more people to have a healthy weight
- Improving mental health and well-being
- Improving health in some specified neighbourhoods, working with community planning partners to develop the 'Thriving Places' component of the Single Outcome Agreement
- Mitigate the impact of poverty and raise aspiration

Some examples of programmes addressing these themes are provided below.

Smoking Cessation

Following a review of tobacco programmes to determine the reach and impact of smoking cessation services, a revised service was launched in April 2015 and implemented in phases over a three year period. Developments have included the introduction of good practice guidelines, advanced data analysis leading to targeted intervention and the implementation of a workforce development plan. In addition, a number of new joint services have been launched supporting closer working between community smoking cessation teams, GPs and local community pharmacies which have improved planning and service delivery in key target areas including Castlemilk, Pollok, Possilpark and Bridgeton. Last year, the target for successfully supporting residents to quit for at least 12 weeks was increased by Greater Glasgow and Clyde (GGC). At Q3 performance was below target however it is anticipated that the annual target will be met once the year-end figure becomes available later in the year.

Number not smoking at 12 weeks post quit, in the 40% most deprived SIMD areas			
Area	**Target Quits 2016-17**	**Target Quits (To Q3)**	**Actual (To Q3)**
Glasgow City	1,388	1,044	**811**

Reducing Alcohol Consumption

Alcohol Brief Interventions (ABIs) are relaxed conversations which offer people the opportunity to look at their alcohol use and decide whether or not to make small changes in their drinking behaviour to reduce potential harm to their health and well-being. We continue to expand the delivery of ABIs across a range of community settings in order to reach harder to reach communities, including smoking cessation groups, workplaces, health centres, colleges, Glasgow Club Gyms, job centres and libraries. Interventions have also been delivered via the NHS Police Custody Healthcare service with recipients indicating they welcomed the opportunity to engage with health improvement opportunities whilst in custody, where they have time to reflect on their behaviours and make decisions to accept the help offered.

The ABI performance target was met by the Partnership in 2015/16, and in 2016/17 we exceeded target by 46% as shown in the following table. While delivery within the wider settings has grown, recording delivery within primary care has been challenging as a result of the changes to GP contracts which has impacted the way ABI data is recorded and reported. This is an area which may require further focus in future given the requirements to deliver both within primary care and in wider settings.

Alcohol Brief Interventions Delivered		
Year	**2016/17 Target**	**2016/17 Actual**
Performance/Status	5,066	**7,400** 

ABIs are delivered by NHS, statutory and third sector partners. To support this, we implemented an ABI Training for Trainers programme during 2016-17 resulting in over 50 delegates being trained, including 29 smoking cessation staff who now deliver ABIs within their smoking cessation groups.

In addition to ABIs, we have worked with partners to deliver a range of alcohol awareness and educational initiatives including the development of evidence based resources such as the *Oh Lila* nursery programme, and CHAT (Children Harmed by Alcohol Toolkit), which was officially launched in June 2016 and is aimed at professionals working with children and young people who are, or may be, affected by someone in their life's alcohol consumption.

Other work undertaken by the Partnership has included that undertaken by the Alcohol Licensing Health Improvement post, which continues to represent the HSCP in decisions taken upon alcohol availability by the Licensing Board and Forum. During 2016/17, over 150 licence applications were reviewed and 7 objections to licence applications were made which resulted in 3 licences being refused on public health grounds. Emphasis has been placed on objecting to new 'off sales' applications in areas which can already demonstrate alcohol related harm to health.

Healthier Eating

Obesity is a major issue in Scotland and in 2015, over a quarter (29%) of all adults in Scotland (16+) were considered obese (Scottish Public Health Observatory, 2015). Poverty, low income and a lack of skills and confidence with food preparation impact upon poor diet and obesity. There is a gradient of inequality, with obesity levels highest for those living in the most deprived areas.

During the last year, a range of initiatives aimed at promoting improved nutrition and healthier eating choices have been delivered by the HSCP and partners including cookery courses and demonstrations. Across the city, over 250 adults have participated in 47 Get Cooking programmes. Work has also been undertaken in partnership with commercial weight management service providers, with children and their families through the Weigh to Go Service, which targets 12-18 year olds who want to lose weight. Through weight management and activity programmes, this service supports young people to manage their weight, increase their physical activity levels, develop skiills to enable them to prepare healthy nutritious meals, and seeks to build their confidence and self-esteem. In the last year, 101 young people engaged with the programme in Glasgow City. Of those who engaged with the programme for 24 weeks, 66% lost 5% of their BMI (the level at which

there has been shown to be clinical benefit). Of those who engaged for 12 weeks, 34% lost 5% of their BMI. The programme has now been extended and is hosted by Glasgow City and offered at venues across the NHSGG&C Board area.

Case Study

Radek moved to Glasgow from Poland with his family when he was 12. He said "I had health issues, bad eating habits and eventually I reached a point where I couldn't do any exercise. I was also shy and I wasn't speaking to anyone. I didn't get bullied but people were making jokes about me in high school. I wasn't really confident to start with but being overweight made it worse". At age 18 Radek knew he needed to lose weight. "I was Type 2 diabetic and on medication and was breathless during the night".

Radek saw the poster for Weigh to Go in his local health centre and came along to seek support. Radek stayed on the programme for over a year and increased his physical activity levels by attending the local gym. Radek lost weight consistently. He indicated "On the Weigh to Go programme I joined Weight Watchers and thought I would lose 30kg or so and that would be enough, but I was losing the weight easily so I kept going until I reached my target of 80kg eighteen months later". Radek has since completed a sponsored cycle from Edinburgh to Glasgow to raise funds for the British Heart Foundation, has completed two 'Tough Mudder' events and is a young ambassador for Weigh To Go. He is now 21 and is a 4th year student in accountancy, as well as working part time as a waiter.

III. PROMOTING POSTIVE MENTAL HEALTH

During the year, we continued to deliver and support partners to deliver a range of activities designed to promote positive mental health and wellbeing amongst children, young people and adults, in line with NHS Greater Glasgow and Clyde's Healthy Minds Framework and the Child and Youth Mental Health Improvement Framework. Two new services have commenced.

Firstly, the EU-funded *Aye Mind* digital development programme for youth mental health, which was launched in June 2016. Local services worked with young people aged 13 to 21 to develop a range of resources for harnessing internet, social media and mobile technologies, to create and share a wide range of resources to promote youth wellbeing (www.ayemind.com/)

A new stress service, Lifelink, was also commissioned in April 2016 with the new youth service opening in July 2017, which works with young people aged from 11 to 18 to help them develop the emotional tools and capabilities to deal with life's challenges. Lifelink offers 1:1 counselling, group work and courses. Over the course of the year, over 400 young people have accessed the service and there have been improvements recorded in mean CORE scores of 7.3 in the schools based contract. In addition, over 5,000 adults have accessed the adult counselling services.

Case Study

Client A is a fourteen year old female, living at home with both parents and two siblings. She presented with symptoms of anxiety, difficulty focusing, and fidgeting. They spoke of life at home as being normal and of having a good relationship with her family, but Mum was becoming worried as she was finding being at school very difficult.

During the assessment by Lifelink, the client expressed underlying anger, indicating her frustration with others. She said she was finding being in classes very difficult, especially if the class was very noisy as she was unable concentrate and felt fidgety all the time. She recognised this had become a problem since she was attacked from behind a year ago by three unknown girls.

A block of four counselling sessions were agreed where the client was able to explore her emotions, highlighting negative thought patterns and how these were impacting on her overall sense of wellbeing. This enabled her to begin to challenge her anxiety constructively and test new coping strategies in environments that she previously found very challenging.

As the sessions progressed the client noticed that she was no longer feeling angry and fidgety. She was able to be more assertive in her communication which resulted in her relationships becoming more supportive. After challenging negative beliefs and unhelpful thoughts, she found the school environment a lot less threatening and was starting to engage a lot more. She found her concentration had increased, that she was more able to participate in lessons and did not have a feeling of being left behind.

On the final session she said she had gone to a music festival and had really enjoyed herself without feeling nervous or anxious. She also indicated she was happy she had used the worksheets, as these would help remind her of what to do if she feels overwhelmed in the future.

IV. CAPACITY BUILDING

In recognition of persistent inequalities within and between communities, Community Planning partners, through the Single Outcome Agreement, adopted the 'Thriving Places' approach. This has made great progress during the past year and is seeing a better way of working between organisations and communities, making better use of existing resources and assets to achieve better outcomes. It is making connections with residents at a very local level, supporting them to identify, articulate, and fulfil the aspirations that they have for themselves and their communities. HSCP staff have been aligned to each of the nine Thriving Places to foster action to reduce the persistent health inequalities affecting local residents. These staff have played a key role in supporting local structures, facilitating community consultations, and supporting the development of local programmes and initiatives. The majority of the Health Improvement workforce have been trained in Asset-Based Community Development (ABCD) to support this. A range of initiatives have been taken forward through this approach across the city. For example:

- 'Neighbours Events' have been held which focus on local people recruiting other locals with a view to discovering the gifts, talents and knowledge in the area through conversations and convincing them to share these in a community setting – this is a way to map the potential assets that exist in the local community.
- In one Thriving Place a 'Charrette' approach was used to capture interest and involvement of local residents. This 'festival of engagement' identified a wide range of skills and issues that now bring residents together, with partners, on a regular basis.
- Winterfest community events were organised in Easterhouse, Barlanark and Springboig which attracted over 500 children from local schools/nurseries.
- Café Stork drop-in has been established for new and expectant parents.
- Community breakfast sessions take place regularly in Thriving Places areas with up to 50 people attending each session.
- 'Come Dine with Us' sessions have been established in the Gorbals which are being attended regularly by up to 100 people.
- Widespread consultation has been undertaken on the redevelopment of the Millenium space and bandstand in Possilpark

V. HEALTHY AGEING

We have taken forward a range of initiatives to promote healthy ageing in the city. In its second year, Community Connectors is a free confidential service which connects older people and their carers to local services, facilities and activities. There have been over 630 referrals to this service to date, with approximately 87% from older people. The service has made 1,055 onward referrals, signposting people to 731 organisations.

We have also supported Glasgow Life's Good Moves programmes which deliver a range of physical activty opportunities targeted at older people. During the last year Good Moves has recruited and trained 10 older people as Good Move Motivators. The Revitalise programme which is designed to support older people over 60 to connect with their local community through easy exercise and arts has delivered 1,319 exercise sessions and 738 arts based classes, wiith 14,297 and 4036 attendances respectively.

The Transformation Fund is managed by the Voluntary Action Fund on behalf of Glasgow City HSCP and supports 30 projects which deliver a range of community based services to older people around the themes of physical activity, reducing isolation, mental health & well being, and capacity building oppurtunities. Over 7,000 older people have been supported through these projects during the last year with 70% of participants aged over 65.

Case Study

"Four years ago I was suffering from severe depression. I found it really hard to go out among people and would only go out with my husband to shop in places where I would not meet people I knew. I was attending Parkview Psychiatric Unit where I received great support and was assigned a CPN (Community Psychiatric Nurse) to visit me at home every week. After a few months my nurse mentioned Easy Exercise Classes at Budhill and suggested I should try it.

It was frightening for me to get the courage to go along. Walking in by myself was an ordeal, but as soon as I entered I was made so welcome and some of the ladies almost "adopted" me. When I was introduced to Stephanie she was an inspiration and encouraged me to enjoy the exercises and also have fun. I began to look forward to going along every week and finding out what Stephanie had planned for us. She always explained how each exercise would help different parts of our body and also our mind.

After a short time my doctors at Parkview saw such an improvement in my co-ordination and my frame of mind. I attended there for over three years and when they discharged me recently they said I was indeed one of their success stories. However I owe such a lot to Revitalise for how I am feeling now and the huge impact Stephanie and the classes have made to my life".

May aged 77 - Shettleston Class

2.2 PROVIDING GREATER SELF-DETERMINATION AND CHOICE

Within this chapter, we profile some of the key developments progressed in relation to our strategic priority of Providing Greater Self Determination and Choice. These activities have contributed to a range of the national Health and Wellbeing Outcomes, most notably the following:

Outcome 3	People who use health and social care services have positive experiences of those services, and have their dignity respected
Outcome 4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
Outcome 5	Health and social care services contribute to reducing health inequalities

i. Personalisation

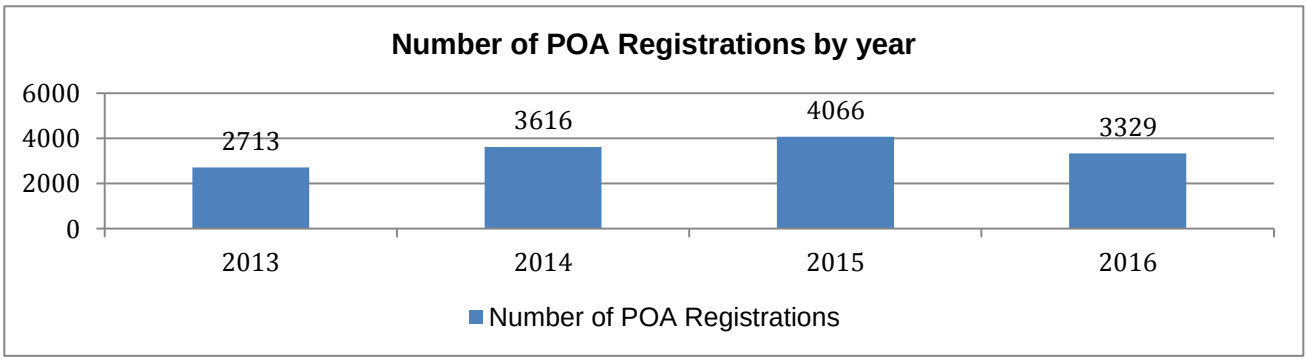
Personalisation, as outlined in the Social Care (Self-directed Support) (Scotland) Act 2013, has now been widely adopted across the City and is used as appropriate to individual needs and circumstances. At the end of March 2017, a total of 2,828 adult service users were in receipt of personalised social care services, an increase of 3.4% since March 2016. Children with disabilities in receipt of personalised services rose by 14% over the same period (from 117 to 133). At the end of March 2017, 15% of all service users with personalised services chose to receive their personalised budget as a direct payment, thereby maximising their choice and control in the services they receive, an increase in 1% over the past 12 months.

ii. Power of Attorney

Power of Attorney (POA) is a written document giving someone authority to take actions or make decisions on another person's behalf. This can be to deal with their financial affairs and/or welfare matters and can be used in the future if the person becomes incapable. Amongst other things, the consequences of not having a Power of Attorney can lead to people being delayed in hospital while awaiting legal documentation allowing them to be discharged.

Scottish Government guidance for anticipatory care planning encourages people to register for Power of Attorney, but rates of uptake across Scotland have remained relatively low, with evidence suggesting this has been due to a lack of understanding of the need for a Power of Attorney and how to register for one. In recognition of this, Glasgow launched a 'My Power of Attorney' public awareness campaign in 2013/14, which has subsequently been supported by other neighbouring local authority areas. This has used in TV and radio advertising campaigns, bill posters, Youtube and other social media channels, and a dedicated website (www.mypowerofattorney.org.uk).

Evaluation of this campaign showed that it is likely to have been responsible for part of the 50% increase in POA registrations between 2013 (2,713) and 2015 (4,066) by raising awareness of and increasing demands for Power of Attorney (see trends below). The numbers appear to be lower in 2016 (3,329) however it is believed that this is the result of a backlog at the Office of the Public Guardian in Scotland (the office responsible for processing registrations) as this reduction can be seen in registration statistics across Scotland.



iii. Fast Track Palliative Care Service

The Fast Track Palliative Care Service was rolled out city wide during the past year. This service aims are to meet patients' needs identified during Anticipatory Care Planning (ACP) conversations; increase the proportion of care provided to palliative patients in a homely setting; and support improvements in palliative care for patients in acute hospitals as set out in *Living and Dying Well,* the national action plan for palliative and end of life care.

The service, which is delivered by Marie Curie, works with acute hospitals, hospices and the HSCP to create a referral pathway, which involves supporting discharge at the end of life by providing comprehensive practical and emotional support for patients and carers, and preventing palliative care patients being unnecessarily admitted to hospitals or hospices when they want to remain at home. The numbers of patients supported by the service and the estimated impact in terms of avoiding unplanned acute bed days over the course of the last year is shown on the following table.

Indicator	Actual
Number of Patients	**556**
Number unplanned acute bed days avoided by preventing admissions	**4,440**
Number unplanned acute bed days avoided by facilitating discharge	**14,961**

Notes Estimate based on dates of death and dates of admission/discharge from the service.

This service contributes to the national aim of supporting more people in the community in the last 6 months of their lives (National Integration Indicator 15). As indicated in Chapter 5, this proportion has increased from 85% to 86% during 2016/17. This followed a similar 1% rise during 2015/16, having remained static at 84% over the preceding 4 years.

iv. Advocacy

We aim to ensure that individuals receive appropriate help and advice, and wherever necessary, are supported to access independent professional advocacy. Access to independent professional advocacy is recognised as contributing to health and social care policy goals such as health improvement, equity and involving individuals as partners. Independent advocacy is about speaking up for an individual or group. It is a way to help people have a stronger voice and to have as much control as possible over their own lives.

Within Glasgow City HSCP, we reconfigured the way in which Advocacy Services are provided by moving to a single contracted service during 2016. This was intended to enable a more co-ordinated approach that focused on the most vulnerable groups including adult mental health, dementia, learning disability, physical disability, and prison healthcare. The new service commenced in December 2016 and on average, approximately 750 people a month are supported. Whilst the bulk of advocacy work is based around Mental Health Tribunals, we, in conjunction with the service provider, ensure that the most vulnerable continue to receive this service.

Case Study

This case involves a young woman with learning disabilities and autism who was referred to social work learning disability services from criminal justice. She was in trouble with the police but it was identified that she appeared to be a victim of sexual, physical, financial and emotional harm and that adult protection procedures required to be initiated. She found face to face communication extremely difficult, particularly being asked direct questions by people she does not know, and has problems processing information quickly. The advocacy service started to support her and she built a trusting relationship with her advocate who liaises with Social Work staff prior to meetings about the topics to be discussed. The advocate is then able to go over these topics at a pace and in a way the woman understands and is able to record her views and opinions. Following the investigation, a protection plan has been put in place and the women is now being supported through the personalisation process with her advocate supporting her to participate in care needs assessments and the formulation of plans for the future.

v. Engagement with Children and Young People

As a Partnership it is important that we listen to our Children and Young People, particularly those who are most vulnerable. The Children's Rights Service (CRS) offers rights information, support and advocacy to children and young people from Glasgow who are looked after and accommodated, and to young people leaving care. Between April 2016 and March 2017 the CRS had contact with 288 children and young people, and received 878 referrals from 258 of those children and young people.

Work has also been progressed to establish a Glasgow Young People's Champions' Board which will include care experienced young people. This board will seek to maximise opportunities for children and young people to get involved and have their voices heard by services and leadership groups. In addition it will seek to identify barriers to participation and work jointly on ways of addressing these, identify issues and concerns and work with children's service decision makers to find solutions, improve young people's leadership skills and help get them ready for employment.

User Feedback

During the last year, the Children's Rights Service has been supporting young people's involvement in residential staff interviews. Young people received training from Human Resources and were supported to take part in main interview panels in November 2016 and February 2017. The feedback from this was very positive with young people identifying a range of positive outcomes from their involvement:

- "Great for your CV"
- "Confidence builder"
- "Makes you feel like an adult"
- "It makes you see things from a different point of view"
- "It's good that young people are included in the process because we're the ones that know what units [Children's Residential Units] are like"

Social Workers use several tools to aid children and young people to express their views and encourage participation. In Glasgow, children and young people over the age of 5 who are looked after away from home, on the Child Protection (CP) Register, or subject to Vulnerable Young Person's (VYP) procedures, are offered the opportunity to use an interactive software package called *Viewpoint* in preparation for case reviews.

Viewpoint allows the child or young person to complete a questionnaire; the questions being linked to the GIRFEC (Getting It Right For Every Child) Wellbeing Indicators: *Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible and Included*. The table below presents a selection of questions taken from the *Viewpoint* Survey, along with the percentage of children who responded positively. Some of the questions are not applicable to both children on the Child Protection register and those who are looked after and this is denoted as "not applicable (n/a)" in the following table.

User Feedback

Viewpoint Question	% responding positively (2016/17)		Children's Wellbeing Indicator
	Children Looked after away from Home (n=150)	Children on the CP Register or subject to VYP procedures (n=127)	
Would you describe yourself as happy?	94%	92%	Healthy
Do you feel safe where you live now?	99%	n/a	Safe
Do you feel safe in your home?	n/a	94%	Safe
Are things going well for you?	97%	n/a	Achieving
Is your Social Worker someone you can talk to?	94%	88%	Respected
Do you enjoy school?	92%	86%	Achieving
Are you treated fairly where you live now?	97%	n/a	Respected
Do the people or person looking after you notice when you have done well at something?	95%	n/a	Nurtured
Do you think your views are listened to?	93%	92%	Respected
Do you take part in regular activities you like doing?	93%	82%	Active
Do you help out with the chores where you live now?	81%	n/a	Responsible
Do you see your friends when you want to?	78%	79%	Included

Young people who have used *Viewpoint* have commented that:

- "Viewpoint really helps me get my views across".
- "I like using Viewpoint to tell people about me".

vi. Supporting Minority Communities and Asylum Seekers

In Govanhill, a multi-agency group called Romanet exists and an action plan has been developed which is being taken forward by statutory and voluntary sector partners and covers education, employability, health and social care, and housing. This group is linked into an EU wide network which aims to promote and share learning in relation to Roma inclusion across Europe.

Specific initiatives undertaken in the last year have included the development of a Roma children and families social work team, and facilitating increased access for EU nationals to a range of NHS services. A Roma Peer Education project has also been established and its third cohort has been recruited during the year. This aims to increase knowledge within the Roma community of local services and their rights and entitlements, through training members of the Roma community as Peer Educators.

Partnership staff are also engaged in the city's integration networks and fund, support and directly deliver programmes for refugees and asylum seekers which support health improvement, promote broader integration, and encourage appropriate service responses across the spectrum of local services and supports. Work has been undertaken in the last year with unaccompanied young asylum seekers aged between 16 and 18 with social work staff looking to identify suitable local families who would be able and willing to offer accommodation and support for these young people. Following a promotional campaign in January, assessment processes have been undertaken and by the end of June, it is anticipated that we will have resources to place 25 young people.

2.3 SHIFTING THE BALANCE OF CARE

Within this chapter, we profile some of the key developments progressed in relation to our strategic priority of Shifting the Balance of Care. These activities have contributed to a range of the national Health and Wellbeing Outcomes, most notably the following:

Outcome 1	People are able to look after and improve their own health and wellbeing and live in good health for longer
Outcome 2	People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
Outcome 4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.

I. UNSCHEDULED CARE

Over the course of the last year, the Partnership has been developing an Unscheduled Care Strategic Commissioning Plan, to cover the period 2017/18 to 2019/20.

This Plan focuses on three main areas for action, in line with the HSCP's priorities set out in our Strategic Plan. These are the HSCP's change programme to better support people in the community and prevent admission to hospital, the improvement programme to support the hospital discharge process and the transfer of patients home or to other appropriate care settings, and the HSCP purchasing intentions agreed at the IJB in December 2016 showing the estimated impact on acute activity. Key components of this strategy include the following:

i. Intermediate Care

Intermediate care is delivered within dedicated units in care homes and provides patients who require it, on discharge from hospital, with further rehabilitation and assessment, with the aim of preparing them for a return to their own home, or if that is not considered suitable, to alternative care within their local communities. The need for this model was shaped by the high numbers of older people delayed in acute hospital beds and Glasgow City having a higher rate of older people being admitted to care homes than other parts of Scotland.

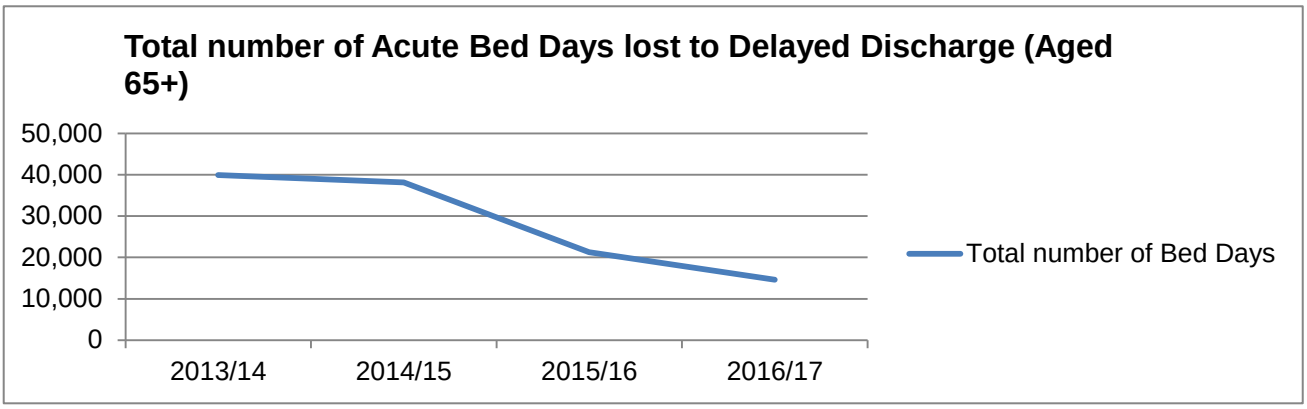
During 2016/2017, we continued to develop the role of intermediate care in the city, implementing a tender process and commissioning 90 beds city-wide. A model of medical and nursing care to support the outcome of the tender process has also been introduced, and we have implemented new practice guidance regarding Adult with Incapacity (AWI) across all current units.

Occupancy levels within the intermediate care units have been close to or above the target of 90% throughout the year. The average length of stay of service users has been higher than anticipated and in March 2017 sat at 35 days, in excess of the original target of 30 days, as a consequence of the frailty of this group which can impact on length of stay. The review process will continue to promote throughput in the units in order to maximise efficiency and promote the quality of assessment and support, but the target will be reviewed during 2017/18.

The target is to achieve 30% of service users being transferred home from intermediate care. Generally speaking, this was not met throughout the year as shown below, although moved to within the target range in February and March 2017. Further work is underway to promote alternatives to nursing or residential care and staff are committed to getting people back to their own home wherever possible, supported by an increase in the availability of housing and other supported community options.

Percentage of intermediate care users transferred home						
Target	**Apr 2016**	**Nov 2016**	**Dec 2016**	**Jan 2017**	**Feb 2017**	**Mar 2017**
30%	**21%** 🔴	**13%** 🔴	**21%** 🔴	**18%** 🔴	**32%** ✅	**29%** ✅

The impact of the intermediate care beds is demonstrated in the trends in the total number of bed days lost to delayed discharge. For the city as a whole, there was a significant reduction between 2014/15 and 2015/16 (from 38,152 to 21,288) and this has continued into 2016/17, with bed days lost falling to 15,557. This has been supported by the reclassification of the AWI beds which the HSCP commission in community settings, which in line with national guidance, are no longer included.



ii. Anticipatory Care

Our population is living longer, often with multiple long term conditions, frailty and increasing risk factors. Older people tell us that they want to be cared for at home for as long as possible. Anticipatory Care Planning (ACP) helps people to think about their future health and social care needs, and plan for changes to help them achieve their goal of staying at home while reducing their need for emergency care. Within Glasgow, we agreed an ACP model in August 2016 and developed an accompanying suite of material including practice guidance, service user information and a Personal Plan proforma. The model has been promoted across the partnership with awareness sessions provided to over 900 staff. Work has also been undertaken with partners to look at how ACPs can be supported by the third sector.

During the course of the year, the number of service users with community services led Anticipatory Care plans has risen steadily and the first annual target has been met as shown below.

Total number of Community Services Led Anticipatory Care Plans in place	
2016/17 Target	**2016/17 Actual**
360	**482**

This target will be reviewed for 2017/18 and will reflect the growing awareness and understanding of the role of these plans across the Partnership and local communities. The development of these plans will play a part, along with the other initiatives outlined within our Unscheduled Care Plan, in preventing attendances at A&E and emergency admissions to hospital, which, as shown below, have both increased slightly during the last year.

Indicator	2015/16	2016/17
New Accident and Emergency (A&E) attendances - crude rate per 100,000 population	**2,284**	**2,307**
Emergency Admissions (Aged 65+) Numbers	**27,891**	**28,557**

iii. Community Respiratory Service

In Scotland, approximately 100,000 people live with Chronic Obstructive Pulmonary Disease (COPD) and Glasgow has the highest rate of hospital admissions nationally. In response to this, the multi-disciplinary Glasgow Community Respiratory service was established and has been further developed over the last year. The service aims to facilitate earlier discharge and prevent unnecessary hospital admission by treating patients suffering from COPD in their own home and avoid the need for hospital admission. The service works with patients to develop and implement individualised care plans and self-management strategies and the patients have been targeted as part of the roll out of Anticipatory Care Planning.

During the last year, the service exceeded its monthly target of 75 new referrals. Of these, approximately 50% are either directly related to admission avoidance or early supported discharge from an acute hospital. The service uses validated outcome measures – including the COPD Assessment Test (CAT) and the EQ5DL (health outcome measure) – and all measures show statistically significant changes following intervention. Service users have also provided positive feedback in questionnaires coordinated independently by the Person Centred Health & Care Collaborative. The service has also received positive feedback from the Scottish Government who use the Glasgow Model as an exemplar of good practice and it was chosen by the British Lung Foundation as an example of quality practice for press release on World COPD Day Nov 2016

Case Study

Mount Florida resident, Benny's COPD got so bad he had ended up in hospital, and for some time he had not been able to get out of his high rise flat. That's when Deborah from the Glasgow team was called in to help. Working with her, Benny set his own personal goal to work towards – to be able to get out of his flat, so he could see his neighbours come and go. Benny explains: "I felt as though I wasn't going to make it – as though it was my last day. When Deborah first came here I was sleeping on the recliner, I couldn't walk to the toilet. Just talking for any length of time was difficult."

"Deborah had me using my walking aid and she's had me walking around, out on my landing…and standing out the front so I can meet my neighbours coming in. I've progressed 100% I would say – and the breathing's been better. It's given me a better quality of life...without Deborah and the team I wouldn't have that."

II. HOUSING FIRST

The Homelessness Strategy includes a strong commitment to further develop the Housing First approach across the city. The aim is to rebalance existing accommodation provision within homelessness services, moving from institutional to mainstream living, and increasing capacity within a community based Housing First model. Transition funding was provisionally agreed in 2016/17, with potential capital investment of up to £12 million sourced from external funding, as a result of the strengthened partnership approach developed with the third and independent sectors.

III. KINSHIP CARERS

Currently, approximately 1,300 children are in kinship care across the city. Many of these children would have been directly looked after by the Council without these arrangements in place. The level of kinship placement breakdown in the city is low for children in kinship care and this stability keeps family and local community connections alive and enables the child to keep a sense of identity.

We support kinship carers by developing their capacity and resilience to allow them to provide improved care and support. For example, they have been provided with a range of training opportunities, such as attachment and bonding, parenting, sexual health and the legal processes related to children in care. We also recognise the importance of ensuring that kinship carers have sufficient income. Kinship carers now receive comparable payments to foster carers and the welfare rights service have completed financial reviews for all kinship carers to ensure their benefits are maximised. We have also set up a permanence planning working group focusing specifically on kinship care and agreed a £500 contribution towards kinship residence orders in compliance with local authority expectations contained within the Children and Young People (Scotland) Act 2014. Practical supports for children living with kinship carers have also been put in place, such as the provision of laptops and homework clubs, in order to seek to improve educational attainment levels.

In the past 12 months we have enhanced the level of support offered by Quarriers in recognition of the quality of their work and their ability to engage directly with kinship carers, in keeping with the expectations of community voluntary engagement. This new initiative compliments the introduction of Family Group Decision Making (FGDM), which has a proven record of improving kinship stability and quality of placement, as well as reducing the need for longer term statutory involvement. We have also been selected as one of two local authorities within Scotland to participate in a national research trial focusing on the ‘Life Long Links’ (LLL) model of practice, which uses genealogy and extended family networking searches to ensure all available sense of family connectedness remains at centre of our practice. Both FGDM and LLL are being reviewed closely, with designated research and development resources in place and an interim evaluation will be available from September 2017.

IV COMMUNITY MENTAL HEALTH TEAMS

Adult Community Mental Health Teams (CMHTs) form part of a whole system approach to mental health services for the adult population. The service is delivered in conjunction with Primary Care Mental Health Teams (PCMHT), Acute Services (Crisis / Home Treatment Services & out of hours [OOH] Services), specialist Mental Health services and a range of statutory and non-statutory services that support the delivery of care.

During the last year, the CMHTs have updated and began implementation of their Operational Framework. The intention of this framework is to promote a recovery based model of person-centred care that takes into account patients' needs, preferences, strengths, and which drives consistency of service delivery processes through each CMHT. The operational framework describes the pathway of care through the CMHTs, covering all aspects of service delivery from the principles, ethos and values base for practice, through to quality assurance and clinical and care governance processes.

2.4 ENABLING INDEPENDENT LIVING FOR LONGER

Within this chapter, we profile some of the key developments progressed in relation to our strategic priority of Enabling Independent Living for Longer. These activities have contributed to a range of the national Health and Wellbeing Outcomes, most notably the following:

Outcome 1	People are able to look after and improve their own health and wellbeing and live in good health for longer
Outcome 2	People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
Outcome 4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
Outcome 6	People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being

i. Supported Living

Alongside the development of intermediate care, the Partnership has been working with care providers to expand the number and range of Supported Living options in line with our wider accommodation based strategy, and have also made additional investment into aids and equipment. We aim to shift the balance of care by enabling greater numbers of older people to be supported at home with enhanced packages of care, while reducing the numbers going into residential or nursing care. At the end of March 2017, 231 older people were in receipt of Supported Living packages although we are currently revisiting this data as it is suspected that significantly higher numbers of older people are currently receiving this service but are not being recorded as such because they are funded through dedicated personalisation budgets.

While progress has been made, we recognise that further activity will be required to meet our original 2016/17 target of 1,200 older people with access to these enhanced packages of support. Ongoing input and support from Older People's Commissioning teams is, therefore, being provided to local care management teams and provider organisations in order to facilitate increased placements. Care management teams have also created structures to offer greater levels of support to staff when they are appraising all service options and to help them identify appropriate alternatives to care home provision.

ii. Telecare

Another strand of the accommodation based strategy is the ongoing development and expansion of telecare solutions, which are pivotal in enabling individuals to live as independently and safely as possible within their own homes. Throughout 2016/17 there has been a significant increase in the uptake of both traditional telecare equipment (Basic), as well as more sophisticated technology (Advanced) designed to track older people's movements and provide families with peace of mind when an older relative is at risk of wandering as a result of dementia.

Telecare Provision		
Type of Telecare provided	**2016-17 Target**	**2016-17 Actual**
Basic	2,248	**2,581**
Advanced	304	**835**

In recognition of the further work that is required to fully optimise telecare for the citizens of Glasgow, a full diagnostic review of our current telecare provision was undertaken in 2016/17. A number of recommendations for improvement were made. These included a redesign of the operating model, process and governance arrangements, establishing a new brand for care and technology across the city, and reviewing the funding model for the service, including the charging policy. We will continue to progress these recommendations during 2017/18.

User Feedback

Home Care services are delivered on behalf of the Partnership by Cordia LLP. During the past year Cordia carried out a service user consultation on this service; the headline figures are presented below.

Statements	***% who "strongly agree" / "agree" with statement***	***National Health and Wellbeing Outcome***
The home care service I receive has made me feel safer at home	*84%*	*Outcome 7*
The contact I have with home carers has improved my quality of life	*81%*	*Outcome 4*
I get up and go to bed at times that suit me	*84%*	*Outcome 3*
I feel that I am listened to and my wishes respected	*85%*	*Outcome 3*
The home care service enables me to maintain the standard of personal care that I want	*87%*	*Outcome 4*
My home carers are helpful and friendly	*97%*	*Outcome 3*
My home carers treat me with dignity and respect	*97%*	*Outcome 3*
My home carers are thorough at what they do	*88%*	*Outcome 4*
I feel that my right to confidentiality is respected by my home carers	*92%*	*Outcome 3*
I am confident that my home carers have the training and skills to support me	*89%*	*Outcome 8*
Telephone calls to the Cordia office are always answered promptly	*76%*	*Outcome 3*
The Cordia office staff are always polite and helpful	*86%*	*Outcome 3*
Cordia managers and staff respond to any concerns I have about the service	*73%*	*Outcome 8*

The survey points to a high degree of satisfaction with the service in general, for example 84% of service users agree that they feel safer at home, and 81% agree that their home carers have improved their quality of life. The professionalism of home carers was particularly highlighted with 97% agreeing that their home carers are helpful and friendly, and 97% agreeing that their home carers treat them with dignity and respect. Survey comments from service users and their families underline the high degree of satisfaction with the service:

"*The home carers who attend my mother are exceptional and are a part of the family."*

"The service I get is excellent and my carers are professional and treat me with respect and dignity."

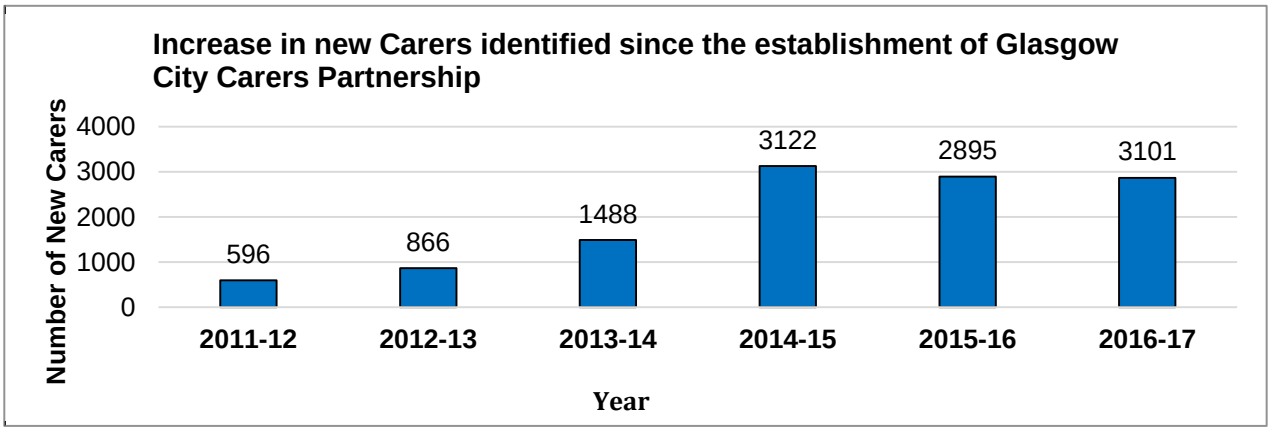
"It is a wonderful service. I couldn't manage at home without it"

iii. Supporting Carers

Glasgow City Carers Partnership, launched in December 2011, is regarded as a model of good practice in carers support services. A universal carers pathway has been developed and services/resources offered include a carers information line, a carers booklet and self-assessment/referral form, health reviews, emergency plans, and a Carers Privilege card which provides a range of discounts, and has over 10,000 people registered. A Carers Champion has also been appointed in the city who has in the last year supported carers in a variety of ways, including offering individual carers assistance to engage with partnership services, organising carer development sessions, and providing carer representation on the Integration Joint Board.

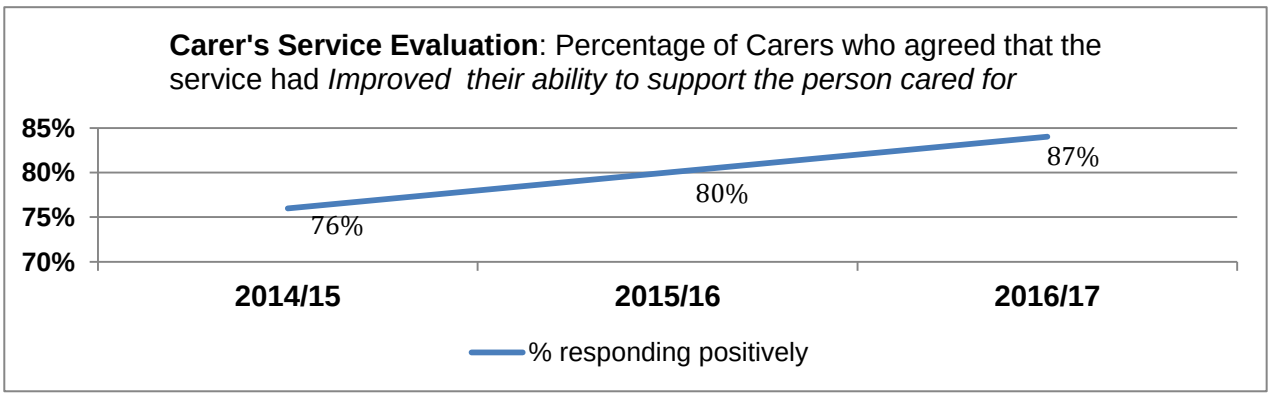
i. Carer Assessments

During 2016-17, 3,101 new carers were identified, a slight increase on the 2015/16 figure of 2,895 new carers. It is believed that we have reached a natural plateau of approximately 3,000, having increased year on year between 2011/12 and 2014/15, although part of this increase may be explained by the more consistent recording methods used since 2014.



ii. Outcomes

Carers service evaluation forms are sent to carers after their assessment has been undertaken and services are in place. Of those who completed the form, the percentage who indicated that the support they received improved their ability to support the person they care for increased between 2014/15 (76%) and 2016/17 (87%) as shown in the following graph.



The integrated assessment processes allow for carers to be triaged to access the right levels of support at the right time. We have a focus on early identification and during 2016/17, 73% of carers were able to be supported though the provision of information, advice and anticipatory services, 21% were assessed as having moderate to substantial needs, and 6% with critical needs for whom the intervention was often an increased package for the cared for and respite for the carer.

iii. Short Breaks and Support

In 2016/17 just over £262,400 was spent providing 17,217 hours of short breaks to 713 individual carers. This enabled crises to be prevented, allowed carers to attend personal appointments or events, and enabled them to attend the range of training and support opportunities provided.

Over the course of 2016/17 881 carers attended the 88 courses offered: 54 received bespoke moving and handling advice, and 118 attended 1 to 1 appointments for Power of Attorney/Guardianship advice. There were also 21 different peer support groups run with 1041 places available over 275 group sessions.

Work has also been undertaken over the last year with Education to develop a range of promotional materials aimed at young people, resources to help teachers to identify young carers, and to develop a young carer support pathway from schools to young carer support services. 216 young carers were referred in 2016/17 and the impact of these initiatives upon these numbers will be closely monitored going forward.

Case Study

Mrs C cares for her dad who lives alone in Partick. He does not like to accept help, making the caring role more difficult. He has had two strokes and a knee replacement and has become increasingly prone to falls over the last 12 months resulting in crushed vertebrae and damaged replacement knee joint, which has impacted upon his mobility. Mrs C works full time as a primary teacher in Cumbernauld and lives in the North East of Glasgow. She likes to spend time with her grand-children and her husband, to whom she's been married to for four years. She is being treated for stress and depression due to the pressure of her commitments and anxiety about her dad. She had no previous awareness of carers' centres or their role in providing support, but was made aware of them and contacted her local social work carers team who helped her complete an emergency plan and carers assessment.

Her dad was encouraged to accept support to reduce the risks of further falls and the Carers Centre made a referral to the Community Falls Prevention Team who were able to secure his shower enclosure, provide handrails and provide a tray for his zimmer. A telecare system has also now been installed and dad's income has been maximised by £3,200 which helps to fund a laundry service, taking off some pressure from Mrs C. A blue badge application has been completed to make trips out more viable for both Mrs C and her dad. Power of Attorney has also been recommended and the process to put this in place is now underway.

Mrs C reports that she is delighted with the support plan in place for her father. She is less stressed knowing that an emergency plan is in place and that her dad is now at significantly less risk of falling. She reports that she felt listened to, valued and respected as an individual and that her dad now felt much more secure in his home.

iv. Supporting People with Dementia

In May 2016 we launched the Glasgow City Dementia Strategy. This 3 year strategy and overall vision has been developed in collaboration with Alzheimer Scotland and co-produced with people with dementia, their families, carers and a wide range of stakeholders.

The Strategy outlines our commitment to improve health and social care services for people with dementia. A key part of this is ensuring we are effectively diagnosing dementia in order to enable the delivery of appropriate interventions. Within the city, the numbers diagnosed with dementia have consistently exceeded the population based prevalence estimates and at present, we have over 4,350 people on local GP dementia registers compared to a target of 4,210 (see Chapter 5).

A key Scottish Government target is to ensure that all people newly diagnosed with dementia have a minimum of 1 year's post diagnostic support co-ordinated by a link worker and have a person-centred support plan in place. Following a review of alternative locality pilots, we agreed a city-wide model which was implemented from April 2017. Over the course of the last year, information systems to record activity have been under development and this will be reported on in future reports.

Over the last year, we have been working with the Council City Centre Regeneration Team to develop Glasgow city centre as a dementia friendly location. This has involved an initial 'walkabout' by people affected by dementia, and will result in the formation of an action plan. As part of this, we will work closely with local organisations and businesses to ensure that premises are welcoming to people affected by dementia, and that staff have an awareness of their needs, as well as looking at related environmental and transport issues.

Case Study

Mr M is an 82-year-old man who lives with his son in the south side of Glasgow and has a diagnosis of Alzheimer's. He is a very independent man who attends his day centre 3 times a week, and he routinely travels to a local shopping centre. The telecare team were approached by a carers development worker who enquired if there was anything that could help Mr M and his son as Mr M was getting confused and on few occasions had been unable to find his way home. Mr M's son was quite distressed about this, especially as the winter and darker nights were approaching and he was concerned that his Dad would come to harm.

The telecare team identified that Mr M would be a suitable candidate to participate in the testing of a non-speech GPS device which allows an individual's location to be tracked. The device was configured to incorporate a safe zone whereby if Mr M went out of the areas close to the shopping centre or his day centre, his son received a text message informing him of his dad's location. The device also enabled his son to text the device and receive a location report if he had concerns about his father not returning home by his usual time.

The experience has been very positive for Mr M and his son. Mr M continues to travel independently and enjoy his range of activities and his son has confidence in the GPS system to support and enable him to do so. For example Mr M missed his bus when returning from day care and subsequently became confused. Mr M's son was able to text a message to the device to confirm his location and was then able to go and collect him and take him home safely.

v. Income Maximisation

Within the HSCP Welfare Rights Section there is an Income Maximisation team that visits people in receipt of a range of chargeable social work services including home care, day care, personalisation and telecare. The purpose of the visit is to ensure that they are receiving all relevant benefits which they are entitled to. This in turn enables them to contribute to the cost of their care package. A new recording system to measure the increases in benefit income was introduced in August 2016. Between August and the end of March, the service made 697 successful claims for different benefits generating an additional £1.9m in ongoing benefit and £1 million in backdated awards as shown in the table below. On a pro-rata basis, if replicated over a 12 month period, this would equate to over £4.43 million.

Period	Arrears	Annual Additional Benefit	Combined
Aug 16 to Mar 16	£1.00 million	£1.95 million	£2.95 million
12 month equivalent	£1.50 million	£2.92 million	£4.43 million

In 2016 Welfare Rights staff also represented clients at 971 social security appeal tribunals. 53% of the appeals related to disability benefit appeals and 40% related to incapacity for work. The overall success rate for the concluded appeals was 66% resulting in a total gain of £4 million which represents an average annual gain per successful appeal of £7,300.

We also invested £400k in financial advice services in Glasgow to receive referrals from any of our NHS and GP Practice based staff throughout the city, including our 'Healthier Wealthier Children' service, which enables midwives and health visitors to support families to prevent and reduce child poverty wherever possible. During the course of 2016/17, over 3,000 patients benefitted directly from these services.

Case Study

Client A was referred to the Income Maximisation service by their housing association. The client had previously received the middle rate of care Disability Living Allowance (DLA) for three years for their now seven year old child. The Department of Work and Pensions on review, took the view that the client and child could manage the child's conditions and care needs, which included blood testing, dietary control, and dealing with the effects of hypoglycaemia when blood sugar levels become too low. The housing association had to persuade the client to appeal as they had been influenced by negative press coverage of 'benefits scroungers" and initially resisted the suggestion. However, the appeal was successful and the previous payments were reinstated. It was also identified that the client was entitled to the disabled child element of Child Tax Credit and recommended that she start claiming Carers Allowance and Income Support, allowing her to stop claiming Job Seeker's Allowance. As a result of these interventions, the family's weekly income has increased by £150 per week and they received a backdated sum of £5,312.

vi. Employability

Health and Social care users are now the priority target group for both UK and Scottish Government employability efforts. In the last year, we commissioned an independent review of the employability programmes delivered or commissioned through health and social care services. The review made a number of recommendations for improvement, and found services to be cost effective and to be performing comparably with wider employability services in the city.

During 2016/17, we invested around £2.5m within 16 projects spanning a number of service areas, including mental health, addictions, health improvement, leaving care services and learning disability. As a result, approximately 2,700 service users/patients were supported through employability services, with strong performance in supporting people into work**.**

User Feedback

- *I would say try and get into the working environment as soon as possible. It lifts your self-esteem, lifts your confidence, I come home from work and I am gleaming for the rest of the day.*
- *Having no structure was devastating to my wellbeing, being supported to find work that was right for me has changed how I feel… I have hope.*
- *Getting work has boosted my confidence, changed my perception on things, helped me to break the cycle and move forward.*
- *Now I can say that I'm a chef in one of the best hotels in town…I'm so much more than just a mental health patient.*
- *You can still have them, symptoms and go to work. I suffer from Post-Traumatic Stress Disorder, sometimes I get flashbacks and I had one at work, I dealt with it and it was fine. It's easier to deal with at work…I have just put it to the back of my mind and I go on to the till or sort the bags.*

2.5 PUBLIC PROTECTION

Within this chapter, we profile some of the key developments progressed in relation to our strategic priority of Public Protection. These activities have contributed to a range of the national Health and Wellbeing Outcomes, most notably the following:

Outcome 1	People are able to look after and improve their own health and wellbeing and live in good health for longer
Outcome 5	Health and social care services contribute to reducing health inequalities
Outcome 6	People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being
Outcome 7	People using health and social care services are safe from harm

i. Public Protection

Public protection is central to the ethos and underpinning of the Partnership, runs through every aspect of HSCP service delivery and is evidenced by its profile within our organisational structure. Key aspects in which it is specifically manifested include: Child Protection, Adult Protection, and the Multi-Agency Public Protection Arrangements (MAPPA) in respect to the management of sex offenders and other high risk offenders.

Child Protection

In late 2016 Glasgow underwent a Children's Services inspection as summarised in chapter 5, part of which involved reviewing child protection arrangements. Feedback from the report was positive, and acknowledged good multi-agency working, while recognising that the challenges facing the city in terms of keeping children safe were significant.

Specific activity undertaken in the last year include the following:

- Hosting of successful conferences on *Child Sexual Exploitation* and *Adult Services Role in Tackling Childhood Neglect*
- Ongoing work in relation to the dissemination of learning from local and national Significant Case Reviews.

At the end of March 2017, there were 495 children on the child protection register; this figure was almost identical to the 494 on the register at the end of March 2016. 43% of these children were aged 0-4, 39% aged 5 to 11, 16% aged 12 to 15, and 2% aged over 15. Between April 2016 and March 2017, there were 564 new child protection registrations, falling from 686 for the same period in 2015/16. The number of de-registrations also fell from 668 in 2015/16 to 579 in 2016/17, with the average number of days on the register before deregistration rising to 272 during 2016/17, from 251 in 2015/16.

Adult Protection

Within Glasgow Health and Social Care Partnership we have continued to raise awareness of adult protection and continue to develop and expand the training and awareness raising opportunities for front line staff and managers from across health, social work and partners. Within each calendar year, we organise six multi-agency development sessions. Other areas of activity undertaken in the last year have included:

- Production of an easy guide to adult support and protection.
- Organisation of multi-agency learning events to draw upon the lessons learned from the Significant Case Review of Mrs A., published in September 2015.
- Increased the availability of single and multi-agency training in Adult Protection.
- Created a specific working group on financial harm.
- Facilitated and supported service user representation on the Adult Protection Committee.

During 2016/17, there were 372 Adult Support and Protection investigations undertaken, an increase of 26% from the 296 undertaken during 2015/16.

User/Carer Feedback

"Knowing that people were listening to me and were wanting to support me was the best thing about the Adult Support and Protection process". – female service user

"I'm pretty sure that without any help I'd have either wound up dead or in a bad way, living on the streets or maybe in a hostel". – male service user

"The support I got from social work and the community police and my support team has made me feel safer". – female service user

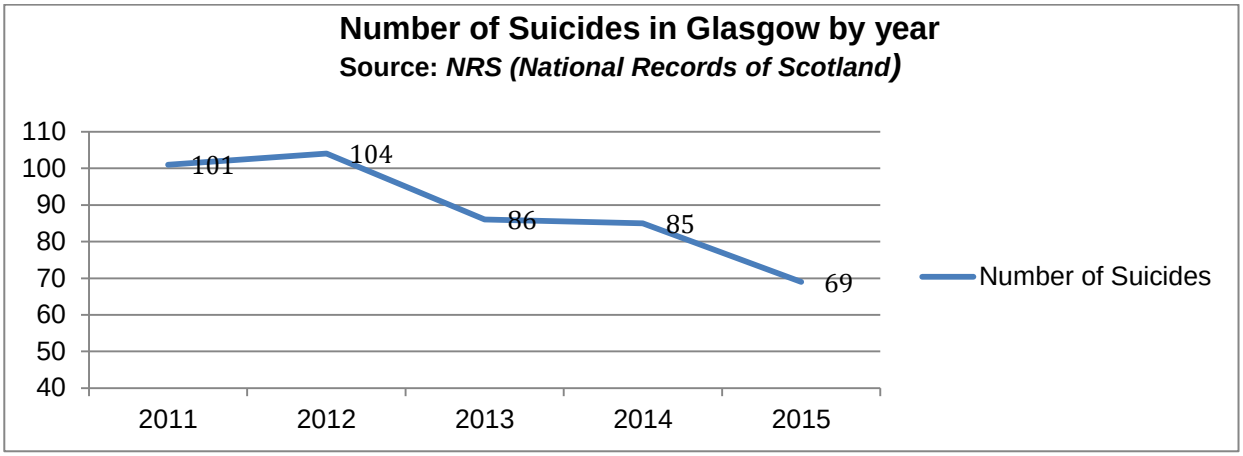
MAPPA

The MAPPA arrangements across Scotland were reviewed in 2015. The report was largely positive both in national and local terms, highlighting Glasgow's management of lower level offenders as an area of good practice. Recommendations within the report have informed local practices and activities undertaken in the last year have included:

- Continuing to make slow but steady progress in increasing appropriate housing options for registered sex offenders through the Glasgow National Accommodation Strategy for Sex Offenders (NASSO) group.
- Organisation of a session with staff from adult services and criminal justice, to improve joint practice and benchmark Glasgow against the recommendations in the Significant Case Review undertaken in another area of the country highlighting overlapping issues between MAPPA and Adult Protection.
- Continuing to evidence strong multi agency working, which is likely to be enhanced by the planned co-location of police and Partnership staff.

ii. Suicide Prevention

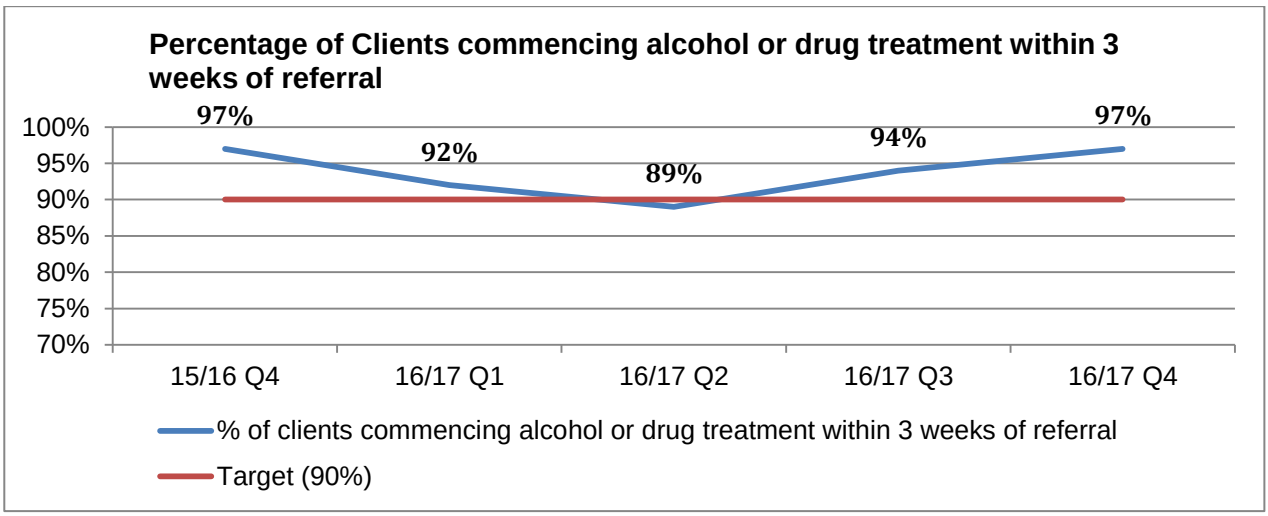
Glasgow City Choose Life Working Group has continued to lead a multi-agency initiative aimed at reducing self-harm and suicide, working collaboratively and sharing good practice with other partnerships across NHS Greater Glasgow and Clyde. Suicide prevention training has now been undertaken by over 10,000 workers in Glasgow from a range of services including mental health, addictions, children's residential units, school nursing, education, housing, money advice services, and violence against women support programmes. A decade ago, Glasgow had one of Scotland's five highest suicide rates, but the latest data for the period 2011-15 shows Glasgow at the same level as the Scottish average (see graph below). This significant reduction, particularly in the last five years is welcomed and all partners wish to see the rates continue to decline.



iii. Reducing Alcohol & Drugs Harm

During 2016, we have extended the 'Glasgow City Assertive Outreach Pilot'. This was initiated around concerns relating to public injecting by individuals who were rough sleepers, and associated crime and anti-social behaviour. Using an assertive outreach approach to engage with these traditionally hard to reach groups has led to an improved understanding about their wellbeing and how they can be best engaged with and supported. Other benefits have included decreased drug paraphernalia in the city centre and reduced risks of the spread of HIV and other Blood Borne Viruses. Building on the Public Health needs assessment and work of the Assertive Outreach Team, the Glasgow City IJB have also recently approved an outline business case for a pilot Safer Drug Consumption Facility and Heroin Assisted Treatment Service in the city centre. Work is ongoing to deliver these services in 2017.

It is important that people are able to access our services quickly and a target exists that 90% of clients should commence alcohol or drug treatment within 3 weeks of referral. As shown below, this has consistently been achieved during the past 12 months.



More generally, Glasgow continues to develop a tiered Recovery Orientated System of Care (ROSC) by enabling individuals to progress on from their problem alcohol or drug use, towards life as an active and contributing member of society.

New arrangements for Alcohol & Drug Community Rehabilitation Services were put in place in 2016. 3 Recovery Hubs were commissioned by the HSCP, and are provided by Third Sector Partners. These new Hubs provide a range of advice and support that can

be directly accessed by those affected by substance misuse. The Hubs work in partnership with the Community Addiction Teams (CATs) and the Recovery Communities which offer crucial peer support and are led by individuals with lived experience.

The Hubs aim to be more responsive to individual needs and provide greater assistance to individuals moving towards their own recovery. These services promote health and well-being, but also seek to build the confidence and resilience of the individuals they work with, making recovery more sustainable. In support of this, we fund 'Elevate', to help support the development of appropriate employment options. We have also been involved in the design and piloting of the Scottish Government's Drug and Alcohol Information System (DAISy) based recovery outcome tool, and use this to develop care plans and monitor the progress in the recovery journey.

iv. Prison and Custody Suite Healthcare

The partnership has responsibility for providing healthcare services across NHS Greater Glasgow and Clyde to prisons and police custody suites. In the last year, we have enhanced our health improvement activity within these environments and seen an increased uptake. We have also implemented a mental health pathway for people in police custody over the last 12 months, which has transformed the service response to those in custody who require specialist mental health input. This has led to a vast improvement in access and enabled more appropriate, timeous input from specialist mental health services, enhancing patient safety as a result.

We have also undertaken a review of progress made in taking forward the recommendations made following a 2012 Health Needs Assessment conducted with prison populations of HMP Barlinnie and Greenock. The report will be published later in the year, but the initial findings suggest that significant progress has been made in relation to multiple service areas and recommendations.

v. Homelessness

There continues to be a focus within homeless services on harm reduction for people with multiple/complex needs. The existing City Ambition Network (CAN), a collaborative project operated jointly with a range of voluntary sector partners, has secured additional external funding, enabling the service to be extended to 50 service users, identified through the Winter Shelter and street team service (Rough Sleepers and Vulnerable People service, RSVP). As a result of collaborative working, through deployment of Homelessness Services staff to work alongside the voluntary sector Winter Shelter team, a pilot initiative to provide a multi agency city centre hub has been agreed, with the CAN project working in partnership with the HSCP, to offer a wide range of interventions an support for the City Centre homeless population. This initiative will help to inform new ways of working, and strengthen the partnership with voluntary/independent sector providers as part of the emerging HSCP strategy for vulnerable adults.

2.6 ENGAGING AND DEVELOPING OUR STAFF

National Health and Wellbeing Outcome 8 indicates that people who work in health and social care services should feel engaged with the work they do and feel supported to continuously improve the information, support, care and treatment they provide.

We recognise that staff have a key role to play in identifying and leading on the transformational changes in health and social care services which we are pursuing following integration. To facilitate this, over the course of the last year we have undertaken a range of activities in pursuit of this aim, which are summarised below.

i. Service Improvement

- Commenced roll out the HSCP Voice initiative which will provide staff with the opportunity to identify areas for service improvement, with nominated service improvement champions supporting them to take these forward.
- Launched the iMatter programme which involves the use of a continuous improvement tool designed to help individuals, teams and organisations understand and improve staff experience. This is based on evidence which shows that patients and their families have improved care experiences when staff feel more engaged and motivated.
- Provided a range of online and face to face learning opportunities on the LEAN continuous improvement principles and methodology.
- Delivered a range of staff engagement sessions to create awareness and understanding of the Partnership's vision, update staff on key developments, and enable them to share their views and discuss issues affecting them.

ii. Communications

- Developed a two-year communications strategy, which sets out the framework, channels and audiences for communications and engagement with internal and external stakeholders. This was informed by a communications survey undertaken just prior to the formal establishment of the Partnership in 2016.
- Implemented a follow up communications survey in early 2017 to better understand the effectiveness of Partnership communications and identify where further improvements can be made. This will be used as a baseline to monitor and measure the impact of communications and staff engagement activities and the effectiveness of the communications strategy at its mid and end points.
- Introduced regular Partnership newsletters aimed at keeping staff and external stakeholders updated on the work of the Partnership and key developments.
- Developed Health and Social Care Integration webpages on the Council's external website on which we publish strategic publications and papers of the Integration Joint Board and its sub-committees. We are also now in the process of developing a dedicated external website where this information will feature going forward.
- Introduced a Twitter profile to communicate the work of the Partnership in real-time and have been working to increase its utilisation.

iii. Development

In addition to the ongoing range of training and development opportunities which we offer, over the course of the last year we have developed an induction process for any new staff entering the HSCP, which they receive in addition to any service specific inductions. We have also ensured that all staff have access to leadership development initiatives including Ready to Lead and Coaching Conversations. A large number of teams also have participated in team effectiveness workshops, at which they work to establish shared objectives for their team which supports the locality, SMT and wider HSCP strategic objectives.

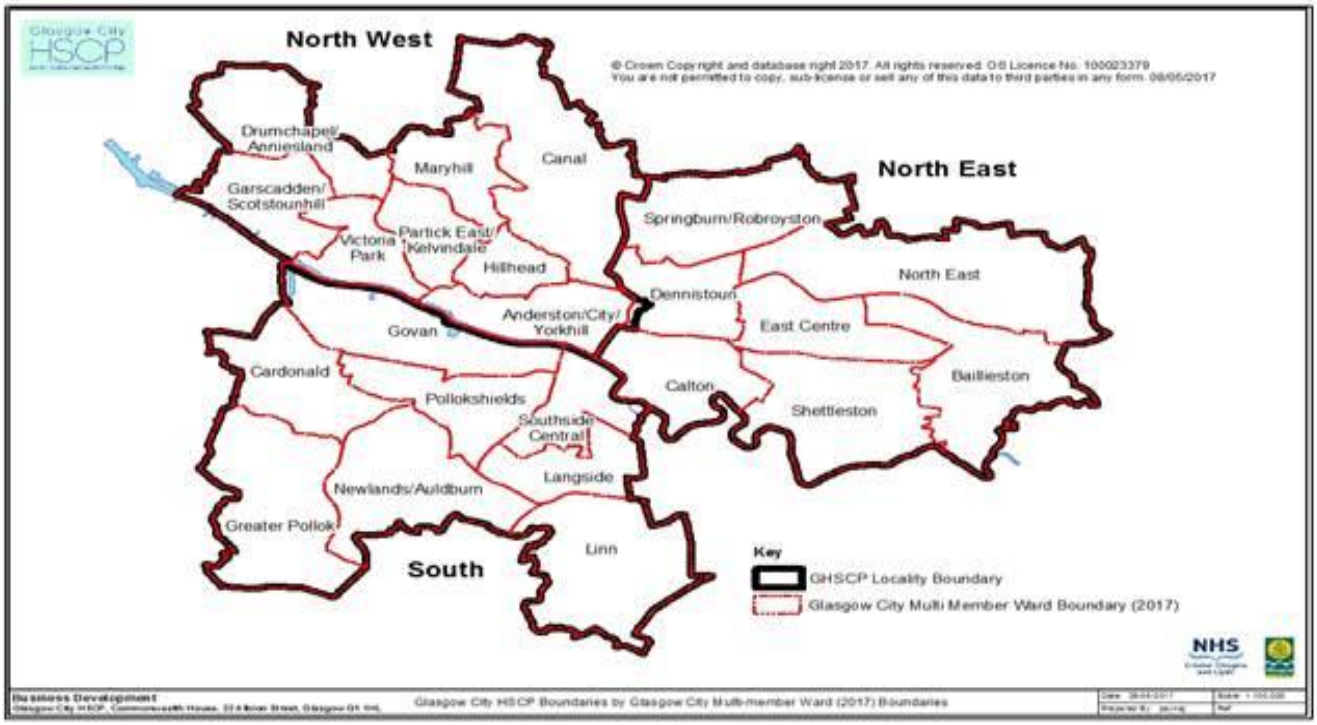
iv. Healthy Working Lives

In Glasgow City, the Partnership has received a Gold Healthy Working Lives award. Our Healthy Working Lives team has also been supporting other employers to build healthy working environments that are safe, protective and promote wellbeing. In 2016-17, the team supported 160 registered companies in Glasgow City alone including 90 small to medium enterprises, equating to over 240,000 employees from across a range of sectors including building and construction, financial services, media, call centres, transport, logistics, engineering, retail and hospitality.

3. LOCALITY PLANNING IN GLASGOW

3.1 Locality Structures

To make sure there is consistency in how local services are delivered, the Glasgow City Health and Social Care Partnership have adopted the same strategic areas as the Glasgow Community Planning Partnership and divided the city into three local areas, known as localities, to support service delivery. These localities - North West, North East and South - are shown on the city map then described in more detail below.



North East Locality

North East Locality covers the following wards:

- Calton
- Dennistoun
- Springburn/Robroyston
- East Centre
- North East
- Shettleston
- Baillieston

The total population of North East Glasgow is 170,613 people and a breakdown by age is shown below (Source: National Records of Scotland for 2015).

Age band	Number of people	% of population	% of this age band in Glasgow City
0 to 15 years	28,971	17	16.1
15 to 64 years	116,630	68.3	70.1
65 years and over	25,012	14.7	13.8

North West Locality

North West Locality covers the following wards:

- Anderston/City/Yorkhill
- Hillhead
- Canal
- Maryhill
- Partick East/Kelvindale
- Victoria Park
- Garscadden/Scotstounhill
- Drumchapel/Anniesland

The total population of North West Glasgow is 213,562 people and a breakdown by age is shown below (Source: National Records of Scotland for 2015).

Age band	Number of people	% of population	% of this age band in Glasgow City
0 to 15 years	29,558	13.8	16.1
15 to 64 years	156,953	73.5	70.1
65 years and over	27,051	12.7	13.8

South Locality

The South Locality covers the following wards:

- Greater Pollok
- Cardonald
- Govan
- Pollokshields
- Newlands/Auldburn
- Southside Central
- Langside
- Linn

The total population of South Glasgow is 222,165 people and a breakdown by age is shown below (Source: National Records of Scotland for 2015).

Age band	Number of people	% of population	% of this age band in Glasgow City
0 to 15 years	39,003	17.6	16.1
15 to 64 years	151,722	68.3	70.1
65 years and over	31,440	14.1	13.8

3.2 Locality Management and Engagement Arrangements

Each locality includes a senior management team responsible for delivering and co-ordinating services and making sure the partnership's policies and plans are put into practice at a local level. Individual care group management teams are also established in each locality and are responsible for overseeing service activity and delivery.

Wider locality planning arrangements are also in place which involve a range of partner agency representatives, service user and carer networks and groups, and GPs and other primary care professionals. Links with Community Planning partners are maintained at a strategic level through the Community Planning Area Senior Officers Group and the Community Planning Partnership Board.

During 2016/17, each locality established local engagement forums which brought together representatives from Public Partnership Forums (Health), Voices for Change networks (Social Work), and other local networks and groups. As part of the process of developing these, each area consulted widely on the HSCP's Participation and Engagement Strategy.

Each locality also has a Primary Care Group engaging with the wider independent contractor body, which all link to the overall city wide Primary Care Steering Group. Over the course of the last year, the localities have been working to develop General Practice 'clusters'. It has been agreed within the city that there will be 20 GP clusters ranging in population size from 19,000 to 76,000. There are 7 clusters in both the South and North West localities and 6 situated in the North East. Each of the clusters has identified a Cluster Quality Lead and a development programme has been implemented to support their learning needs, with a specific focus on quality improvement methodology.

These clusters provide an opportunity for GPs and their associated primary care services to work more closely to share good practice and identify priority areas for quality improvement, and to look at how community services can align with the clusters to facilitate more integrated working. To support this activity, a suite of measures have been generated in Practice Activity Reports, which are shared quarterly within the clusters allowing them to compare performance between member practices.

3.3 Locality Planning

During the course of the last year, each area developed their own individual locality plans, which showed how they will implement the HSCP's Strategic Plan in their respective areas, and how they will respond to locally identified needs and priorities. These plans covered a one year period and were initially produced for 2016/17. They have recently been reviewed and updated plans have subsequently been produced for 2017/18. These plans include the following:

- Service priorities; progress made during 2016/17 and key actions and associated timescales for 2017/18.
- Performance; an assessment of performance against key targets, identifying where they have done well and areas for improvement.
- Locality budgets and savings.
- Health and social care needs and any changes year on year.
- Community engagement mechanisms and development.
- Equalities activity and priorities.

Implementation of these locality plans is monitored on an ongoing basis and reported to locality and citywide management teams, as well as to the Integration Joint Board. The detailed plans for each locality for 2017/18 can be accessed at the link below.

Locality Plans

4. FINANCIAL PERFORMANCE

4.1 Introduction

As indicated in Appendix A, National Outcome 9 relates to *'Resources being used effectively and efficiently in the provision of health and social care services'.* Within this chapter, we seek to demonstrate this by providing an overview of financial performance during 2016/17. We also describe the transformation programme we have been taking forward and the key capital investments progressed, before briefly considering the financial outlook for 2017/18.

4.2 2016/17 Partnership Budget

The total financial resources available to the partnership for 2016-17 were around £1.1billion. As per the original Strategic Plan, these resources were allocated as outlined in the table below.

Services Provided in Pursuance of Integration Functions to Service Users by Care Group per Strategic Plan			
Care Group	**Gross Exp Budget**	**Income Budget**	**Net Annual Budget**
	£000	**£000**	**£000**
Children and Families	150,213.50	1,603.60	148,609.90
Prisons Healthcare and Criminal Justice	23,243.00	18,624.60	4,618.40
Older People	221,396.00	10,342.00	211,054.00
Addictions	48,274.30	1,121.70	47,152.60
Carers	1,846.60	94.20	1,752.40
Elderly Mental Health	24,832.10	923.90	23,908.20
Learning/Physical Disability	87,667.00	11,646.60	76,020.40
Mental Health	109,566.10	11,979.70	97,586.40
Homelessness	76,158.70	35,495.50	40,663.20
GP Prescribing	123,071.30	0.00	123,071.30
Family Health Services	173,521.30	8,814.60	164,706.70
Hosted Services	11,278.30	1,010.40	10,267.90
Support Services	66,491.50	5,217.90	61,273.60
TOTAL	**1,117,559.70**	**106,874.70**	**1,010,685.00**

Figures include Care Homes (£69.7m), Supported Living (£12.0m), Personalisation (£63.1m).

In 2016-17, the Scottish Government directed £250m from the national health budget to Integration Authorities for Social Care. Glasgow City IJB's share of this funding was £33.28m. Details of how this was allocated to support the aims of integration were set out in the papers to the IJB in March 2016, available at the following link:

Report to IJB

4.3 2016/17 Set Aside Budget

In addition to the above, there is a “Set Aside Budget” which is made available by the Health Board to the Integration Joint Board in respect of ‘’those functions delegated by the Health Board which are carried out in a hospital within the Health Board area and provided for two or more Local Authority areas’’. The total set-aside budget for 2016/17 was £120.8m, which excludes the budget value for Adult Mental Health and Elderly Mental Health inpatient services.

4.4 2016/17 Financial Performance

Glasgow, like all public services in Scotland, has faced significant financial challenges in recent years, with further pressures expected in the future. Financial pressures on health and social care services have included:

- reduced levels of public sector funding
- increasing costs of medications and care services
- an ageing population leading to an increase in the number of people who have more than one long-term condition (multimorbidity) and the number of people with complex needs
- increasing rates of dementia
- increases in National Insurance contributions for employers
- the increasing minimum wage and move to a living wage, leading to increased employer costs and requests from health and social care contractors for more money to help meet their costs, and
- superannuation increases and the effects of people automatically paying into a pension arrangement.

Budget Monitoring throughout 2016-17 has shown the IJB projecting a break-even position or small underspend by the end of the financial year. This is as a result of effective budget management across the Health and Social Care Partnership. Where an underspend is achieved at the end of the financial year, any unallocated funds will be retained in the IJB’s reserves to meet future pressures.

4.5 Transforming Our Services

Within the Partnership, we have been taking forward a Transformational Change Programme across the entirety of the HSCP’s business over the course of the last year. This Programme is being monitored via an Integration Transformation Board, chaired by the Chief Officer, the aims of which are to:

- Deliver transformational change in health and social care services in Glasgow in line with the Integration Joint Board’s vision and Strategic Plan, and the National Health and Wellbeing Outcomes.
- Monitor and evaluate the short, medium and long term impacts of the transformational change programme.
- Monitor and realise financial savings arising from Transformational Change programme.
- Engage with stakeholders and promote innovation within and beyond the Glasgow City Health and Social Care Partnership.

The IJB reviewed a mid-year update on progress of the Transformation Programme in October 2016. Good progress continues to be made, demonstrating best value for the IJB, Council and Health Board, with an end-of-year assessment due to be completed and reported to the IJB Finance and Audit Committee later in 2017. Details of the Transformation Fund and progress reported to the IJB are available through the following links:

- Programme
- October Update

Examples of key pieces of work carried out over 2016/17 which have helped to transform the delivery of health and social care services include the following:

Children's Services

During 2016/17 we have implemented a major transformation programme within Children's Services, with the objective of shifting investment from high cost, residential forms of care towards family-based, wrap-around support for children and young people, enabling them to remain within their families and community, wherever possible. We have been able to substantially reduce the number of children and young people in high cost care from 116 in March 2016 to 90 by May 2017. At the same time, we have been working with the Third Sector and Education Services to develop a wider family support strategy, with a focus on intervening early to prevent children and young people from needing more intensive forms of care, with the aim of improving their longer term outcomes.

Review of Speech and Language Therapy Care Homes Service

During the course of the last year, we have also completed a review of our Speech and Language Care Homes service to ensure that we can better meet the needs of people in residential and nursing homes with swallowing and/or communication difficulties. Additional staff are now involved in delivering this service and are involved in implementing the recommendations from this review. As a result, we have seen a reduction in waiting time for urgent referrals from four weeks to two working days and a reduction in waiting time for routine referrals from 30 weeks to two weeks.

Occupational Therapy Review and Reform

In 2016, Glasgow City HSCP set out to transform the way we organise and deliver Occupational Therapy (OT) services in the community. Our aim was to provide an integrated model of service that makes the best use of available staff and other resources, provides easy and timely access to services, reduces bureaucracy, and reduces multiple assessments and duplication. We have now completed our review and are in the process of implementing a number of key recommendations including developing an understanding of the core skills that should be applied by all Occupational Therapists, ensuring consistency in the range of aids and equipment that staff can provide, and extending the number of staff groups who can order equipment.

District Nursing Single Point of Access

Traditionally district nurses managed referrals and telephone calls at a local level, resulting in a variable response to callers, multiple telephone numbers and a lack of governance around referral pathways. The new Single Point of Access was introduced in 2016, with callers now accessing a single telephone line. This is manned by admin staff who process referrals and messages for nursing staff, thus freeing up more of their time for clinical duties and enabling them to manage their workload more effectively and respond to 'same day' or urgent referrals. Since January 2017, the service has been answering over 6000 telephone calls and processing over 1,000 electronic referrals monthly from GP practices.

Primary Care Mental Health Team Review

Over the course of the year we have worked to improve access to primary care mental health teams and psychological therapies, and an updated service specification is now being implemented in each locality. Data recording issues are currently being progressed with the planned rollout and introduction of a new clinical management information system, but local indications are that performance has improved and services are meeting agreed waiting times for accessing primary care mental health teams and psychological therapies.

Homelessness Alliance

The Integration Joint Board has approved a proposal to take forward a Tender for a Framework of Providers in homelessness services to engage in future joint commissioning activity. This work will inform future roll out of the alliance commissioning approach, and transform the future planning and delivery of homelessness services from 2018/19.

4.6 Capital Investments and Priorities

The new Maryhill Health and Care Centre opened in September 2016, incorporating GP Practices, a youth health service, health improvement teams, and a range of community health and dental services.

In 2016-17, the IJB approved full business cases for new Health and Social Care Centres in Gorbals and Woodside. Work has now commenced on both centres and have expected completion dates of Autumn 2018. During the last year, the IJB also agreed to the development of a business case for a new health and social care facility in the North East.

We have also been developing two new fit for purpose wards at the Stobhill site and work is expected to complete during 2019. Refurbishment is also underway on four wards on the Gartnavel Royal and Stobhill sites and is expected to complete later in 2017.

Over the course of the last year, we have been developing a Property Strategy for the IJB. This will set out details of proposed capital investment priorities going forward and will be approved later in 2017.

4.7 Financial Outlook for 2017/18

The financial position for public services continues to be challenging, and the IJB must operate within significant budget restraints and pressures. Glasgow City Council set its budget in February 2017, confirming its contribution to the IJB and incorporating a savings target which has been included in the IJB's financial plans for 2017-18. At time of writing, the NHS Greater Glasgow and Clyde contribution to the IJB has yet to be confirmed, however the Scottish Ministers have directed that NHS contributions to Integration Authorities for delegated health functions be maintained at least at 2016-17 cash levels. In simple terms, this means that budgets for allocation from NHS Boards to Integration Authorities for 2017-18 must be at least equal to the recurrent budgeted allocations in 2016-17. The allocation should include the total of the sum set aside for hospital services.

A wide-ranging programme of service reforms and efficiencies has been identified to address budget pressures in 2017-18 and to support achievement of the National Health and Wellbeing Outcomes. Progress on achievement of this programme will be reported in the 2017-18 Annual Performance Report.

5. PERFORMANCE SUMMARY

5.1 Introduction

In chapter 2 of this report we highlighted key areas of work carried out by the Partnership during 2016/17. In this chapter we have drawn upon a number of different sources to give a more detailed picture of how the Partnership is performing. Section 5.2 summarises how we are performing in relation to our suite of Key Performance Indicators and the National Integration Indicators, while section 5.3 describes a number of local and national surveys which will provide a useful baseline for future comparison as health and social care integration progresses. Finally in section 5.4 we provide a summary of the internal and external audit and inspection processes which ensure that all of our services provide high quality care and support to the people of Glasgow.

5.2 Performance Indicators

i. Glasgow City HSCP Key Performance Indicator Summary

The Glasgow City HSCP reports quarterly on a range of local and national indicators to evidence progress made in relation to the 9 National Health and Wellbeing Outcomes, as well as our own strategic priorities. The 9 Health and Wellbeing outcomes are detailed in Appendix A.

A full list of the key performance indicators reported to the IJB, comparing current and baseline performance, is provided in the following tables, along with a description of the system used to rate our performance. A more detailed set of operational indicators are reported quarterly to our Finance and Audit Committee and management teams and are available online at:

IJB Finance and Audit Committee Meetings

HSCP RAG Rating System

Where status against target is available, performance measures have been rated on a traffic light basis using Red, Amber or Green (RAG) categories to reflect this. Outlined below is a key to the classifications used in this report. Please note that *Status* compares current performance with target, while *Direction of Travel* compares the baseline figure from March 2016 (unless otherwise stated) with the year end figure for 2016/17, or the most recent data when year end information is not yet available.

Key to Performance Status		
	**RED**	Performance misses target by 5% or more
	**AMBER**	Performance misses target by between 2.5% and 4.99%
	**GREEN**	Performance is within 2.49% of target
	**GREY**	No current target and/or performance information to classify performance against.

Direction of Travel	
▲	Improving
▶	Maintaining
▼	Worsening

Performance Indicator	Outcome No.	2015/16	2016/17		
		Baseline /Status	Target	Year End /Status	Direction of Travel
Older People					
1. Number of Community Services led Anticipatory Care Plans (ACPs) in place	2	61	360	482	▲
2. Number of people in Supported Living services	2	231	1,200	231	▶
3. Percentage of service users who receive a reablement service following referral for home care	2	Hospital discharges 83%	75%	73%	▼
		Community referrals 79%		76.5%	▼
4. Intermediate Care : Percentage of users transferred home	2	25%	>30%	29%	▲
Unscheduled Care					
5. New Accident & Emergency Attendances for NHS Greater Glasgow and Clyde locations - crude rate per 100,000 population	9	2,284	N/A	2,307	▼
6. Emergency Admissions – Numbers (Aged 65)	9	27,891	N/A	28,557	▼
7. Total number of patients over 65 breaching the 72 hour discharge target (excluding Adults with Incapacity (AWI)), Learning Disability and Mental Health patients).	9	22	0	24	▼
8. Total number of patients over 65 classed as Adults with Incapacity (AWI) breaching the 72 hour discharge target (excluding Learning Disability and Mental Health patients).	9	50	0	2	▲
9. Total number of Adults under 65 breaching the 72 hour discharge target (excluding Mental Health patients).	9	16	0	19	▼
10. Total number of Mental Health patients breaching the 72 hour discharge target (Under and Over 65s including AWI patients).	9	39	0	31	▲

Performance Indicator	Outcome No.	2015/16	2016/17		
		Baseline /Status	Target	Year End /Status	Direction of Travel
11. Total number of Acute Bed Days lost to Delayed Discharge (Older People 65+)	9	21,288	TBC	15,557	▲
12. Number of Bed Days lost to delayed discharge for Adults with Incapacity (AWI)	9	10,715	TBC	6,050	▲
Carers					
13. Number of Carers who have started an Assessment	6	3,372	2,100	3,101	▼
Children's Services					
14. Percentage of HPIs (Health Plan Indicators) allocated within 24 weeks	4	95% (NE) 93% (NW) 96% (S)	95%	99% (NE) 98% (NW) 98% (S)	▲ (All areas)
15. Access to CAMHS services - Longest wait (weeks)	9	18 weeks	18 weeks	18 weeks	▶
16. % young people receiving an aftercare service who are known to be in employment, education or training	4	67%	75%	61%	▼
17. Number of 0-2 year olds registered with a dentist	1	52%	55%	52.7% (Sept 16)	▲
18. Number of 3-5 year olds registered with a dentist	1	98.7%	90%	95.3% (Sept 16)	▼
19. Mumps, Measles and Rubella Vaccinations (MMR): Percentage Uptake in Children aged 24 months	1	94.6%	95%	93.8%	▼
20. Mumps, Measles and Rubella Vaccinations (MMR): Percentage Uptake in Children aged 5 years	1	95.9%	95%	96.4%	▲
Alcohol and Drugs					
21. % of clients commencing alcohol or drug treatment within 3 weeks of referral	7	97%	90%	97%	▶
Homelessness					
22. Percentage of decision letters issued within 28 days of initial presentation: Settled (Permanent) Accommodation	9	77%	95%	91%	▲

Performance Indicator	Outcome No.	2015/16	2016/17		
		Baseline /Status	Target	Year End /Status	Direction of Travel
23. Percentage of decision letters issued within 28 days of initial presentation: Temporary accommodation.	9	67%	95%	76%	▲
24. Percentage of live homeless applications over 6 months duration at end of quarter	9	44%	<20%	45%	▼
25. Increase in provision of settled accommodation made available by social sector landlords (Section 5)	9	1,742	3,000	1,941	▲
26. Number of households reassessed as homeless or potentially homeless within 12 months	4	395	<300	493	▼
27. Number of individual households not accommodated (last month of quarter).	7	351	< 150	209	▲
Criminal Justice					
28. Percentage of Community Payback Order (CPO) work placements commenced within 7 days of sentence	9	64%	80%	65%	▲
29. Percentage of Community Payback Orders (CPO) with a Case Management Plan within 20 days	9	94%	85%	97%	▲
30. Percentage of Community Payback Order (CPO) 3 month Reviews held within timescale	4	75%	75%	71%	▼
31. Percentage of Unpaid Work (UPW) requirements completed within timescale	4	54%	70%	65%	▲
Health Improvement					
32. Alcohol brief intervention delivery (ABI)	4	5,643	5,066	7,400	▲
33. Smoking Quit Rates at 3 months from the 40% most deprived areas	5	1,229	1044 (Dec 16)	811 (Dec 16)	▶
34. Women smoking in pregnancy – general population	1	13.7%	TBC	13.4%	▲
35. Women smoking in pregnancy – most deprived quintile	5	20.7%	TBC	19.7%	▲

Performance Indicator	Outcome No.	2015/16	2016/17		
		Baseline /Status	Target	Year End /Status	Direction of Travel
36. Breastfeeding at 6-8 weeks (Exclusive)	1	25.3%	24%	26.5%	▲
37. Breastfeeding: 6-8 weeks - In deprived population – 15% most deprived data zones (Exclusive Breastfeeding)	5	18.2%	20.1%	19%	▲
Primary Care					
38. Prescribing Costs: Compliance with Formulary Preferred List	9	79.8% NE 78.3% NW 79.0% South	78%	80.18% NE 78.7% NW 79.41% South	▲ (All areas)
39. Prescribing Costs: Annualised cost per weighted list size	9	£163.79 NE £156.55 NW £164.48 South	Below NHS Board average	£163.27 NE £156.47 NW £168.52 South	▲ (NE & NW) ▼ (South)
40. Numbers of people with a diagnosis of dementia on dementia register and other equivalent sources	4	4,416	4,210	4,333	▼
Human Resources					
41. NHS Sickness absence rate	1	6.3%	4%	5.6%	▲
42. Social Work absence rate (No. of Average Days Lost) (ADL)	1	2.6 ADL	<2.53 ADL	2.7 ADL	▼
43. NHS staff with an e-KSF (%)	8	51.3%	80%	53.1%	▲
44. Percentage of NHS staff with standard induction training completed within the agreed deadline	8	29%	100%	57%	▲

Performance Indicator	Outcome No.	2015/16	2016/17		
		Baseline /Status	Target	Year End /Status	Direction of Travel
45. Percentage of relevant NHS staff who have completed the mandatory Healthcare Support Worker training within the agreed deadline	8	27%	100%	50%	▲
Business Processes					
46. Percentage of NHS Complaints responded to within 20 working days	3	95.5%	70%	95.5%	►
47. Percentage of Social Work complaints handled within 15 working days (local deadline)	3	66%	65%	64%	▼
48. Percentage of Social Work complaints handled within 28 calendar days (statutory deadline)	3	84%	85%	82%	▼
49. Percentage of elected member enquiries handled within 10 working days	3	93%	80%	92%	▼

As described in chapter 1, a range of mechanisms are in place to scrutinise performance at city wide and locality levels, as well as by the Integration Joint Board. This enables areas for improvement to be identified and actions taken forward and monitored on an ongoing basis.

ii. National Integration Indicators

The Core Suite of 23 National Integration Indicators was published by the Scottish Government in March 2015 to provide the basis against which Health and Social Care Partnerships can measure their progress in relation to the National Health and Wellbeing outcomes. As these are derived from national data sources the measurement approach is consistent across all Partnerships.

The Integration Indicators are grouped into two types of measures: 10 indicators are derived from Partnership operational performance data and 9 are outcome indicators based on feedback from the biennial Scottish Health and Care Experience survey (HACE). A further 4 indicators are currently under development by NHS Scotland Information Services Division (ISD).

The following tables provide the most recent data for the 19 indicators currently reportable, along with the comparative figure for Scotland. Due to availability, data for 12 of the indicators relates to performance prior to the formal establishment of the HSCP and so does not directly measure our performance over the last 12 months. This will, however provide a useful baseline for comparison within future performance reports, so has been included here. Data for the remaining 7 indicators relating to 2016/17 is also provided along with, for comparative purposes, historical and Scotland wide data, with the direction of travel highlighted

Indicator No. /Outcome	1. Percentage of adults able to look after their health very well or quite well
Outcome 1	**2015/16**
Glasgow City	91%
Scotland	94%

Indicator No. /Outcome	2. Percentage of adults supported at home who agreed that they are supported to live as independently as possible
Outcome 2	**2015/16**
Glasgow City	84%
Scotland	84%

Indicator No. /Outcome	3. Percentage of adults supported at home who agreed that they had a say in how their help, care or support was provided
Outcome 3	**2015/16**
Glasgow City	81%
Scotland	79%

Indicator No. /Outcome	4. Percentage of adults supported at home who agree that their health and social care services seemed to be well co-ordinated
Outcome 3	**2015/16**
Glasgow City	72%
Scotland	75%

Indicator No. /Outcome	5. Percentage of adults receiving any care or support who rate it as excellent or good
Outcome 3	**2015/16**
Glasgow City	82%
Scotland	81%

Indicator No. /Outcome	6. Percentage of people with positive experience of the care provided by their GP practice
Outcome 3	**2015/16**
Glasgow City	88%
Scotland	87%

Indicator No. /Outcome	7. Percentage of adults supported at home who agree that their services/support had an impact on improving or maintaining their quality of life.
Outcome 4	**2015/16**
Glasgow City	84%
Scotland	84%

Indicator No. /Outcome	8. Percentage of carers who feel supported to continue in their caring role.
Outcome 6	**2015/16**
Glasgow City	40%
Scotland	41%

Indicator No. /Outcome	9. Percentage of adults supported at home who agreed they felt safe
Outcome 7	**2015/16**
Glasgow City	86%
Scotland	84%

Indicator No. /Outcome	11. Premature mortality rate per 100,000 persons: by calendar year
Outcome 1	**2015**
Glasgow City	634
Scotland	441

Indicator No. /Outcome	12. Rate of emergency admissions per 100,000 population for adults.		
Outcome 9	**2015/16**	**2016/17**	**Direction of Travel**
Glasgow City	14,733	14,039	▲
Scotland	12,138	12,037	

Indicator No. /Outcome	13. Rate of emergency bed days per 100,000 population for adults.		
Outcome 9	**2015/16**	**2016/17**	**Direction of Travel**
Glasgow City	138,401	135,584	▲
Scotland	122,713	119,649	

Indicator No. /Outcome	14. Readmissions to hospital within 28 days of discharge per 1,000 admissions.		
Outcome 4	**2015/16**	**2016/17**	**Direction of Travel**
Glasgow City	97	97	▶
Scotland	96	95	

Indicator No. /Outcome	15. Proportion of last 6 months of life spent at home or in a community setting		
Outcome 9	**2015/16**	**2016/17**	**Direction of Travel**
Glasgow City	85%	86%	▲
Scotland	87%	88%	

Indicator No. /Outcome	16. Falls rate per 1,000 population aged 65+		
Outcome 7	**2015/16**	**2016/17**	**Direction of Travel**
Glasgow City	29	30	▼
Scotland	21	21	

Indicator No. /Outcome	17. Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections
Outcome 9	**2015/16**
Glasgow City	81%
Scotland	83%

Indicator No. /Outcome	18. Percentage of adults with intensive care needs receiving care at home
Outcome 9	**2015/16**
Glasgow City	55%
Scotland	62%

Indicator No. /Outcome	19. Number of days people aged 75+ spend in hospital when they are ready to be discharged, per 1,000 population		
Outcome 9	**2015/16**	**2016/17**	**Direction of Travel**
Glasgow City	627	464	▲
Scotland	915	842	

Indicator No. /Outcome	20. Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency		
Outcome 9	**2015/16**	**2016/17**	**Direction of Travel**
Glasgow City	23%	23%	▶
Scotland	23%	23%	

The indicators below are currently under development by NHS Scotland Information Services Division (ISD).

Indicator No.	**Outcome**
10. Percentage of staff who say they would recommend their workplace as a good place to work	8
21. Percentage of people admitted to hospital from home during the year, who are discharged to a care home	2
22.Percentage of people who are discharged from hospital within 72 hours of being ready	9
23. Expenditure on end of life care, cost in last 6 months per death	9

5.3 Key Survey Findings

The surveys detailed in this section were undertaken prior to the establishment of the Partnership, however as with the 12 national integration indicators referred to above, these will provide a useful baseline against which to measure and report upon future performance of the Partnership.

i. Scottish Health and Care Experience Survey (2015/16)

As mentioned in section 5.2, 9 of the National Integration Indicators are derived from the biennial Scottish Health and Care Experience survey (HACE) which provides feedback in relation to people's experiences of their health and care services. The most recent survey report, relating to the period 2015/16, can be accessed at the link below:

- Scottish Government Health & Care Experience Survey

ii. NHS Greater Glasgow and Clyde Health and Wellbeing Survey (2014/15)

The Health and Wellbeing Survey is a research study carried out on behalf of NHS Greater Glasgow and Clyde every three years. The survey reports on 4 key areas: People's Perceptions of their Health & Illness, Health Behaviours, Social Health and Social Capital. The latest full survey report for 2014/15, along with locality level reports, can be accessed at the link below:

- Greater Glasgow and Clyde Health and Wellbeing Survey

iii. Glasgow City Schools Health and Wellbeing Survey (2014/15)

Since 2006/7 NHSGGC have carried out a 3 yearly School's Health and Wellbeing Survey. In the most recent survey in 2014/15, secondary school pupils from S1 – S6 across all 30 secondary schools in Glasgow City were surveyed on a range of topics. The latest full survey report for 2014/15, can be accessed at the link below:

- Glasgow City Schools Health and Wellbeing Survey

5.4 Inspections Undertaken, Grades Awarded and Requirements

A number of inspections have been carried out in the city during the course of the last year, and where required, any recommendations for improvement are being progressed by the HSCP and/or our partners. Details of these inspections along with recommendations made are summarised below.

i. Care Inspectorate Gradings for Glasgow City HSCP Registered Services

The Care Inspectorate undertook both scheduled and unscheduled inspections across 42 services during 2016/17. The overall quality of care was assessed as 'good' or better (Grade 4 and above in each Quality Theme) in 38 (90.5%) of these services between April 2016 and March 2017.

The following table details the grades achieved for Glasgow City HSCP services which were inspected by the Care Inspectorate between April 2016 and March 2017, along with the number of requirements made. Full details of these inspections, along with any requirements and recommendations can be accessed at the link below:

www.careinspectorate.com/index.php

Key to Grading:

1 – Unsatisfactory**, 2 –** Weak**, 3 –** Adequate**, 4 –** Good**, 5 –** Very Good**, 6 –** Excellent

Unit	Date Inspection Completed	Quality Theme Care Grades (out of 6)				No. of Requirements
		Care and Support	Environ-ment	Staffing	Manage-ment & Leadership	
Care Homes (Older People)						
Forfar Avenue	08/09/2016	4	4	5	5	0
Hawthorn House	31/01/2017	4	6	4	5	2
Crossmyloof Care Home	21/02/2017	3	3	4	3	1
Davislea Home For The Elderly	21/07/2016	4	4	5	5	0
Drumry House	22/07/2016	4	5	4	4	0
Rannoch House	08/09/2016	5	4	4	4	0
Orchard Grove House	09/02/17	5	5	5	5	0
Fulton Lodge	31/03/2017	5	4	5	4	0
Loancroft House	30/03/2017	5	4	4	5	0
Peter McEachran House	30/03/2017	4	4	4	4	0
Day Care Centres						
Carlton Centre	30/04/2016	4	4	4	4	0
Purdon Street Day Care	27/05/2016	5	5	5	5	0
Muirhead Road	22/07/2016	5	5	5	5	0
Mallaig Road	08/12/2016	5	5	4	4	0
Orchard Grove Day Care	02/11/2016	5	5	6	5	0
Residential Children's Units (RCU)						
Airth Drive	07/07/2016	4	4	4	4	0
Crawford Street	24/10/2016	5	4	5	5	1
Wallacewell	29/08/2016	4	4	4	3	1
Dalness	24/06/2016	5	4	5	4	0
Kempsthorn	25/08/2016	5	5	5	5	0
Monreith Road	03/11/2016	4	4	4	4	1
Newark Drive	17/10/2016	5	5	5	5	0
Norse Road	28/10/2016	4	4	4	4	0
Crossbank Crescent	20/07/2016	4	4	4	4	0
Plenshin Court	30/09/2016	5	5	5	5	0
Hamilton Park Avenue	01/07/2016	5	4	4	4	0
Wellhouse	03/06/2016	4	4	5	3	0
Milncroft Road	12/10/2016	5	5	5	5	0
Seamill Street	11/01/2017	5	4	4	4	0
Eriboll Crescent	16/03/17	5	5	5	5	0

Unit	Date Inspection Completed	Quality Theme Care Grades (out of 6)				No. of Requirements
		Care and Support	Environ-ment	Staffing	Manage-ment & Leadership	
Broomfield Crescent	01/03/2017	5	5	5	6	0
Chaplet Avenue	16/03/2017	4	5	4	5	0
Hinshaw Street	16/03/2017	3	5	4	3	0
Main Street	01/03/2017	5	5	5	5	0
Netherton	28/03/2017	5	5	5	5	0
Homelessness Emergency/Assessment Centres (1, 2 & 3)						
The Chara Centre (1)	17/06/2016	5	not assessed	5	5	0
Elder Street (2)	08/06/2016	6	not assessed	5	6	0
Clyde Place (3)	23/06/2016	5	not assessed	5	5	0
Other Services						
Petershill Road Community Support Project	14/07/2016	5	not assessed	4	4	0
Glasgow City Adoption Service	02/03/2017	4	not assessed	4	4	0
Glasgow City Fostering Service	02/03/2017	4	not assessed	4	4	0
Supported Carers Service	27/03/2017	5	not assessed	4	4	0

A breakdown of inspection grades by service area for 2016/17 is provided below. This table shows that every Day Care Centre, Homelessness Emergency/Assessment Centre and Other Service Area inspected during 2016/17 were graded 4 and above in each Quality Theme.

Service Area (Number of Units)	% of Services graded 'good' or better* across all quality themes
Care Homes (Older People) (10)	90%
Day Care Centres (5)	100%
Children's Residential Units (20)	85%
Homelessness Emergency/Assessment Centres (3)	100%
Other Service Area (4)	100%

*Grade 4 and above

ii. Integrated Children's Services Inspection

An Inspection of Children's Services within the Community Planning Partnership (CPP) led by the Care Inspectorate was carried out between November 2016 and February 2017, with input from education, health, social work and the police. The inspection looked at how our services are led, planned and organised, and delivered by staff from all organisations involved in the lives of children in the city. Services were assessed in relation to 9 Quality Indicators and grades awarded in relation to each of these are summarised in the following table.

How well are the lives of children and young people improving?	
Improvements in the wellbeing of children and young people	Very good
Impact on children and young people	Very good
Impact on families	Good
How well are partners working together to improve the lives of children, young people and families?	
Providing help and support at an early stage	Good
Assessing and responding to risks and needs	Adequate
Planning for individual children and young people	Adequate
Planning and improving services	Good
Participation of children, young people, families and other stakeholders	Good
How good is the leadership and direction of services for children and young people?	
Leadership of improvement and change	Very good

Key to Grading: **Excellent** - outstanding, sector leading, **Very good** - major strengths, **Good** - important strengths with some areas for improvement, **Adequate** - strengths just outweigh weaknesses, **Weak** - important weaknesses, **Unsatisfactory** major weaknesses

The full report, which highlights particular strengths that are making a positive difference for children and young people in Glasgow, and notes areas for further improvement, can be accessed at the link below.

- Children and Young People Joint Inspection Report

iii. Practice Audit

In addition to external inspections, the Partnership has an ongoing planned programme of audit and self-evaluation to give quality assurance across all service areas. A list of Practice Audit activity carried out by Social Work between March 2016 and March 2017 and submitted through the Social Work Professional Governance Board is listed in the following table.

Audit/Self-Evaluation	Service Area	Completion Date
Self-Evaluation	Families for Children Adoption service	March 2016
Self-Evaluation	North East Children and Families Children's safeguards	March 2016
Audit	Re-Audit Permanence Planning for Children	May 2016
Audit	Report on Eligibility Criteria	May 2016
Multi agency Self-Evaluation	Tripartite Adult Support and Protection Audit: Social Work, Health and Police Scotland	June 2016
Audit	Countersigning Practice	July 2016
Audit	Housing Options (Homelessness)	August 2016
Self Evaluation	South Area Child's Plan	March 2017

Appendix A – National Health and Wellbeing Outcomes

Outcome 1	People are able to look after and improve their own health and wellbeing and live in good health for longer
Outcome 2	People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
Outcome 3	People who use health and social care services have positive experiences of those services, and have their dignity respected
Outcome 4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
Outcome 5	Health and social care services contribute to reducing health inequalities
Outcome 6	People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being
Outcome 7	People using health and social care services are safe from harm
Outcome 8	People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide
Outcome 9	Resources are used effectively and efficiently in the provision of health and social care services