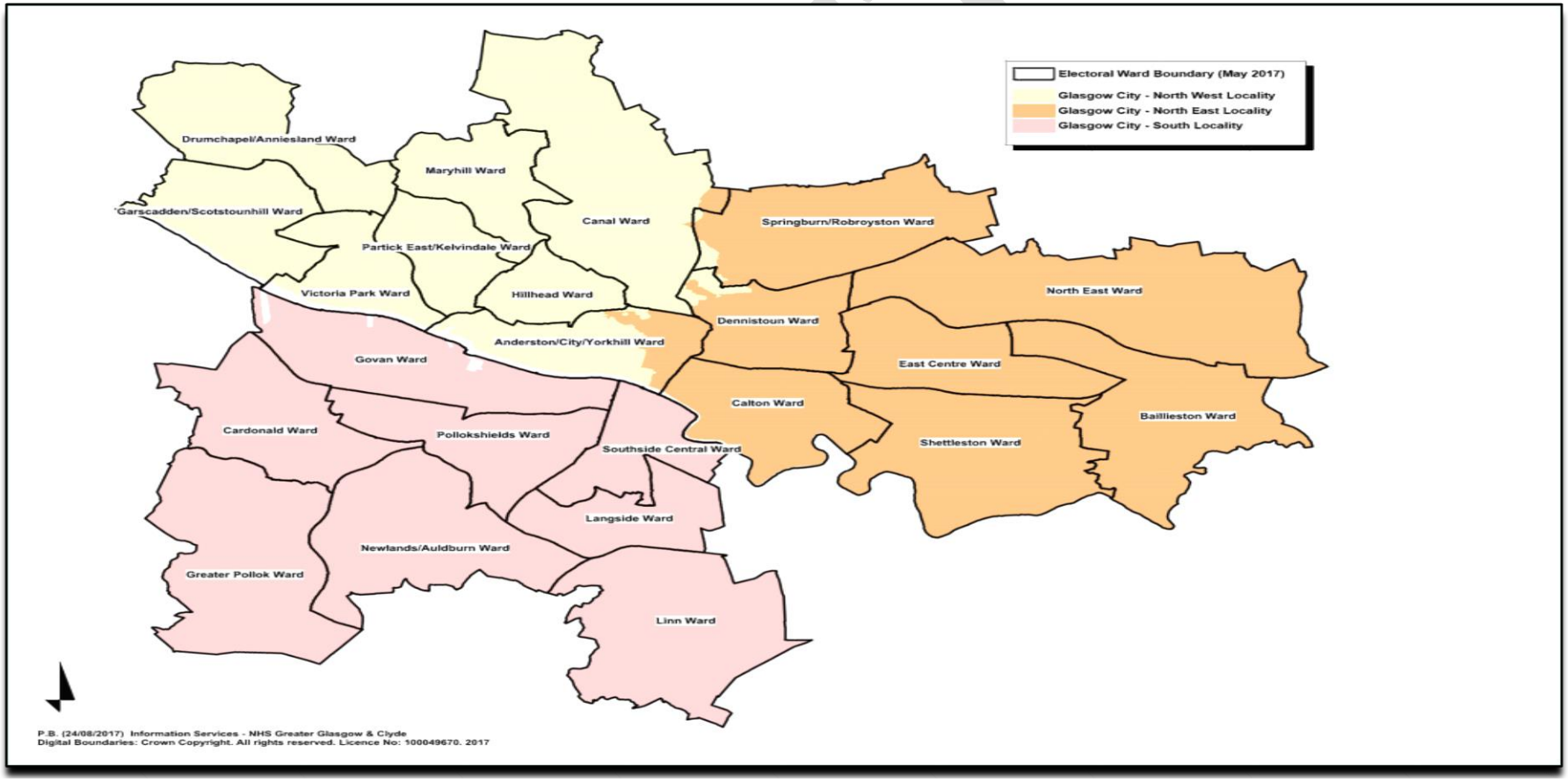
North East

Draft Locality Plan 2019-22



FOREWORD NORTH EAST LOCALITY PLAN 2019-2022

The actions outlined within this 2019/22 Locality plan support the second Strategic Plan for Glasgow City Health and Social Care Partnership, which was widely consulted upon with many stakeholders, including citizens, patients and service users.

The Strategic Plan covers health and social care services across the entire City.

Each of the three local areas (North East, North West and South) that make up the Glasgow City Health and Social Care Partnership have developed their own Locality Plan with partners, including patients, service users, carers, the third and independent sectors. Within this North East (NE) Locality Plan we have included actions and areas for improvement which are being implemented on a city wide basis and highlighted those more specific to the North East.

Each Locality Plan is updated each year to show how the Strategic Plan is being implemented locally. Such Locality Plans ensure services reflect the local priorities, needs and community issues.

This Plan captures some of the ways that the North East Locality will work to deliver on the Strategic Priorities over the next three years. This is far from an exhaustive list, but instead represents some of the most significant pieces of work being taken forward across North East and the City during the lifetime of this Strategic Plan. There is a particular emphasis on equality of access and service provision, community engagement, partnership working and also in using information and data to support improvement.
New services, such as the New North East Health and Care Centre, along with staff and changes to our facilities will help us to deliver the high quality care and planned developments for the people of North East Glasgow

Glasgow City HSCP believes that the City's people can flourish, with access to health and social care support when they need it, so it is crucial to ensure that the services delivered reflect the needs of individuals.

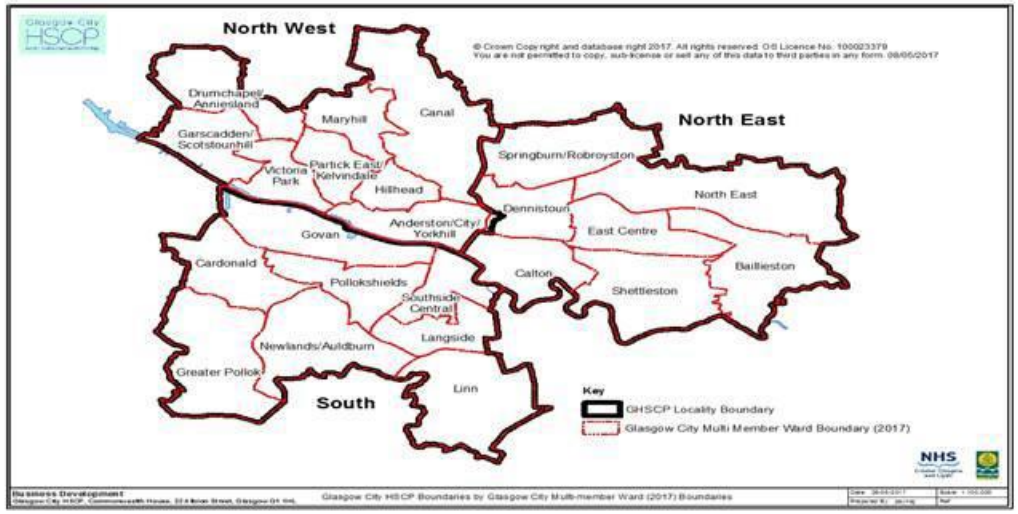
North East Locality is committed to planning and designing services in partnership with local people, working in partnership with staff, independent contractors and also our key partners across acute services, housing, community planning, care homes and the Third Sector.

I look forward to the continued provision of high quality health and social care services

Assistant Chief Officer
Children's Services and North East Operations

1. LOCALITY PROFILE *NORTH EAST*

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:

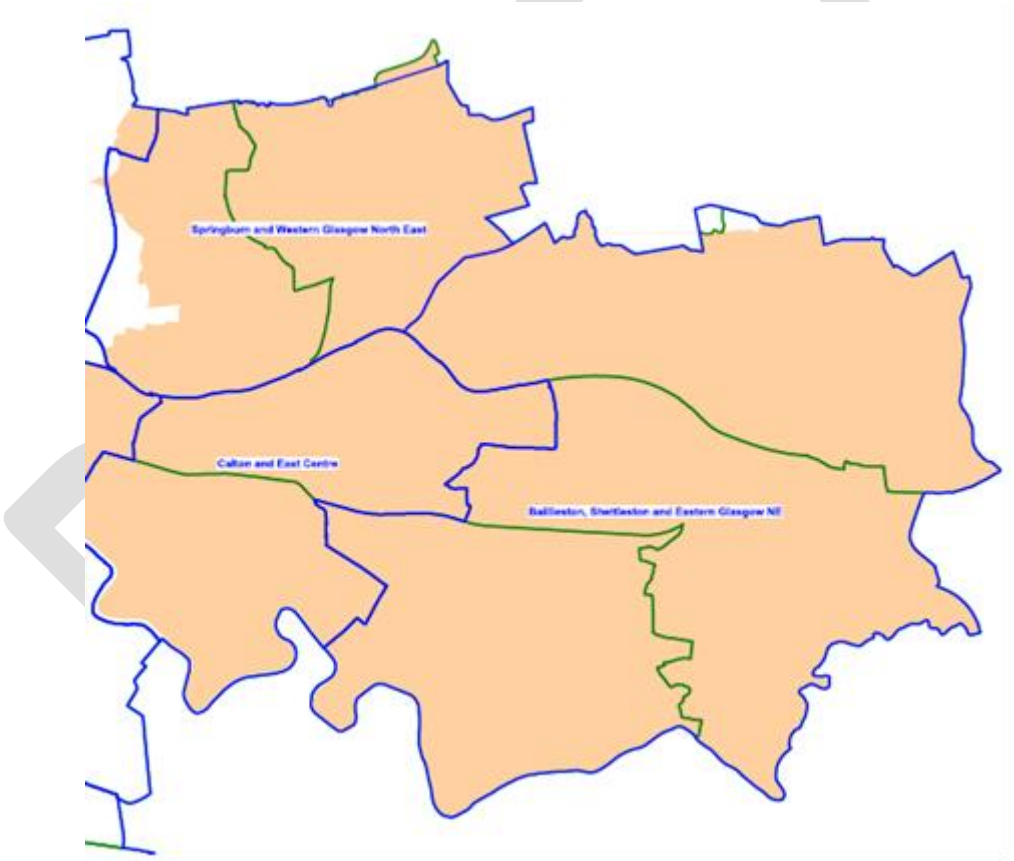
- Calton
- Dennistoun
- Springburn/Robroyston
- East Centre
- North East
- Shettleston
- Baillieston

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 n Glasgow City**
0-15years	**27,971**	**17**	**16.1**
15-64	**116,630**	**68.3**	**70.1**
65years and over	**25,012**	**14.7**	**13.8**

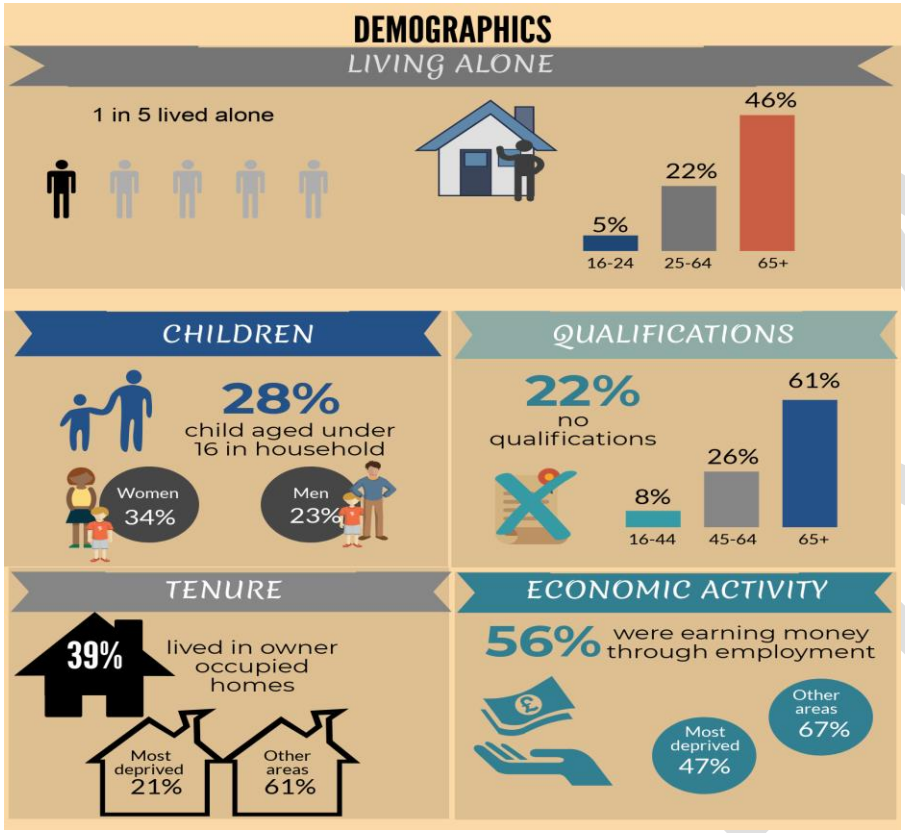
We are keen to ensure that there is a strong and effective connection between our services and the local communities we serve. To further assist this, we have structured our community services for older people into Neighbourhood Teams within North East. This will also help to improve joint working with GP Clusters and other partner organisations, such as Housing providers.

The 3 Neighbourhood Team Areas within North East for Older People's Services



NE Locality Health & Wellbeing Survey

The adult Health and Well Being Survey has been undertaken by the Health Board in NHSGGC on a three yearly basis since 1999. Reports are available for Glasgow City, each geographic locality and a number of Thriving Places. The survey covers a wealth of topics in relation to respondents' perceptions of their health, including health behaviours, social health, financial well being and perceptions of services. The 2018 reports for each Locality were recently launched. Below is some key data and trend information for North East Glasgow, including the demographic profile.



Upward trend in number of people in NE consuming 5 a day fruit and veg , from 29% in 2014/15 to 41% in 2018 (Glasgow city rate 39%)

Positive trends in tobacco prevalence and exposure to second hand smoke: NE prevalence down by 4% to 28% and exposure down by 11% to 30.5% in NE

27% of people have difficulty meeting necessary expenses (more common in those aged 16-24 at 40%) and ithis rose to 33% in the most deprived areas

Fewer people feeling valued as a member of their community , down 11% to 57% (Glasgow city rate 61%)

Fewer people feeling able to influence local decisions, down by 16% . NE rate overall of 62%, most deprived areas 59%, Glasgow city rate 70%

14% of NE respondents aged 35-64 experienced food insecurity in the last year

Full report: North West Glasgow - https://www.stor.scot.nhs.uk/handle/11289/579886

Summary report: North West Glasgow - https://www.stor.scot.nhs.uk/handle/11289/580029

Ruchill/Possilpark Report - https://www.stor.scot.nhs.uk/handle/11289/579895

2. HSCP KEY PRIORITIES

Glasgow City Integration Joint Board (IJB), at its meeting in March 2019, endorsed a three year Strategic Plan for the period 2019-22 (see: https://www.glasgow.gov.uk/index.aspx?articleid=17849). In that plan, the IJB set out its vision for health and social care services:

> 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

It also recognised that delivering 'more of the same' will not be enough to meet the challenges of rising demand, budget pressures and inequalities. Transformational change is therefore needed to the way health and social care services are planned, delivered and accessed in the City.

Within Glasgow City HSCP, localities play a vital role in delivering better, integrated health and social care services for the people of Glasgow.

The purpose of this locality plan is to:

- show how we will contribute to the implementation of the IJB's Strategic Plan 2019-22; and
- how we will respond to local needs and issues within the North East Locality of the City

To better align locality plans with the overarching IJB Strategic Plan, locality plans will also now cover the 3 year period 2019-22. In compliance with the Scottish Government's Localities Guidance (July 2015), locality updates are included within the HSCP's annual performance report.

The locality plan is based on:

- what we know about health and social care needs and demands and any changes from our 2018/19 locality plan;
- our current performance against key targets;
- our key service priorities, informed by the IJB Strategic Plan 2019-22
- the resources we have available including staffing, finance and accommodation.

The detailed priorities and actions set out in this locality plan are grouped under the 5 strategic priorities set out in the IJB Strategic Plan, namely:

- early intervention, prevention and harm reduction
- providing greater self-determination and choice

- shifting the balance of care
- enabling independent living for longer
- public protection

3. COMMUNITY ENGAGEMENT – NORTH EAST LOCALITY ENGAGEMENT FORUM

COMMUNITY ENGAGEMENT – LOCALITY ENGAGEMENT FORUM

North East Locality Engagement Forum (LEF) reviewed its membership in 2018 and agreed to work towards building a wider engagement network developing closer links with Housing providers, Carers, Mental Health service users and Refugees/Asylum seekers. Working in partnership with the Mental Health Foundation the Forum members took part in the making of an information video explaining the importance of civic participation focusing on promoting engagement with public services among refugee/asylum seekers. The production crew filmed discussions at one of the regular N. E. LEF meetings they also interviewed the chair who spoke about the contribution members can make to improving local services. The video will be released on the 25th September 2019 and shared throughout the refugee/asylum network. A key aspect of this project is to make sure this seldom heard group form part of the mainstream engagement process rather than an exclusive one issue focus group. In addition to the work with the refugee/asylum seekers the forum has been collaborating with the Glasgow School of Art who are conducting research into developing a new type of community engagement platforms to raise participation levels among the general public.

Local people, community groups and organisations had an opportunity to discuss and give their opinions on a range of Locality topics including:

- North East Locality Plan 2018 – 19
- Development of the Volunteer Charter
- Older Peoples' Services
- 70th Anniversary NHS Road Show
- Medical Surgery Closure Springburn Health Centre
- Implementation of the Mental Health Strategy
- Monitoring progress of the North East Health and Care Centre Hub
- Presentations from 3rd Sector partners such as Mental Health Network, Marie Curie

N.E. LEF members have met with Mental Health service recovery groups to discuss their ideas on service provision at the proposed North East Health and Social Care Hub. Examples from service users that are now actively being considered are a café to help combat social isolation with community garden maintained by volunteers to develop skills and build the confidence of local people who are in recovery. N.E. LEF

members have taken part in four separate engagement sessions with the appointed **architects Hoskins** and completed visits to Gorbals, Eastwood, and Maryhill Health and Social Care centres.
This level of public engagement will continue through to the completion of the Hub project.

Forum members, 3rd sector partners and the wider community have also participated in events and had the opportunity to contribute to HSCP and Board wide service priorities, reviews and consultations .These included

- Review of Out of Hours Services
- Moving Forward Together
- Primary Care Improvement Plan
- Review of Overnight Support
- HSCP Strategic Plan 2019-22

The main focus for community engagement will continue to be around the proposals for the North East Hub with meetings covering wide range of groups including Councillors, IJB Board members, L.E.F. Community Councils, Area Partnerships Tenants groups, Carers groups, Third Sector organisations.

4. PERFORMANCE INFORMATION NE LOCALITY

This section summaries our performance in the North East Locality against the targets and indicators that are reported regularly to Glasgow City IJB's Finance, Audit and Scrutiny Committee. The table below shows the progress made over the course of 2018-19 to improve our performance (GREEN), as well as those areas where further improvement is required (RED). Delivering on the range of actions set out in this locality plan will make a positive contribution towards the efforts to continually improve performance in these areas

Indicator	**Q1 Performance/ Status**	**Q4 Performance/Status**
Achievements		
Number of New Carers identified that have received a Carers Support Plan	**N/A**	**709 (GREEN)** **(Target 550)**
Prescribing Costs: Annualised Cost Per Weighted List Size	**£157.21 (GREEN)**	**£150.84 (GREEN)**
% of HPIs allocated by Health Visitor by 24 weeks	**93% (GREEN)**	**97% (GREEN)**

% of young people receiving an aftercare service who are known to be in employment, education or training	**73% (AMBER)**	**83% (GREEN)**
% Alcohol and Drug service users with an initiated recovery plan following assessment	**74% (GREEN)**	**77% (GREEN)**
% of Community Payback Order 3 month reviews held within timescale	**61% (RED)**	**79% (GREEN)**
Exclusive Breastfeeding at 6-8 weeks (General Population)	**22.5% (GREEN)**	**22.8% (GREEN)**
% of SW Stage 1 Complaints responded to within timescale	**89% (GREEN)**	**93% (GREEN)**
Areas For Improvement		
% of service users leaving reablement with no further home care support	**34.8% (RED)**	**34.3% (RED)**
Total Number of Older People Mental Health Patients Delayed	**5 (RED)**	**3 (RED)**
Intermediate Care (Average Length of Stay - Days)	**34 (RED)**	**37 (RED)**
Total Number of Acute Delays and Acute Bed Days Lost to Delayed Discharge	**N/A**	**15,288 (citywide)** **4794 (NE)**
Flu and Shingles Immunisation Rates	**Various for different groups**	**Various for different groups**
Access to CAMHS Services	**N/A**	**90%**
% of Looked After and Accommodated Children under 5 who have had a permanency review	**94% (RED)**	**85% (RED)**
% of people who have started a psychological therapy within 18 weeks of referral	**87% (AMBER)**	**78.2% (RED)**

Total Number of Adult Mental Health Delays	**N/A (RED)**	**3 (RED)**
% Homelessness Decisions made within 28 days of initial presentation	**90% (RED)**	**88% (RED)**
% of live homeless applications over 6 months duration at quarter end	**48% (RED)**	**44% (RED)**
% of Community Payback Order unpaid work placements commenced within 7 days of sentence	**82% (RED)**	**64% (RED)**
% of Community Payback Orders with a case management plan within 20 days	**92% (GREEN)**	**76% (RED)**
% of Unpaid Work requirements completed within timescale	**56% (RED)**	**59% (RED)**
Women Smoking in Pregnancy (General Population)	**14.8% (RED)**	**15.5% (RED)**
Women Smoking in Pregnancy (Deprived Population)	**19.6% (AMBER)**	**21.2% (RED)**
Exclusive Breastfeeding at 6-8 weeks (Deprived Population)	**19.8% (GREEN)**	**17.6% (RED)**

5. STRATEGIC PRIORITIES & SERVICE ACTIONS

The detailed priorities and actions set out in this locality plan are grouped under the 5 strategic priorities set out in the IJB Strategic Plan, namely:

- early intervention, prevention and harm reduction
- providing greater self-determination and choice
- shifting the balance of care
- enabling independent living for longer
- public protection

The following section highlights activities underway for 2019/20 using the key care group / service delivery headings. Each section shows how the care group will deliver the five strategic priorities for the Partnership. The main activities will be delivered consistently across each

Locality area and are identified as “City-wide”, but these will be delivered and monitored by the Locality teams. Some specific actions will be delivered in a single Locality, but may be subject to wider roll out in future years across the Partnership if appropriate

5.1 Children’s Services

Children’s Services			
Prevention, early intervention and harm reduction			
City Wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Develop a Family Support Strategy	Work with partner agencies and third sector to improve the range of preventative supports and sustainability of services for families that will provide long-term benefits for local children and families Provide better support to mums, dads and carers in our most vulnerable neighbourhoods. Continue to work with third sector agencies to improve the range and sustainability of family support services that will provide long-term benefits for local children and families	**2019**	The aim of the service is to provide community supports to prevent young people being referred to social work and/or taken in to local authority care. Families who do not require statutory support from social care, can access a range of preventative third sector services
Develop the Consortium approach city wide informed by the North East Test of Change with the third sector	Through the Lottery funding develop a consortium approach: • Third sector organisations coming together as a consortium. • Consortium staff co-located with the social work duty team. • Families not requiring social work involvement	**2019**	Early and effective intervention aiming to give all children and young people the best possible start in life

	immediately referred to the consortium to ensure that they receive the appropriate level of support at the right time. • Co-developed family support delivered by the third sector rather than social work led.		
Work with the Centre for Excellence for Looked After Children in Scotland (CELCIS) and the Robertson's trust to improve our approach to supporting children and young people on the 'edge of care'	Commissioning of services from the third sector to provide intensive family support to children on the edge of care	**2019/20**	Reduction in the numbers of children being taken into local authority care
Children's services – Whole system change .	Implement a framework to promote child and youth mental well-being Create services that can provide earlier interventions for children at risk of entering the care system and their families Improve families' wellbeing and prevent children from compulsory measures (such as becoming 'looked after') To work with families to build positive relationships, ensure right measures are put in place to improve the family circumstances and the wellbeing and development of the child Test out different approaches in each of the city's three localities during the next three years	**2019/20**	Children and young people will achieve positive physical and emotional health and wellbeing outcomes
Community based mental health and wellbeing services (children)	Undertake scoping to inform the development of a service model options to address mental health and	**2019/20**	As above

	wellbeing in children Continued delivery of commissioned service to improve the mental health and wellbeing of young people		
Creating a culture for health reducing alcohol, drugs and tobacco use	Delivery of multiple risk contract to young people comprising curricular programme and 1:1 service delivery of programmed activities to support the prevention and education component of the ADP strategy	**2019/20**	Support for young people to build resilience Increased capacity for targeted early intervention programmes around drug and alcohol issues
Full implementation of Healthy Children Programme	To begin all additional assessments and visits to all families as per Universal Pathway (including antenatal pathway)	**By 31/3/2020**	Programme is fully implemented All children have access to Universal pathway which will improve early assessment, planning and intervention Children's needs are met earlier reducing need for specialist or statutory services
Improvement in breast feeding at 6 weeks	Having successfully achieved Gold Award. Maintain and build on this success and continue to work with mothers to encourage breastfeeding	**Ongoing**	Babies are breast fed longer Fig at Q4 exclusive Breastfeeding 6weeks 22.8%
Development and Implementation of the	Central Parenting Team will continue to widen and	**2019/20**	Increase parental uptake

Glasgow Parenting Framework	strengthen collaborative working with partner agencies to support and enhance parents experience, engagement and participation in Triple P group programmes providing accessible, appropriate, culturally sensitive parenting support in Glasgow Expand the development and implementation of a culturally sensitive community based approach to service delivery to identify and respond effectively, efficiently and sensitively to parenting needs within local community groups and settings Develop and implement parenting support pathways for targeted Triple P Teen Discussion Group support within Glasgow Secondary Schools in partnership with Police Scotland Campus Officers and Education Continue the provision of the Glasgow Solihull Approach Workforce training programme expanding the programme development to include the Solihull Plus Trauma Awareness training to support trauma informed practice across Children and Families		and engagement in Triple P parenting support within local community groups and services Increased support to families through the provision of accessible Targeted Teen Parenting programmes and workshops available in Glasgow Secondary Schools Children & Families staff across services will understand the impact of trauma on children, young people, families and adults. Use the Solihull Approach model to help and support families
School nursing services are to be reviewed across the city.	Interim plan to pool 3 locality School Nursing team to one Glasgow city school team complete. Glasgow will focus on 2 priority pathways: Emotional health & wellbeing and CP. Information being shared with key agencies.	**July 2019**	Glasgow City School Team in place
Locality Specific Action	**Priority Actions**	**Timescale**	**Outcomes Sought**

North East			
Review of vulnerable pregnancy liaison group	Once agreed to progress test of change which will mirror the pre-school JST model. This will be done in partnership with SWS, Midwives and Third Sector	**When agreed**	Improved access and planning for women who do not fit child protection criteria but do need additional support in the antenatal period

Children's Services			
Providing greater self determination and Choice			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Listening to children and young people	Provide the best tools for children and young people looked after by Glasgow City HSCP to enable them to give their views and for these to be listened to and taken into account in decision making	**2019/20**	Promotion of the participation and engagement of young people in Glasgow which truly informs service provision 93% of looked after children agreed their views were listened to. Annual Performance figs 2017/18/19

Glasgow Young people's Champion's Board	This board seeks 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		Increased numbers of young people being involved in decision making and informing service development
Continue to consult with young people and develop contemporary strategies which reflect how young people currently communicate through social media and determine how this can influence child protection and looked after children and processes	Children's Rights Group is exploring innovative ways of consulting with young people including looked after and accommodated children. Review of Viewpoint/Have your Say is ongoing	**Ongoing**	Involve children in decisions that affect them, have their voices heard

Improve educational attainment and achievement of care experienced children and young people	Narrow the gap between the educational achievements of care experienced young people and their peers.	**Ongoing**	Continued increase in attainment levels for care experienced young people in the last 3 years across a number of measures. Whilst the general school population in Glasgow out performs the care experienced young people, the attainment levels for Glasgow's care experienced young people are better than the national average for a number of indicators.
Positive Destinations	• Identify potential barriers within NW • Identify young people who should be going to positive destinations and determine what additional support or resources may be required to support them • Ensure robust links in place with employability service	2019-21	More young people are encouraged and supported into positive destinations
Reduction of impact of poverty	To continue to increase the referrals made by Health Visitors to Financial inclusion services Health Visiting teams to discuss the use of food banks as part of general discussions to minimise stigma Ensure all staff are kept informed of where to access equipment etc. for children from Third Sector colleagues	Immediate and Ongoing	Income is maximised Stigma for families reduced Staff have up to date information to share with families

Locality Specific Areas of Activity	Priority Actions	Timescale	Outcomes Sought
North East			
Continue to find innovative ways of consulting with young people on the development of the new NE Health and Social Care HUB	Work with the Architects to develop a virtual tour of the new NE Hub targeted at young people.	2019	Increased numbers of young people being consulted on service development in NE

Children's Services			
Shifting the Balance of Care			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
High-cost placements for children and young people	Reduce reliance on high-cost residential care placements Re-focus investment on family and community based supports located in Glasgow for young people who are currently 'looked after' by the Council	**2021/22**	Reduce reliance on high-cost residential care placements Number of children in high cost placements decreased by two-fifths, from 111 the previous year to 67. 2018-19 (to Quarter 3)
Shift the emphasis from placements out with Glasgow	Children and young people who require to be looked after and accommodated by the local authority can expect to remain living in the city and maintain connections important	**2019/20**	Further reduce the number of children living

	to them.		out with the city by 10%.
Work with families to improve the life chances for children, with a specific focus on family resilience, health improvement, educational attainment and reducing the number of children looked after away from home	Continue to Develop the Intensive Outreach Family Support Service (IOFSS**)** .The aim of the service is to provide intensive community supports to prevent young people being taken in local authority care:	**2019/20**	Continued reduction in the no's of children placed on the CPR and length of time on the Register, including referrals to high cost placements

Children's Services			
Public Protection/Keeping Children Safe			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Improve the identification of, and response to, children living with neglect in the City.	City wide training of social work, health staff in the identification of neglect Continue to work across all services and partners to improve our approaches to early identification of neglect Continue to work with colleagues in adult services to raise awareness of children living with neglect.	**Ongoing**	Increase in numbers of children receiving support

	Qualitative analysis to be undertaken with HSCP staff to explore and understand why the Glasgow Neglect Toolkit is not used to its full potential.		
Asylum Seeking families	Ensure all new staff have access to training on legislation that impacts on access to services and benefits for asylum seeking families Explore use of translation app to potentially reduce DNA at appointments	End 2020 End 2020	Staff have access to up to date information Families are able to access appointments more easily and DNA rate is reduced
Sexual exploitation and trafficking	Ensure all new staff have access to information sharing on this topic Implement a CSE Community Engagement model to increase awareness of CSE amongst our communities and partner agencies	Ongoing	Protection of vulnerable groups
.Tackling Domestic Abuse	Increase coordination and delivery of services supporting vulnerable families affected by domestic abuse	March 2020	Families affected by domestic abuse in the city will receive a timely and multiagency coordinated response

5.2 Adult Services

ADULT SERVICES			
Prevention Early Intervention and Harm Reduction			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Mental Health: Suicide Prevention	• Update Glasgow City multi- agency suicide prevention action plan to reflect new National Suicide Prevention Action Plan “Every Life Matters” and Living Works Suicide Safer	August 2019	• Contribute to public awareness of how to prevent suicide.

	Communities pillars. • Continue to contribute to NHSGGC Suicide Prevention Group, including work to identify areas/groups for focused activity and development of a GGC-wide suicide prevention concordat. • Continue to provide city wide calendar of suicide prevention training and awareness raising sessions to public, third sector and businesses. • Develop and implement a calendar of activities for National Suicide Prevention Week	October 2019 Ongoing September 2019	• Contribute to reduction in numbers of deaths by suicide in Glasgow City. • Increased numbers of people briefed/ trained in suicide awareness/ prevention.
Community based mental health and well being services (adult and children)	Deliver preparatory work and commissioning process to determine a service provider for community based adult mental health and well being support from April 2020 Delivery of community based stress service for adults Undertake scoping to inform the development of service model options to address mental health and well being in children Continued delivery of commissioned service to Improve the Mental Health and Wellbeing of Young People In conjunction with both Board-wide and Glasgow City contracts / posts to be established via Action 15 monies, progress mental health based training delivery with multiple partners and service areas, including mental health improvement / awareness	By March 2020	Adults experiencing poor mental health and well being can access community based support service Delivery of counselling and group work services to over 5000 adults citywide Development of recommendations to discuss with partners to support mental well being of children Delivery of counselling & group work programmes in schools and Youth Health Service to over 930 young people

	training and suicide prevention training		
Mental Health Counselling Service for people who are Deaf	Implement and evaluate a test for change pilot service with Lifelink for people who are deaf that require a mental health counselling service are able to access a counsellor who can communicate through British Sign Language (BSL).	2019/20	The experience of Deaf people is improved. The evaluation will also consider uptake and pathways to other services to determine if this service should be maintained.
Access to Mental Health Awareness Training for Support workers	• Training needs analysis and further scoping exercise • Development of Mental Health Awareness training programme	By October 2021	Support Workers will have increased knowledge and skills to be able to recognise and support individuals who are experiencing mental health issues. People will be supported to live in their owns homes
Addressing Inequalities	Building on previous years' work on equalities development at Board-level for mental health and allied services, which has focused on the priority themes of sensory impairment, financial inclusion and human rights, the appointment of a new post-holder will allow a comprehensive engagement and review of priorities.	2019-22	A refreshed GGC action plan for mental health equalities, in conjunction with relevant HSCP service leads.
Develop robust transition arrangements for young people and older people into and out of adult LD services	• Scope current and predicted service demand • Review current and planned service capacity • Ensure effective transition protocols are in place	2020/21	People have their assessed care and treatment needs met at an early stage, in the most appropriate setting and experience continuity of

			care
The Keys to Life Implementation Plan 2019-21	Develop multi-service local action plan in response to national implementation plan, focusing on improvements for people with a learning disability in: • Living • Learning • Working • Wellbeing	2019-21	Contribute to the achievement of the priorities set out in the implementation plan, empowering people to • Live healthy and active lives • Learn to reach their potential • Participate in an inclusive economy • Contribute to a fair, equal and safe Scotland
Make progress towards meeting the key objectives within the City's 5 year Rapid Re-Housing and Transition Plan (RRTP) 2019-24	• Reduce time in temporary accommodation by more than 50% • End use of B&B accommodation for homeless people • Develop 600 Housing First tenancies for the most complex and disadvantaged service users • A system change in the homelessness commissioning model from accommodation based services to community based supports	Robust processes and plans in place by 2022 (to achieve full delivery by 2024)	To prevent homelessness, wherever possible. Where it is not possible to prevent homelessness, the priority is to provide a safe and secure home for every homeless household as quickly as possible.
Improve interfaces with Housing Providers to increase access to settled accommodation	• Work with Housing Access Team, continue to coordinate citywide casework input to Local Letting Communities • Monitor number and duration of homelessness applications.	2019/20	Targets being agreed Homeless applications over 6 months duration: target 40% or less.

Increase throughput in temporary and emergency accommodation to settled accommodation	• Work to agreed targets for provision of initial decision, prospects / resettlement plans and case durations	2019/20	Targets: Provision of 95% of decisions made within 28 days. Completion of Prospects / Resettlement Plan within 28 days
Develop a sustainable, holistic response to homelessness by ensuring collaboration across housing, health, social work, third and independent sectors	• Working alongside the Flexible Homeless Outreach Support Service (FHOSS), locality Money and Debt Advice Services, and continue to develop integrated working with money and debt advice, mediation, wider support services • Facilitate a broader involvement from HSCP, including mental health, services in supporting tenancy sustainment and preventing homelessness. • Continue to improve partnership working with Registered Social Landlords (RSLs) and local providers of homelessness services • Facilitate housing liaison sessions and training to improve knowledge, access and interface with Health and Social Care Partnership services for people at risk of homelessness • Continue to offer single point of contact for RSLs on tenancy sustainment issues and improve access to third sector support services • Monitor the impact of the GHSCP Hoarding Protocol across the City • Support discharge planning arrangements relating to housing and tenancy sustainment within mental health inpatient services	2019-22	• Improve referrals to FHOSS /Welfare Rights/ Mediation Services • Increased tenancy sustainment and reduced levels of homelessness • Evidence though local Essential Connections Forum and Homeless Provider Forum • High levels of participation and engagement • Efficient response times and qualitative support and advice • Identification of hoarding and then effective support • Tenancy sustainment / improved discharge planning
Reduce drug and alcohol related	• Provide open access responsive services within existing alcohol and drug community	2019-22	Achieve and maintain

harms and drug and alcohol related deaths	services to improve assessment and access to appropriate care and treatment • Increased emphasis on assertive outreach and early harm reduction interventions. Performance framework to be established and reviewed to work collaboratively with Deep End GPs to identify patients with problem alcohol use who do not engage with specialist services. • Increase Naloxone supply • Optimise Opiate Replacement Treatment (ORT) dosing: Review the result of ORT staff survey and create action and training plan. • Better understand changes in novel benzodiazepine-type drug use by: - Review drug monitoring in acute presentations at Emergency Departments - Review GADRS audit of lab benzodiazepines and gabapentinoids toxicology audit result, creating an action and staff training plan - Embed "Guidance on the Principles of Benzodiazepine Prescribing with Concomitant Opiate Dependence" into day to day practice - Implement action plan from the Street Drug Summit recommendations • Screening for Early Fibrotic Liver Disease in Alcohol Misusers		waiting times targets Reduce drug and alcohol related disease

Once approved Implementation of the recommendations from the Sexual Health Services review (Applicable NHSGGC-wide)	• Access to service for young people aged up to 18 will be improved with new and more service locations established for them, including early evening and a Saturday afternoon service, resulting in better outcomes for young people. • Introduction of an improved 'tiered' model of service for adults allowing more appointments to be offered across fewer service locations, more people able to be seen each year, and to have more of their needs met in ways that better suit them and by the right staff at the right time. • People will be able to virtually attend services and access sexually transmitted infection (STI) testing and oral contraception services online. • Improved access to long acting and reversible methods of contraception (LARC) by providing these appointments at all Sandyford locations. • Access to sexual health services will be improved by expanding the provision of Test Express services (fast access testing service provided by Health Care Support Workers for people without symptoms) across all Sandyford locations. • Quicker and easier telephone booking and access, and a comprehensive online booking system introduced.	2019-22	- Sexual Health Services are accessible and targeting the most vulnerable groups - Encourage those who could be self-managing to be supported differently - Improved use of existing resources - Urgent sexual health care should be available within 48 hours
Fewer newly acquired HIV and sexually transmitted infections	• Improve access to testing at clinics, and introduce some test-only walk-in clinics and targeted home or self-testing • Ensure HIV testing is being targeted appropriately at groups who are most at risk	Ongoing	Increase in testing, particularly amongst priority groups. Reduction in HIV infections Reduction in sexually transmitted infections
Fewer unintended pregnancies	• Increase the uptake of very long acting reversible contraception (vLARC)	Ongoing	Reduction in unintended pregnancies

	• Increase the uptake of vLARC in women who have undergone a termination of pregnancy procedure • Reduction in teenage conceptions, with targeted action in areas where there are higher rates		
Locality Specific Areas of Activity North East	**Priority Actions**	**Timescale**	**Outcomes Sought**
Mental Health Services Continue to improve waiting times to access Primary Care and Community Mental health	Continue to monitor the 18 weeks to referral to treatment - Access target for Community Mental Health Teams (CMHTS)/Primary Care Mental Health Teams (PCMHTS) Review staffing profiles in the community and agree an action plan. Recruitment issues - reduce temporary/secondment post to encourage sustainability of the workforce	**2019/2020**	**Waiting times for Primary care and CMHTS reduced**
	Continue to ensure we have the most appropriate and efficient staffing model as we further develop the future CMHT models and clinical care pathways		
Drug and Alcohol Services	Continue to deliver specialist Hepatitis clinics alongside opiate replacement therapy Specialist clinics have been established and there has been an increase in patients engaging in Hepatitis treatment	**2019/2020**	**Reduced harm from drug/alcohol misuse**
Homelessness	Improve knowledge, access and interface with Health and Social Care Partnership services for people at risk of homelessness	Ongoing	Reduce the numbers of people becoming homeless

ADULT SERVICES			
Provide Greater Self Determination and Choice			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Continue to develop a Recovery Orientated System of Care (ROSC) model	Embed the Scottish Government Strategy 'Rights, Respect and Recovery' published 2018 actively promote ROSC.	2019-22	People access and benefit from effective, integrated person-centred support to achieve their recovery
Provide a range of person centred alcohol and drug care and treatment options	New Residential Rehabilitation and Stabilisation Services to be established in 2019. Monitoring and review of the new services will take place in 2020. Work in close partnership with Recovery Hubs as part of the addiction continuum, offering recovery opportunities. Explore new developments in Opiate Replacement Treatment : review of injectable Buprenorphine pilot. Establish Buprenorphine wafer. Embed the recently commissioned new advocacy service and monitor the uptake	2019-21 Ongoing	Qualitative feedback from service users Continue to increase referrals. Qualitative feedback from service users. Achieve target uptake numbers.
Personalisation: Maintain a continuing focus on delivering the best possible outcomes and quality of life to all people in the City that require	• A continued emphasis on family and carer support building on the significant progress made in this area over recent years and the new Carers Act requirements. • Develop a sensitive approach to allow service users to move to more economically efficient models of support.	2019-22	People are supported to live safely and as independently as possible in a community setting

support from the HSCP and Locality services	• A greater and more effective application of technology to help sustain that carer role and community living in general. This will combine the use of technology enabled care for people with higher level care needs. • Embed the resource allocation policy guidance to support the delivery of a consistent approach to personalisation and the ongoing commitment required by the HSCP to funding the "relevant amount" (the level of funding required to meet each individuals assessed care needs and their outcome based support plan within a community setting).		
Access to Psychological Therapies	• To provide Mental Health Services that will maintain patients seen within 18 weeks performance • Promote use of cCBT (computerised cognitive behaviour therapy)	Ongoing Ongoing	To achieve the Psychological Therapies 18 week Referral to Treatment standard Equality of access of cCBT
Reprovision of Mental Health Advocacy Service for Glasgow City	• Review and develop new service specification in partnership with relevant stakeholders	October 2021	Appropriately independent commissioned service in place
Review of Mental Health employability and meaningful activity services within Glasgow City	• Review and develop new service specification in partnership with relevant stakeholders	March 2020	Employability services that supports the recovery and resilience of individuals
Locality Specific Areas of Activity North East	**Priority Actions**	**Timescale**	**Outcomes Sought**
Mental Health			
Inpatient Activity	Improve therapeutic interventions for inpatients Reduce illicit drug use Increase referrals to Link Workers, financial inclusion	**2019/202**	Increased numbers of people accessing

	services and employment opportunities Implement supplementary staffing action plan Reduce the use of Bank staff		meaningful activities including employment and training Increased income and opportunities for people with mental health issues
Drug and Alcohol Services			
Recovery Services	Implement a new assessment and careplan tool, with a focus on recovery goals and supports. Introduce a Recovery Outcome Web tool that measures recovery potential and improvements from first assessment and treatment.		**recovery is an integral part of treatment, from the first point of contact through to exit from service**

ADULT SERVICES			
Shifting the Balance of Care			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Identify suitable and sustainable community provision to reduce reliance on NHS inpatient services (Tier 4) for people with a learning disability.	• Commission specialist residential services for adults with learning disabilities requiring complex care, with an emphasis on supporting individuals to potentially move on to more independent models of care. • Explore the development of specialist robust supported living models for people requiring complex care.	2021/22	People are cared for in a homely environment that maximises their independence and the opportunity to progress to more independent models of care The discharge of all Glasgow City patients

			currently in NHS LD long stay beds. Reducing delays in the discharge of people from LD assessment and treatment beds
Implementation of 5 Year Adult Mental Health Strategy 2018-23 Linked to the MH strategy: Procure and commission a new service to provide an alternative distress response for individuals within Glasgow City Effective and Efficient Community Mental Health Services	• Develop suitable community alternatives (statutory and non-statutory services) to support people to be discharged from hospital, and prevent hospital admissions. • Linked to the above, reduce the level of mental health inpatient beds across acute, rehabilitation and hospital based complex care beds, freeing up resources for reinvestment in community services. • Reduce average length of stay ensure effective use of beds • Ensure delayed discharges are within target range • Unscheduled Care – ensure early identification of barriers to discharge • Develop a service specification in partnership with key multiagency stakeholders that will meet the needs of individuals in distress • Improve the Effectiveness and Efficiency in	Significant progress by 2022 (full implementation of strategy by 2023 April 2020 2022	People are supported to live safely and as independently as possible in a community setting. Achieve bed number targets set out in AMH strategy Target of zero delayed discharges An accessible alternative distress response service will be available Adult Community Mental Health Services are effective and efficient

	Adult Community Mental Health Services		
Integration of secondary care services in community teams. Making secondary care treatment more accessible to service users in the community	Continue to develop HCV (Hep C) clinics and further promote and support the BBV (blood-borne virus) agenda. Review of fibroscan pilot to detect early liver disease and to provide early interventions, with a view to expanding city wide. Promote harm reduction with Injecting Equipment Programme (IEP) and foil. Continue to work closely with GP colleagues to review all service users and identify how best to meet the needs of service users who are prescribed Opiate Replacement Treatment (ORT) Shared Care teams to continue to promote referrals into Recovery Hubs	2019-22	Reduction and eventual eradication of HCV (Hep C) Better early detection rates Increase HIV testing within teams. Increase numbers of individual being prescribed ORT via their GP. Increase in referrals
Alcohol & Drugs inpatient and day	Explore potential to improve the standard of existing	2019-22	People are supported to live

service provision	accommodation and the scope to see further shifts towards community alternatives		safely and as independently as possible in a community setting.
Locality Specific Areas of Activity North East	**Priority Actions**	**Timescale**	**Outcomes Sought**
Mental Health			
Improve mental health inpatient accommodation	Deliver new, purpose built accommodation for mental health acute inpatient accommodation at Stobhill Hospital	2020	Improve the physical and therapeutic environment to the benefit of patients and staff
Drug and Alcohol Services			
	Deliver training to an increased number of Children's residential units		**Children and Young People affected by their own, or their carers', alcohol or drug use are supported**

ADULT SERVICES			
Enable Independent Living			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Implementation of Assisted Technology (TECS) and where appropriate alternative models of	• Progress transformational change programme to embed consideration of TECS within assessment processes and explore alternative	2019/20	People are able to live, as far as reasonably practicable, independently

support	arrangements to sleepovers. • Pending evaluation of Connecting Neighbourhoods test for change work in Castlemilk and Shettleston, roll out new responder service for overnight care elsewhere in the City	2021/22	and at home or in a homely setting in their community Reduction in the volume and cost of sleepover provision
Modernising Learning Disability Day Services	• Extend the range of health clinics offered at day centres • Improve access to health checks • Consider alternative and quicker responses to service users or carers in times of 'social or care crisis' • "Respite" or increased support for short periods within a structured environment. • Undertake an option appraisal to consider the replacement of 2 LD day care centres	2020/21	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
Integration of Learning Disability services	Informed by test for change work in North East, implement and evaluate new processes, protocols and systems that support the delivery of more integrated Learning Disability services throughout the City, including improved access to and experience of 'mainstream' services	2019-21	People who use health and social care services have positive experiences of those services, and have their dignity respected Reduction in waiting times to access services
Improve links between Alcohol & Drug Recovery services and with housing support services.	• Continue to work closely with housing providers and housing support services to identify individuals who require alcohol and/or drug interventions to assist in tenancy sustainment.	Ongoing	Early access to care and treatment. Tenancy sustainment

Review frequent Emergency Department presentations and aim to support to reduce attendances	Continue to review and audit frequent Emergency Department attenders.	2019/20	Reduction in A&E attendances
Locality Specific Areas of Activity North East	**Priority Actions**	**Timescale**	**Outcomes Sought**
Mental Health Services			
Complete personalisation assessments for all people who have a mental health difficulty and are eligible for services	Improve performance in relation to the completion of Support Needs Assessments and Outcome Based Support Plans which will improve access to social care services. Additional performance targets to be set with all plans to be routinely completed within two month period	**Ongoing**	Outcome based support plans(OBSPs) are developed in collaboration with service users, families and other partners ensuring that people are safe, protected and supported to live as independent lives as possible and exercise choice and self determination in their lives
Supported Living	Review all models of support to take forward the reshaping of supported accommodation and supported living to meet current needs, ensuring that people in most need can be prioritised for high levels of support		More people are able to live independently with support
Drug and Alcohol Services			
Recovery	Continue to support recovery volunteers though formal supervision; Further develop in-reaching to treatment clinics by	**2019/2020**	recovery is an integral part of treatment, from the first point of contact through to exit

	recovery volunteers; Develop a weekly reception area presence of recovery volunteers in ADRS		
Homelessness	Continue to input into Local Letting Communities and improve interface with Housing providers to increase access to settled accommodation	**2019/2020**	Increase in numbers of households securing permanent accommodation

ADULT SERVICES			
Public Protection			
City Wide areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Adult Support and Protection Act	• Ensure staff continue to be supported to meet ASP standards and requirements • Contribute to maintaining and where necessary, improving practice arising from the annual joint self evaluations	Ongoing	Continue to ensure people, particularly the most vulnerable, are kept safe from harm and that risks to individuals or groups are identified and managed appropriately.
Develop more integrated working practices between Criminal Justice and other Adult Services to better manage vulnerability	• Develop more integrated risk assessment and risk management processes with Alcohol and Drug Recovery Services (and ensure all MAPPA clients with alcohol and /or	2019-21	Clients have timely access to appropriate services, including better access to Addiction and Homelessness services Criminal Justice staff to be aware of the housing first model and be able to support

	addiction issues are able to access local services). • Ensure criminal justice staff have a full understanding of processes and supports aimed at preventing homelessness • Review referral pathways with Mental Health and promote best practice with service users with complex mental health needs • Ensure follow-up for non-engagement, with particular consideration to vulnerability and risk • Develop more robust links and working practices with Scottish Prison services		service users to access / utilise this service when appropriate Criminal Justice staff have a better understanding of complex mental health issues (eg personality disorder) and the best approach to manage / address these needs Early identification of vulnerability.
The efficient processing of community payback orders (CPOs) and criminal justice social work reports	• Ensure all CPOs are reviewed by a Team Leader at the 3 month stage and throughout the order.	Ongoing	75% of CPOs 3 month Reviews held within timescale Compliance target of 85%

	• Ensure service users have a comprehensive risk assessment and supervised action plan in place within 20 days of a CPO.		
Increase BBV testing and support access to Hepatitis C and HIV treatment	• Continue to increase testing and access to BBV (blood-borne virus) treatment. • Increase staff trained in Dry Blood Spot testing (DBST)	2019-22	Reduction in the number of people infected with Hep C and HIV
Establish the Enhanced Drug Treatment Service (EDTS)	• The Enhanced Drug Treatment Service will commence in September 2019 with a focus on prescribed diamorphine treatment for a small group of people who inject drugs within the city centre.	2019/20	Reduction in drug deaths and supporting people to access other care and treatment pathways as necessary
Develop a service improvement programme for Prison Healthcare	• The development of Advanced Nurse Practitioner posts across the service to address the challenge of providing accessible medical cover. • The review of recruitment practice around nursing and medical staff to support retention and vacancy management. • A review of the	2019-22	Performance framework to be developed Within available parameters, people in prisons have equity of access to safe, effective and responsive healthcare

	workforce to enable improved service delivery, including enhanced mental health /psychology provision funded through 'Action 15' monies. • A robust Health Improvement approach is in place • The development of enhanced IT provision to assist service improvement opportunities		
Continue to provide a combined high quality Police Custody healthcare service, including delivery of Forensic Medical Service provision	• Be responsive to the health care needs of people in custody and to ensure appropriate links are made to other services (e.g. Addiction, Mental Health Services) to meet individuals' on-going health needs. • Enhance mental health service provision through 'Action 15' monies. • The development of enhanced IT provision to assist service improvement opportunities • The development and	2019-22	Performance framework to be developed Within available parameters, people in police custody have equity of access to safe, effective and responsive healthcare

	implementation of a robust Health Improvement approach		
Development of Archway Sexual Assault and Referral Centre (ASARC)	• Work with partners to maintain the high standard of forensic care and increased opening hours in the Archway sexual assault and referral centre. Progress development of a new West of Scotland regional service, including transfer of ASARC from Sandyford to upgraded accommodation at William Street Clinic		Improved access to specialist care and support
Development of Community Custody Unit for women	Work in partnership with Scottish Prison Service to develop the HSCP service and staffing model required to provide effective care and support to women in the new facility to be developed in Maryhill	2020	Provide safe accommodation and support the needs of women who are suitable for, and would benefit from, closer community contact and access to local services, to create and sustain independence in preparation for successful reintegration into the community
Ensure North East Women's Team continue to be effective in terms of impact on service user's wellbeing indicators	The North east Women's Team (NEWT) will contribute to a citywide evaluation of services for Women within the Criminal Justice system	**2019/2020**	Overall services / supports for women within the CJ system to be improved with any gaps in provision addressed.

	The outcomes of the most recent evaluation of the NEWT to be shared with criminal justice colleagues / senior management		Learning from the positive review of the NEWT to be shared with colleagues both within NE and across the city in terms of best practice approach to working with women

5.3 Older People and Physical Disability

OLDER PEOPLE'S & PHYSICAL DISABILITY SERVICES			
	Prevention Early intervention and Harm Reduction		
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Anticipatory care plans	1089 were completed last year which is more than doubled since 2017. A new model National model called my ACP is being introduced in 2019/20. • Complete staff awareness sessions • Implement Clinical Portal Version of ACP summary • Raise public awareness • Provision of additional support to Partnership staff from MacMillan ACP Facilitator • Develop and agree new HSCP ACP Booklet • Work with HIS to form and develop a Living and Dying Well Frailty Collaborative	Introduced this financial year.	Targeted use of ACP within District Nursing Services, Long Term Conditions and Care Homes Share ACP summaries with GPs and other relevant professionals involved in the persons care. Empower people through greater awareness, control, choice and self management of their LTC.

			Test new approaches to the identification and management of Frailty
The use of falls prevention and projects to support frail older people.	Glasgow's target rate is 6.75 per 1,000 but the current rate is 7.5: a number of actions are identified including; • Develop a referral pathway with Scottish Fire and Rescue to carry out level one conversations and refer into NHS falls and rehab services Introduce a frailty tool with specific focus on evidence based interventions. • Promote the use of the "Up and About" resources on prevention of falls • Agree ways of improving data collection for falls including determining a realistic and meaningful baseline. • Continue to support Scottish Ambulance to reduce the number of non injured fallers conveyed to hospital • Contribute to the response to the Falls and Fracture Prevention Strategy for Scotland 2019 -2024 consultation document • Contribute to the development of the NHSGGC Falls Strategy • Promote the use of Technology Enabled Care for those who are at risk of falling • Connect various sources of information on people who fall to services i.e. homecare and rehab	Actions to be progressed in 2019/20	Increased referrals to rehab services and community falls team. and established use of frailty tool

Maximise use of Link worker capacity within Primary care, Dementia Services and Community Connectors	• Raise awareness of roles of links workers • Promote networking of Links Workers to make efficient use of capacity		

Older People and Physical Disability Services			
Shifting the Balance of care			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Delayed Discharge	Target to reduce the number of lost bed days to under 1910 per annum. Above target currently not being met. A working group has been established to develop an action plan and take forward specific priorities related to 13ZA and AWI issues	Progress required this financial year.	Reduction in delays and bed days associated with delays
Evidencing shifting the balance of care and evidencing projects that support independent living (Telecare	2,706 telecare referrals were taken during 2018/19 which was above the target of 2248. 1,337 advanced telecare referrals were implemented which is above the target of 304. Referrals are above the performance targets but the strategic plan highlights the need to increase the pace of telecare uptake.	Track referral rates during 2019/20	Increase of uptake of telecare
The role of neighbourhood teams in supporting older people in the community.	• Neighbourhood teams will develop a delivery model to deliver more joined up and integrated health and social care services for older people/people with physical disabilities in partnership with GPs, housing providers, community and voluntary sectors to take a proactive and preventative approach to care, delivering better outcomes for older people and people with physical disabilities, their	Work to address recruitment issues and pathways to be undertaken during 2019/20	Delivery of 75% target for re-ablement

	families and carers, The neighbourhood model will assist in the development of multi-disciplinary front line teams to deliver on the strategic priorities of the HSCP		
Develop more alternatives to acute hospital admissions.	Neighbourhood teams will develop a delivery model to deliver more joined up and integrated health and social care services for older people/people with physical disabilities in partnership with GPs, housing providers, community and voluntary sectors to take a proactive and preventative approach to care, delivering better outcomes for older people and people with physical disabilities, their families and carers, The neighbourhood model will assist in the development of multi-disciplinary front line teams to deliver on the strategic priorities of the HSCP	Further work on the transformational change programme will be ongoing throughout 2019/20.	Reduced attendance at ED and Assessment Units by use of alternative routes for support
Need to reduce admissions to hospital from care and residential settings.	Work is primarily led via the unscheduled care group examples of work related to this are; • The red bag programme • Work underway around the GP Consultant Geriatrician interface in the community. • A review of admissions from a care home in NE to GRI. • Work with residential and nursing care settings to develop awareness and intervention to support service users with dementia • Further develop Advanced Nurse Practitioner role within Partnership Residential Homes • Provide support and advice from mainstream community services to inform care home staff about a variety of clinical conditions including continence care, tissue viability etc	2019/20	Reduced attendance, admission and length of stay for care home residents within acute system
Continue to develop the Community Respiratory Team and to maintain /	• Review data from the Community Respiratory team to identify areas for improvement and	2019/20	• Review data from the Community

increase the positive impact on admissions to hospital and length of stay. Reduce attendances at ED and AU.	greater efficiency • Formulate develop plan and resource required		Respiratory team to identify areas for improvement and greater efficiency • Formulate develop plan and resource required
Link with the five year strategy for older people's mental health	The OPMH 5 year strategy is currently in development and will have a focus on shifting the balance of care including looking at alternatives to admission to inpatient care. Dementia is one strand of the above. **Technology** Ensure all staff have the knowledge, skills & competencies around the availability of technology to support individuals at the different stages of dementia. **Promoting Excellence** All HSCP employees in contact with people with dementia will have a level of training appropriate to the promoting excellence framework. **Advanced Dementia/sharing good practice** Sustainability around good practice in the area of dementia service delivery, shared learning across the HSCP and third sector. **Dementia Public Awareness** Through public awareness and involvement of third sector organisations . People will have a better understanding of basic rights and entitlements, ensuring more resilience and less likelihood of delays in hospital.	To reduce waiting time and gather accurate data in relation completed PDS, referrals and waiting times -Revise IJB Performance measures. -Explore opportunities to develop PDS pathways for people with more advanced dementia -Manage Alzheimer's Scotland PDS contract and consider options	Improved co-ordination across acute and mental health systems Continue to Increase the number of service users with a diagnosis of dementia on the GP Dementia register and ensure effective delivery of pos

	People have a better understanding of lifestyle choices which could impact of the onset of dementia People will feel they can live well with dementia People experience a positive approach to dementia where they live. **Post Diagnostic Support (PDS).** Patients and service users receive timely post diagnosis support **Specialist dementia Unit improvement programme.** A national improvement programme will continue to ensure continuing improvements in the provision of specialist dementia units using and Experience based on a co-design model. **Effective and Efficient Community Mental Health Teams** Ensure that Community Mental Health Teams are operating effectively and efficiently to meet the needs of the current population and improve outcomes for people living with dementia and or functional mental health illness	for how 5 Pillar PDS is delivered in 2020 -Benchmark against the PDS framework for quality improvement -Gather qualitative information from patients/service users	
Integration of Occupational Therapy within Older People's services	The review of OT has focused on creating integrated OT Services within Older People and Primary Care Group. A piece of work to identify competencies has been undertaken and will be rolled out following a successful test of change. This aim of this is to ensure that we can make best and full use of all the skills of OT's, and reduce onward referral to OT colleagues to a minimum There is also a data and performance work stream	2019/20	**Consistent and effective use of services and Occupational Therapy skills**

	that has tested out a number of measures to assess the impact of OT on services user health and well - being and assess the impact of individual OT's. In addition plans are underway to measure waiting times across all services in a consistent way.		

Older People and Physical Disability Services			
Enabling Independent living for longer			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Increases in the amount of homecare reviews undertaken and offered.	During 18/19 83% of those aged over 65 receiving home care were reviewed. This above the target figure of 81%. However South area averaged 78% due to staff shortages and this is an area for improvement.	During 2019/20	Regular review of homecare and maintenance or improvement of target figures
Increases in the amount of supported living placements including the living well project.	The number of people in supported living services increased during 18/19 to 878 which is above the target rate of 830 per annum. The increase in the number of OP personalisation packages is a driver for this. Further increases during 2019/20 are sought.	2019/20	**Delivery of supported living placements**
Development of bespoke OP residential housing with care.	202 service users are currently supported with care and support packages via housing providers. 75 more properties are coming on stream during this financial year.	Track occupancy progress during 19/20.	**Delivery of supported living placements in partnership with Housing providers**
Increase take up and support for palliative care.	Palliative Care services have been a factor in increasing the percentage of people who spend the last 6 months of their life in the community.	Further work during 2019/20 to improve RAG	**Increased use of palliative care provision and choice for people to spend last 6**

	Target for 2019/20 is to increase those spending the last 6 months of their life in the community by 2%.	classifications and data collection.	**months of life in home or community setting**
Creating a safer home environment through Improving identification of vulnerable Older People through Housing and relationship with Registered Social Landlords and Housing Options	Maximise the use of RSLs and HOs to support HSCP in identifying vulnerable older people and assist them in identifying where housing options, Telecare, ACP, adaptations etc.	Measures to be developed around Use of Clustered Supported Living Placements and uptake of appropriate support	Review through Essential connection forum with partner organisations and develop measures for uptake of Telecare and use of Anticipatory Care Plans with appropriate people

5.4 Primary Care and Community Services

PRIMARY CARE SERVICES			
Prevention early intervention and harm reduction			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Primary Care Improvement Programme (PCIP) – General Practice Multi-Disciplinary Team Workflow	• Agree process for application to Health Improvement Scotland Practice Administrative Staff Collaborative (PASC) collaborative for general Practice in Glasgow • Support applications under PASC – signposting training • Support roll successful practices in the roll out	Aug 2019 Autumn 2019 and ongoing for successful	Glasgow City practices successfully in a national collaborative to promote signposting as a way of working and increasing the number of people seeking consultations who are seen

	and implementation of the PASC Collaborative	applications	first by the person / service most able to help
PCIP - Improve communication and working relationships between the HSCP and General Practices.	• Increasing contact between HSCP and GPs using the cluster guidance, Cluster Quality Leads to be offered by PCIP Team • Agree implementation of cluster guidance for up to 4 sessions per month for clusters • Increase frequency of meetings between HSCP & GPs to boost tripartite arrangements.	12 months	Increased and improved collaboration between HSCP and GPs.
PCIP - Pharmacotherapy	• Continue close working with pharmacy colleagues to ensure that all practices have some pharmacotherapy input by Spring 2020	April 2020	All practices aware by end 2019 of the level of input they can expect
PCIP – Musculo-Skeletal (MSK) Physiotherapy	• To co-ordinate use of Advanced Practice Physiotherapists (APPs) to improve patient care and reduce GP workload. • To embed the learning gained from experience in north east practices.	March 2020	To offer APP to appropriate practices in north east and across the city.
PCIP - Vaccination Transformation Programme (VTP)	• To link Glasgow City VTP to Greater Glasgow & Clyde priorities and programme board. • To effectively and safely transfer current vaccination programme to new service models under PCIP to improve vaccination uptake.	Ongoing April 2021	To maintain / improve vaccination levels under new arrangements.
PCIP Urgent Care	Know Who To Turn To banners in GP practices	Autumn 2019	Raise patient awareness of alternatives to GP visit

Primary Care Services			
Providing Greater determination and choice			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
PCIP – Community Care & Treatment; Phlebotomy	Continued roll out of phlebotomy service to areas of the City/ Locality not served by Health Centres providing patients with more choice about where they attend to have their bloods taken	Autumn 2019 and ongoing	Provision of service to increased number of practices with an initial emphasis on those practices who do not have access to existing Treatment Rooms
PCIP Community Care and Treatment/Phlebotomy/Premises Work stream	Support sourcing of suitable accommodation for Phlebotomy service	Autumn 2019	Provision of service to increased number of practices with an initial emphasis on those practices who do not have access to existing Treatment Rooms
Locality Specific Areas of Activity North East	**Priority Actions**	**Timescale**	**Outcomes Sought**
To improve communication and good working relationships between the HSCP and General Practices.	This will involve increasing contact between HSCP and GPs using the cluster guidance, CQLs to be offered 4 sessions per month for cluster working. We will increase frequency of meetings between HSCP & GPs to boost tripartite arrangements.	12 months	Increased interaction between HSCP and GPs.

Primary Care Services			
Shifting the Balance of care			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
PCIP - Primary Care Sustainability	• Test more systematic and proactive approach to the identification of sustainability challenges e.g. combining our current intelligence with the offer of a proactive survey of all practices in one Locality. • Strengthening support to practices could primarily take the form of ensuring that the wider supports are available to the practices in greatest need, examples of these include; MDT, workflow, administration support, training and other ways of meeting practice specific needs. • Quantify GP time freed up and time spent with those with more complex needs	April 2020	Ensuring continuity of care as implementation of PCIP
PCIP – Urgent Care	• Support the roll out of the ANP model into HSCP care homes. • Develop and provide ANP to new residential units opening in the NW in late summer 2019	Autumn 2019 and ongoing	Enhanced support for care home residents and reduced workload including housecalls for GPs
Locality Specific Areas of Activity North East	**Priority Actions**	**Timescale**	**Outcomes Sought**
Hospital attendance	To liaise with Secondary Care via the local interface groups, by this means to attempt to reduce hospital attendance both at A & E and GP admissions.	12 months	To have closer working relationships and concrete plans to reduce hospital attendance.

Primary Care Services			
Enabling Independent living for longer			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Addressing Frailty	Support any possible application to HIS for inclusion the Frailty Collaborative Increased use of frailty tools to help to identify people who would benefit for rehab etc	Summer 2019 and ongoing	Reductions in house call requests and sharing of learning from practices to take part with cluster and locality colleagues. Optimise the potential benefit from the structured use of frailty tools

5.5 Health Improvement

HEALTH IMPROVEMENT SERVICES			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Youth Health Services	Establish two new sites for a holistic youth health service (one in North East, one in South) Develop implementation plans to include youth engagement processes Commence service model delivery	By March 2020	• Improved access to holistic, bespoke youth health services • Vulnerable young people receive holistic support services before adulthood • Young people

			access enhanced tier 0-2 mental health and well being support
Community Link Worker programme (Primary Care Improvement Plan)	Support the phased rollout of the community link worker programme; working closely with primary care Refine current operational model and data collection Delivery of the procurement processes to determine allocation of additional link workers	Phased 2019-20	Improved collaboration with GP practices and the Alliance Increased uptake of social prescribing in areas of deprivation Improved connectivity into relevant services and local community supports
Community based mental health and well being services (adult and children)	Deliver preparatory work and commissioning process to determine a service provider for community based adult mental health and well being support Undertake scoping to inform the development of service model options to address mental health and well being in children aged 5 – 12	By March 2020	Adults experiencing poor mental health and well being can access community based support service Development of a service model to support mental well being of children aged 5-12
Locality Specific Areas of Activity North East	Priority Actions	Timescale	Outcomes Sought
Placed based work	Contribute to the development of Thriving Places action plans in Easterhouse/Springboig/Barlanark and	September 2019	Neighbourhoods inform priorities for local

	Parkhead/Dalmarnock/Camlachie with community planning partners		development
Financial inclusion	Deliver financial inclusion embedded into GP practices in Bridgeton and Parkhead	April 2019-March 2020	Maximise income and address debt to support health and well being

5.6 Carers

CARERS SERVICES			
City-wide Areas of Activity	Priority Actions	Timescale	Outcomes Sought
Implement the Carers (Scotland) Act 2016	Workforce learning and Development Plan to be made available to all Health and Social Care Partnership staff to ensure Carers are support is embedded within practice. Monitor and evaluate training attendance and effectiveness via North West locality quarterly performance monitoring and annual carers report via the Integrated Joint Board (IJB).	Initially role out for Older People and Primary Care Services. Followed by Adult Services and then Children's Services. All operational staff would be expected to attend awareness raising sessions or complete	Carer's (Scotland) Act 2016 training to be available August 2019 onwards.

		Carer (Scotland) Act 2016 e-learning module.	
Carers are identified early in their caring role	Continue to promote and distribute carer Information Booklets to enable carers to self-refer. Continue to promote SCI-gateway as primary care / GP referral pathway for carers. Continue to offer carer awareness information sessions to raise awareness of carers. Continue to promote the Carers Information Line. Improve Carefirst recording where the carer is supported jointly with the service user.	The 2019/20 target for total number of new carers that have gone on to receive an adult carer support plan or young carer statement in Glasgow HSCP is 1650 per annum. The 2019/20 target for carers being offered preventative support early in their caring role is 70%. Monitor and report the effectiveness of the carer Strategy including protected	In 2018-19 the total carer information booklets distributed were 8724: • North West (NW) distributed 3172 • South distributed 2931 • North East (NE) distributed 2621 In 2018-19 the total calls to the Carers Information line were 482: • NW enquiries totalled 84 • South enquiries totalled 250 • NE enquiries totalled 138 The total New carers offered a support plan or Young Carer Statement in 2018-19 was 2007 64% of new referrals were preventative Equalities Impact Assessment (EQIA) will be

		Characteristics data.	included in performance Monitoring from 2019 onwards. Carefirst e-forms and changes required for Carers (Scotland) Act 2016 expected to be completed August 2019

6. PROMOTING EQUALITY

North East Locality will continue to deliver the actions and priorities set out within Glasgow City HSCP's Equality Plan 2016-18. Key actions and priorities for NE locality include:

- Maintaining accessibility audits of new buildings
- Participation in Equality Impact Assessments of cost savings, service redesigns, service developments and policies
- Hate crime awareness and reporting
- Routine enquiry money worries, gender based violence (GBV), employability and appropriate onward referral
- Extend number of GBV local delivery groups from 3 - 5 to deliver on Equally Safe strategy
- Participation in age discrimination audits as required
- Responding to findings of the Fairer NHS staff survey alongside staff training priorities (Asylum seekers & Refugees, Poverty e-learning module, Key care groups, GBV)
- Meeting the requirements of the HSCP's participation and engagement strategy including equalities monitoring of community engagement
- Analysing performance monitoring and patient experience by protected characteristics as required
- Provision of a programme of equality and diversity training for HSCP staff and local organisations
- Promote multi-agency working to address violence against women through the Glasgow Violence Against Women Partnership and the locality implementation group

7. RESOURCES

7.1 Accommodation

New Health and Care Centre

The selection process for the site of the new North East Health and Social care Hub is now complete. The process identified the Parkhead Hospital /Mental Health Resource Centre/Parkhead Health Centre as the preferred location. The ne expanded Health and Care Centre Hub will be much more than a simple replacement of the existing facility; it will give local people access to state of the art health and care services in a facility fit for the 21st century and all under one roof. Construction for the £45million project is scheduled to begin in 2019., completing in 2023. A broad range of services will be provided from the new facility, including GP practices, children's services, district nursing, health visiting, alcohol and drug recovery services, mental health services a dental practice, as well as physiotherapy, podiatry. As well as transforming the standard of accommodation, this new facility will deliver more integrated health and social care services for the benefit of patients and service users in the east end and the wider north east.

Reviewing Accommodation Requirements and Promoting Co-location

As part of the drive to maximise efficiency, effectiveness and integrated working, there will be an ongoing review of the accommodation needs and requirements across North East Locality. This will be undertaken in the context of supporting integrated working and efficient working practices, such as agile working and co-locating health and social care staff where possible. This will include a review of accommodation needs in relation to the development of the new NE Health and Social care Hub.
We will continue to review all of our accommodation, both leased and owned across the North East to ensure that we have accommodation which meets the needs of services users and staff

7.2 Human Resources

North East Locality directly manages a staffing compliment of :

NE	WTE	Head count
NHS	1522	1716
GCC	1110.37	1393
Total Wte	2632.37	
Total headcount		3109

7.3 Finance

North East Locality has a total net recurring budget for service provision of approximately £230m and directly manages a staffing compliment of approximately 3109 people. The budget for North East Locality in 2019/20 is set out below.

	North East Locality		
Strategic care Groups Grouped	***Health Annual Budget £'000***	***SW Annual Budget £'000***	***Total Annual Budget £'000s***
Children & Families	*5,827.4*	*10,327.8*	*16,155.2*
Prison Services & Criminal Justice		*2,718.5*	*2,718.5*
Carers		*814.7*	*814.7*
Older people		*23,401.4*	*23,401.4*
Elderly Mental Health	*8,827.5*	*287.4*	*9,114.9*
Learning Disability	*1,017.2*	*22,144.0*	*23,161.2*
Physical Disability		*4,777.4*	*4,777.4*
Mental Health	*28,448.0*	*3,117.3*	*31,565.3*
Alcohol + Drugs	*2,154.2*	*2,268.6*	*4,422.8*
Homelessness	*2,895.8*	*2,033.8*	*4,929.6*
GP Prescribing	*40,238.2*		*40,238.2*
Family Health Services	*59,424.3*		*59,424.3*
Hosted Services			*0.0*
Other Services	*16,541.7*	*2,240.8*	*18,782.5*