Glasgow City Integration Joint Board Strategic Plan for Health and Social Care 2023 – ??

Flourishing Communities, Healthier Lives

Introduction

To be included once final draft prepared

About Glasgow City Integration Joint Board and Glasgow City Health and Social Care Partnership

What you said: "*There is too much background information and not enough concrete plans to meet the key objectives". "Most reports and plans have too many words that no one reads. Put all that online".*

Strategic Plans can often be long documents with lots of information in them that is of interest to some people and not to others. To help write this Strategic Plan we asked people what they thought should be in it and what should not. Based on what we heard some of the information in the last Plan has been removed because people didn't think it was needed or because they felt it made the document too long and difficult to read. In this section we've summarised some key areas and provided links to more information on each subject in case you want to learn more.

What is health and social care integration?

There is a piece of legislation called the Public Bodies (Joint Working) (Scotland) Act 2014 (the Act). The Act requires Local Authorities (Councils) and Health Boards to integrate the planning of some health services and functions and most social care functions. The Act says that as a minimum, services and functions delivered to adults and older people must be integrated, although in Glasgow City we go much further. The Council and Health Board working together to do this is known as 'health and social care integration.'

What is the difference between the Health and Social Care Partnership and the Integration Joint Board?

Here in Glasgow City, Glasgow City Council and NHS Greater Glasgow and Clyde deliver integrated services as Glasgow City Health and Social Care Partnership (sometimes shortened to the 'Partnership,' 'GCHSCP' or 'HSCP'). The HSCP is essentially the staff from both organisations working in partnership to plan and deliver the services under the direction of an 'Integration Joint Board'.

The IJB is the formal legal body that makes the decisions about how health and social care services are delivered in the city based on the Strategic Plan. The IJB then directs Glasgow City Council and NHS Greater Glasgow and Clyde to work together (as the Partnership) to deliver services. The membership of the IJB is partly defined in the legislation. Details of the current Glasgow City IJB membership is available on our website at https://glasgowcity.hscp.scot/node/14.

What services and functions are integrated in Glasgow?

The services and functions covered by this Strategic Plan that are planned and delivered by Glasgow City HSCP and a range of partners and providers include:

- social care services provided to children and families, adults and older people
- carers support services
- homelessness services
- mental health services
- alcohol and drug services
- criminal justice services
- welfare rights services
- district nursing services, school nursing and health visiting services
- palliative care services
- GP services
- dental services
- optometry
- pharmaceutical services
- sexual health services
- services to promote public health and improvement.

Why do we have to have a Strategic Plan?

The Act says that each Integration Joint Board in Scotland has to have a Strategic Plan that is reviewed every three years to make sure it is relevant to the needs of the area and the people who live there.

The Strategic Plan covers health and social care services across the entire City. Here in Glasgow the city is divided for planning purposes into three areas (North East, North West and South. These are often referred to as “localities” and we also have plans for each of these localities. These “Locality Plans” are updated every year to explain how the Strategic Plan is being implemented locally. These plans are better able to reflect local priorities, needs and community issues. The most up to date locality plans are available on the Partnership’s website at glasgowcity.hscp.scot/strategic-and-locality-plans.

How was the Strategic Plan developed?

In order to ensure that people who live in the city and who receive or deliver health and social care services have an opportunity to influence the Strategic Plan, the HSCP worked with a range of service users, patients, carers, staff and service providers to find out what is important to them and what the HSCP should be doing during the period of the Plan. This is our engagement approach. You can read more about our engagement approach on our website at ***To be added on completion of engagement/consultation***.

Glasgow City: Population profile and needs analysis

What you said: ***"Poverty and increase in cost of living are only going to make these existing challenges more profound, and put more pressure on services through increased demand"***

The challenges faced by Glasgow City as a result of poverty, deprivation, ill health and inequality are well documented. The HSCP understands that there are a whole range of factors that influence the health and social care needs of people. Meeting those health and social care needs means considering all of these other issues and working with our partners to reduce their impact. We work with a range of partners to address these issues. For example we work with Glasgow City Council to understand the housing needs across the city and work to address those needs and reduce the impact that poor housing has on our health.

To understand the bigger picture and help to plan services the HSCP gathers and considers information from different sources to build a profile of the city and its needs. We call this a **"strategic needs assessment"**. That information drives our priorities and the work our teams do with our partners to try to make a difference to people's lives. Examples of some of the information we take into consideration is included below but a more detailed version is available on our website.

Population and Projections

Glasgow City has a population of **635,640**, which is **11.6%** of the population of Scotland. It's made up of:

- **111,512** (17.5%) children aged 0-17
- **438,505** (68.9%) adults aged 18-64 and
- **85,623** (13.5%) older people aged 65 and over.

Glasgow's **population** is expected to continue to **increase** over the next twenty years. Estimates of population growth between 2022 and 2043 indicate an overall increase of around **27,380** people, or **4.3%**.

It is estimated that there will be a decrease in the child population of **6.8%** in the same period, an increase in the adult age group (18-64) of **1.6%** and a much larger increase in the older age group (65+) of **31.8%** during this period.

88.5% of Glasgow's population are from a White background, with **11.5%** from a minority ethnic group.

1,561 pupils in Glasgow schools are seeking asylum, representing **83.9%** of the national total, compared to Glasgow's 10.1% share of pupils overall.

Glasgow schools have **1,859** pupils who are refugees, **53.1%** of all pupils who are refugees in Scotland.

Among the overall population, nearly all of Scotland's asylum seekers are living in Glasgow (**3,713, 97.3%**).

575,890 people in Glasgow aged 16+ (90.6%) are estimated to be straight/heterosexual. **36,231** (5.7%) are estimated to be part of the LGBTi community.

Life Expectancy

Life expectancy in Glasgow City is lower than across Scotland as a whole. Life expectancy for a Glasgow male is **73.1 years** compared to **76.8** years for a Scottish male, a difference of 3.7 years (compared with 4.5 years in 2016/17). For females this is **78.3** years compared to **81** years, a difference of 2.7 years (3.1 years in 2016/17).

Healthy Life Expectancy is the number of years a person can expect to live in good health from birth. According to the most recent data available, healthy life expectancy at birth is **56 years** for Glasgow males compared to **60.9 years** for Scottish males, a difference of 4.9 years compared with a difference of 7.2 years in 2019. Similarly, Glasgow females are expected to live in good health to **57.4 years**, also lower than the Scottish average of 61.8 years, a difference of 4.4 years. This is also a smaller gap than in 2019 (6.8 years).

Poverty and Deprivation

Glasgow City contains **four in 10 of Scotland's 20%** most deprived areas. This proportion rises to almost six in 10 in the Partnership's North East locality.

More than a quarter of a million people (**over 274,000** and **two-fifths** of Glasgow's population), live in these **deprived areas**. Within Glasgow, around a third of North West locality's population lives in one of the most deprived areas, compared to almost two-fifths in the South and just under three-fifths in North East.

Some groups within the city face additional and multiple disadvantage, which was amplified during the pandemic. For example disabled people are more likely to face multiple disadvantage than non-disabled people, with less access to employment, greater ill-health and mortality, increased social and digital exclusion and food insecurity.

In addition:

- **19.3%** of Glasgow's population, more than 122,000 people, lives in an income deprived area compared to **12.1%** for Scotland
- **13.3%** of Glasgow's working age population, almost 70,000 people, lives in an employment deprived area compared to **9.3%** for Scotland
- **More than half (50.7%)** of Glasgow's child and young person population aged 0-17 years, more than 111,000, lives in the most deprived areas compared to **21.8%** for Scotland
- **42%** of Glasgow secondary pupils are registered for free school meals compared to **17.7%** of Scottish pupils
- Around a third of children aged 0-15 in Glasgow are estimated to be living in poverty, compared with around a quarter across Scotland as a whole
- **11.0%** of Glasgow adults have experienced food insecurity in the past year with 14.0% of those living in the most deprived areas experiencing this compared to 8.0% of those living in other areas
- A quarter of Glasgow households are fuel poor **(25.3%)** with **11.8%** classed as extreme fuel poor
- **36,000** children were living in poverty in Glasgow in March 2020
- It has been reported that since Covid the number of people in employment grew but so did the number claiming benefits, potentially creating an increase in working poverty.

Housing and homelessness

There are **295,761** households across the city. Glasgow has a higher percentage of single parent households (**5.3%**) than Scotland **(4.3%)** with more than a quarter of Glasgow S1-4 pupils **(28.0%)** living in single parent households.

Older people living alone (considered a key indicator of vulnerability) account for **42,600** of Glasgow households (14.4%), lower than the Scotland figure (16.5%).

The percentage of overcrowded households in Glasgow **(4.0%)** is higher than that of Scotland overall **(2.4%).**

More than a third of social housing in Glasgow fails the Scottish Housing Quality Standard (SHQS) (**35.5%** compared with the Scottish average of **41.4%**).

5210 households in Glasgow were assessed as homeless or threatened by homelessness in 2020-21.

Mortality

Premature mortality rates of people under 75 years from all causes is roughly **50%** higher for Glasgow (**678 per 100,000** population) than Scotland (**457 per 100,000** population).

Death rates from drugs, alcohol, smoking and homelessness are **higher for Glasgow** than for Scotland.

-The average annual drug related deaths rate for Glasgow (**38.7 per 100,000** population) is almost double the Scotland rate of **20.6 per 100,000** population.

-In 2020 there were **291** drug related deaths in Glasgow (up from the annual average of 242 in 2016-2020), with almost three quarters of these being deaths of males (211, 72.5%).

-The rate of alcohol specific deaths for males of **48.4 per 100,000** population is more than three times the rate for females of **15.5 per 100,000**.

-Alcohol specific male and female death rates are **higher in Glasgow** than Scotland (male rate of 48.4 compared to 29.3 per 100,000, females 15.5 per 100,000 compared with 12.4 per 100,000). Overall, the death rate for all people specific to alcohol is **53% higher** in Glasgow (31.9 per 100,000 population) than Scotland (20.8).

-The rate of smoking attributable deaths of **508.9 per 100,000** population is more than **50%** higher than the Scotland rate of **327.8 per 100,000**.

The Glasgow rate of homeless deaths of **94.8 per million** is more than **50% higher** than the rate for Scotland of **61.9 per million** people. Figures for Scotland indicate that homeless deaths are more prevalent among males (96.8 per million) than females (28.3 million).

Health and Social Care Needs Profile

- Around **11%** of Glasgow's 16 years and over population has said that they live in **'bad/very bad' health** compared to **8%** of Scotland's adults
- **More than a quarter** of Glasgow adults, 28.6%, live with a **limiting long-term illness or condition**
- More than **8,000** people are estimated to be living with **dementia** in Glasgow
- Around 3,700 people, **0.6%** of Glasgow's population, are recorded as having a **learning disability**, whilst almost 13,600 people, **2.1%,** are reported as having a **learning difficulty**
- It is estimated that around **6,500** people in Glasgow have a form of **autism**
- It is estimated that more than 100,000 people in Glasgow have a **physical disability,** 7.8**%** of the population
- **6.1%** of the population has been recorded as having a **hearing impairment**, and almost 2.5% of the population have a **visual impairment**
- **6.5%** of the population has been recorded as having a **mental health condition**
- The number of adolescents reporting **emotional or mental illness** in the city rose from **5%** in 2015 to **22%** in 2019, with children and young people waiting longer than adults to start treatment (61% start within the 18-week period compared with 89% of adults)
- **14.4%** of Glasgow adults (around 74,000) are **unpaid carers** with a higher percentage of women (16.0%) than men (13.0%) undertaking this role
- **2.5%** of Glasgow children under 15 years are **unpaid carers** compared to **2.0%** of all Scottish children
- Nearly a quarter (**23%**) of Glasgow adults have common **mental health problems** compared to **17%** of Scotland's adults, with higher proportions for females in both Glasgow and Scotland (23% Glasgow and 19% Scotland) than males (22% Glasgow and 15% Scotland)
- A fifth of Glasgow's population, **20.5%,** is prescribed drugs for **anxiety, depression and psychosis**. The Scottish average is **19.3%**
- Glasgow has more than 18,000 **problem drug users**, **3.4%** of the adult population, more than the national average of 2.0**%**
- Over a fifth (**21%**) of Glasgow adults are estimated to drink **hazardous / harmful levels of alcohol,** slightly less than the national average of **24%**
- Only **40%** of Glasgow pupils (S1-S4) **eat breakfast every weekday**, compared with **62%** across Scotland
- **One in three** Glasgow males **smoke**, compared with just under one in five females
- **15.2%** of all Glasgow adults feel **isolated** from friends and family
- Currently, **20,000** people in the City are living with a **cancer diagnosis** and this is forecast to rise to approximately 35,000 by 2030.

Covid -19

What you said: "*Covid has made us think differently about how we deliver services and rather than revert to old processes we should be striving for innovative ways to deliver services and communicate better.*"

When the Covid-19 pandemic emerged in 2020 our city, like so many others across the world, was significantly, fundamentally and in some ways permanently affected. All areas of society were impacted and continue to be so. Health and social care was no different. The HSCP and its partners were required to mobilise their business continuity plans and staff, people that use our services and, in particular their carers, were required to dig deep into their own reserves of resilience to a degree they have never been asked to do before. The Integration Joint Board, the HSCP and society in general owes a huge debt of gratitude to the work carried out by the health and social care workforce, which includes those working formally in these sectors and those volunteering to provide care and support for loved ones and neighbours.

Within Glasgow City, responding to the extreme pressures and rapidly evolving picture during the pandemic was characterised by:

Remarkable examples of partnership working: where partners came together to rapidly design, develop and deliver innovative solutions to the challenge of delivering supports to vulnerable citizens during periods of lockdown and restrictions on movement and social interaction

Shifts in working practices: including staff working from home, online meetings, redeployment to frontline service delivery and the use of personal protective equipment

Changes to service delivery: such as reduced access or removal of services to accommodate government and public health advice and guidance, moves to new ways of receiving services such as telephone or online appointments

New services: for example, the introduction of testing facilities, vaccination centres, community assessment centres and mental health assessment units

Equalities sensitive delivery: for example all the work undertaken to deliver accessible new services such as the community champion work on the vaccination programme (i.e. information in video format for our British Sign Language (BSL) users

Focus on workforce: in particular a focus on the mental health and wellbeing of staff, recruitment of new staff for the new services required and ensuring staff had the necessary equipment to support home working

Innovation: the rapid implementation of new and transformational ways of working that might otherwise have taken years to implement

Communication: the HSCP focussed significant attention on communicating with all of our partners and stakeholders through briefings, newsletters and video messages from senior managers to update them on the current issues and how they were being managed. These were made available on the website throughout the pandemic https://glasgowcity.hscp.scot/covid-19-hscp-update.

It is still very early to say with certainty what the lasting effect of Covid will be on health and social care within the city, but we do know that Covid has impacted on health and social care and services in the city in the following ways:

- An additional 2,000 service users this year in our community alarm service with 26,000 responder requests for assistance in their own home
- A 13% increase in the number of service users accessing home care on care packages higher than 20+ hours between 2021 and 2022
- Increased number of service users accessing packages of care in personalisation with a 12% increase in Mental Health and 15% in Older People
- Increase in children, young people and their families experiencing mental health and emotional wellbeing issues
- During Covid children waited 7% longer than adults to start mental health treatment across Greater Glasgow and Clyde
- Increased waiting lists for carers services and unprecedented demands on carers
- Delayed diagnoses and treatment for individuals resulting in anxiety, poorer prognoses and additional demands on families and carers
- A backlog of provision of unpaid work hours within justice services (108,133 in February 2021)
- A 29% increase in requests for Criminal Justice Social Work Reports due to the backlog of court cases 3016 to 3877)
- Increased activity to District Nurse Single Point of Contact, with over double the levels of activity
- Disabled people faced greater ill-health and higher mortality rates related to Covid-19, were more likely to be socially and digitally excluded during the pandemic and were three times more likely to be food insecure during the pandemic
- Significant levels of unmet need and challenges to undertake assessments for SDS to meet this, along with an almost doubling of assessments required and the subsequent financial impact this brings in meeting the requirement

- High staff absence due to positive diagnoses and/or isolation requirements, impacting on the ability to deliver services
- Increased demand for homeless advice and services
- Increased isolation and (digital) exclusion caused by the requirement to close, reduce or alter services and service provision.

Recovering from Covid-19

As the city emerges from the pandemic attention again turns to recovery planning and renewal, with activity already well underway to re-start suspended services. The HSCP is also trying to understand which elements of the changes made to services are working well and should be retained and which are not working so well and should be reversed or modified when it is appropriate to do so. The approach of the HSCP to recovering from the pandemic is captured in our Recovery Strategy. The strategy outlines the principles of the approach to recovery:

- Phased
- Intelligence-led
- Compassionate leadership
- Opportunities-focussed
- Safeguarding
- Collaboration
- Flexibility
- Transparency
- Proportionality
- Sustainability
- Communication

What you told us

As part of the preparation of this Plan we asked you what you think should be retained in relation to the measures and actions taken to combat the pandemic. Here are some of the things you said we should consider retaining and/or building on:

- The **partnership working** that evolved during the pandemic (e.g. with the 3rd and independent sectors)

- Use of **technology** to facilitate contact with professionals (but only as a choice and as part of a range of options)
- New approaches to **working practices** (ensuring the correct equipment and support is available and again with variation to enable flexibility and choice)
- Removal of **bureaucracy** in certain processes
- New ways of delivering services (such as online/telephone prescription ordering, virtual consultations)
- **New services** (e.g. MHAU, community vaccination sites, Compassionate distress response service)
- Provision of **PPE** and testing kits to frontline services
- Greater focus on **staff wellbeing**
- **Safety measures** in buildings (e.g. protective screens)
- Regular **messaging and communication**
- Acceptance that families may be more **resilient** than we previously gave them credit for (with appropriate safeguarding measures and support where required).

You also told us what you thought we should reverse or review before proceeding. Examples of this include:

- Full time **home or office working** (to ensure staff still have access to face to face office/team working but are not forced into a full time return to office working)
- Use of **technology** to facilitate contact with professionals in certain services (i.e. near me/attend anywhere, telephone etc)
- **Digital access is still a huge issue**. There are still many people who don't have access to devices or wifi
- **Withdrawal of care/support** packages and over-reliance on peer support networks (i.e. that might have gone back to work)
- **Making decisions** about services without the appropriate involvement of stakeholders (e.g. staff)
- **Redeployment** of staff and certain tasks to other teams (e.g. where this has led to excessive additional workload)
- **Short term funding** allocations which cannot always be spent
- Increased **communications a**nd surveys
- **Suspended** services/reduced service levels

The suggestions made during the consultation and engagement stage of developing the Plan indicate that similar issues are on people's minds whether they are referring to what to keep or what to reverse from the measures to deal with Covid. The HSCP will consider these views as we progress with recovery after Covid to try to ensure balance in how services are delivered and people

are supported in future. Staff within the HSCP will consider the following factors in making decisions about medium to long terms changes to services following reviews of the changes made and what the next steps should be.

- Supporting staff health, wellbeing, rest and recovery
- Understanding, acknowledging, measuring and addressing the impact of delayed diagnosis and treatment options on people suffering with ill-health and their support networks
- The need to embrace the positive impacts of new ways of delivering services (including use of technology)
- How to give a voice to people with lived experience of services provision, before and after the pandemic
- How to consider the needs of people with specific communication requirements when thinking about continued use of technology to deliver services
- The importance of addressing digital exclusion
- The importance of building on improved partnership working during the pandemic response (internally and with key external partners) when considering the future of service provision
- The importance of investment in infrastructure to support home working and new digital approaches to service delivery
- Complex interdependencies across the sector and the need to work together to co-ordinate re-starting services
- External factors that may influence decisions about future service provision, such as the National Care Service
- The need to work harder to ensure people aren't excluded from services by their protected characteristics and/or by their income
- The importance of communication with teams.

Local and national influences

While Glasgow City IJB has overall responsibility for planning health and social care services within the city, the IJB has to consider a variety of other national and local strategies, plans, policies and legislation to ensure the work of the IJB and the HSCP is consistent with the work of Glasgow City Council, NHS Greater Glasgow and Clyde, and national expectations.

Some (but not all) of the key local and national influences are included below.

National policies and legislation
Public Bodies (Scotland) Act 2014
Carers (Scotland) Act 2016
Community Empowerment (Scotland) Act 2015
The Equalities (Scotland) Act 2010
Fairer Scotland Duty
National Care Service

National strategies and plans
Scotland's Digital Health and Care Strategy
Independent Care Review (the Promise)
Primary Care Improvement Programme
Volunteering in NHS Scotland Programme
20 Minute neighbourhoods
Housing to 2040

National frameworks and standards
GIRFEC
Health and social care standards
Planning with People
National Health and Wellbeing outcomes
Public Sector Equality Duty

Local strategies and plans
Glasgow City Council Strategic Plan
Glasgow's Community Plan
Mental Health Strategy
Glasgow's Housing Strategy
Food Poverty Strategy
Maximising Independence

In order to align the work of the HSCP with some of the influences above, the IJB has put in place a number of strategies and plans that will be taken forward during the lifetime of this Strategic Plan. Some of these are outlined below.

Glasgow City IJB strategies and plans

Mainstreaming Equalities Plan
Rapid Re-housing Transition Plan
Integrated Children's Service Plan
Primary Care Improvement Plan
Carers/Young Carers Strategies
Family Support Strategy

During the term of this Plan there will be many more strategies, plans and programmes of work that emerge and are implemented. Some of these will be in response to local issues and priorities, and others will be in response to national priorities and expectations. The HSCP will continue to work with our key stakeholders and people with lived experience to plan, design and deliver these priorities and will share details of future work, including opportunities to get involved, on our website (https://glasgowcity.hscp.scot/get-involved) and through publication of the reports that go to our; Integration Joint Board; Finance, Audit and Scrutiny Committee and Public Engagement Committee.

Vision and Priorities: Flourishing communities, healthier lives

What you said: *"What do you mean by stronger communities?"*

We see stronger communities as places where the people who live, work and contribute to activities in those communities can influence what happens in the area, through having all the resources, skills and opportunities they need to do so.

Strong communities are characterised by physical infrastructure like libraries, community centres and parks, but also social infrastructure in the form of locally led third sector (voluntary) organisations, local groups such as community councils and activities which bring people together.

By resources we don't just mean money, but also neighbourliness, volunteering, access to information, skills development, opportunities to engage, etc.

Influencing what happens in the area includes a range of things. It means people can have a community voice heard by public organisations (such as Councils) and their partners, but it also means people are able, encouraged and supported to take positive action themselves. It means that they have resilience to change and capacity to support people who would otherwise be left behind.

Vision

Our medium- to long-term vision is that:
The City's people can flourish, with access to health and social care support at the right time, in the right place and in the right way. This will be done by transforming health and social care services for better lives. We believe that stronger communities make healthier lives.

Over the next 10 years we will do this by:

- focussing on being responsive to Glasgow's population and focussing on reducing health inequalities
- understanding the importance of addressing the impact of poverty (including fuel and food poverty) on people's health
- supporting and protecting vulnerable people and promoting their independence and social wellbeing
- working in partnership with housing partners to reduce the impact of low quality or inadequate access to housing
- planning and developing services with our partners (co-production)

- working with others to improve physical, mental and social health and wellbeing, and treating people fairly
- contributing to eradicating discrimination of all kinds and enabling everyone to have equal access to and benefit from the services we provide
- with our partners to create stronger communities that are able to support people the way they want to be supported
- designing and delivering services with individuals, carers and communities using evidence from their lived experience and from what we know works
- showing transparency, equity and fairness in how resources are allocated to where health and social care needs are greatest
- making decisions based on evidence of what works and using innovative approaches, focussed on outcomes for individuals and accepting and managing risk, rather than avoiding it, where this is in the best interests of the individual
- developing a competent, confident, valued and supported workforce
- evaluating new and existing ways of doing things and delivering services to ensure they are delivering the vision and priorities and meeting the needs of communities
- designing services with equity of access in mind to ensure equal access to health and social care supports
- listening to the views of the people with experience of health and social care services and acting on what they tell us
- focussing on continuous improvement, within a culture of performance management, openness and transparency.

Changing the culture

We've set out examples above which highlight some of the ways we will seek to achieve the vision for the HSCP. These will be progressed within a broader approach to changing the way the HSCP works with the people of the city to identify and manage their health and social care needs. In the previous Strategic Plan we set out the intention to and the importance of the move to develop a relationship with citizens based on helping them to help themselves where they can. A move to listening to and working with individuals in considering and making decisions about their needs and the importance of family and community resources in meeting them.

We need to move to social care support that replaces crisis with prevention and wellbeing; burden with investment; competition with collaboration and; variation with fairness and equity. This requires a culture shift that values human rights, lived experience, co-production, mutuality and the common good.

This is now being developed as part of a major change programme with a current working title of Maximising Independence. The HSCP has been listening to the views of our partners and stakeholders to understand how best to describe this cultural shift and how to take it forward but the principles of the programme continue to be consistent with the strategic priorities of the HSCP. This includes a desire to support people, who can and want, to remain living at home safely for as long as possible with the right support in place for them, and for their carers if they have them.

What this doesn't mean is asking people to live without any support at all, or about expecting all support to be delivered by members of families or the wider community. It's about living as independent a life as you can, making choices about the things that matter to you, to live as full a life as possible, with support when you need it. And it's about ensuring we have strong and reliable health and social care not just now, but for future generations too. This involves talking, listening and collaborating to build a sustainable way of supporting people, so that everyone can achieve their full potential for health, wellbeing and independence. We need to see people as equal partners and experts in their own lives.

The population and needs analysis within this Plan highlights the need to do things differently, to understand the demographic challenges facing the city and to harness the opportunities of people living healthier lives for longer. Changing the way we deliver services and support people includes acknowledging that in some cases the way we do things attracts higher costs because we focus more on managing crises and late interventions. We need to focus more on prevention, early intervention and empowering people to live fulfilling lives. This cultural shift is the foundation of our strategic priorities and this Strategic Plan builds on the work introduced in the previous Plan, with references throughout to the activity being progressed to achieve it.

Strategic Priorities

The five key priorities for Glasgow City IJB / HSCP for health and social care in Glasgow are:

1. Prevention, early intervention, and harm reduction

We are committed to working with a wide range of partners across the City to improve the overall health and wellbeing and prevent ill-health of the people of Glasgow, including increasing healthy life expectancy and reducing health inequalities and the impact of deprivation through the delivery of services where they are needed most. We will continue to promote positive health and wellbeing, prevention, early intervention and harm reduction. This includes promoting physical activity for all-round wellbeing, acting to reduce exposure to adverse childhood experiences and improving the physical health of people who live with severe and enduring mental illness. We will seek to ensure that people get the right levels of advice and support to maintain their independence and reduce the instances of people having to engage with services at points of crisis in their life.

2. Providing greater self-determination and informed choice

We are committed to ensuring that service users and their carers are supported and empowered to actively participate in making informed decisions about how they will live their lives and what outcomes they want to achieve. We recognise that those who have already received services (those with 'lived experience') have unique and valued perspectives that will be harnessed in helping to shape services into the future.

3. Shifting the balance of care

Services have transformed over recent years to shift the balance of care away from institutional, hospital-led services towards services that are better able to support people in the community and promote recovery and greater independence wherever possible. Glasgow has made significant progress in this area in recent years, and we aim to continue to build on our successes in future years by investing in local people, neighbourhoods and communities to help us shift the balance of care. Over the next 10 years we will increasingly move towards health and social care services being delivered in local communities across Glasgow.

4. Enabling independent living for longer

Work will take place across our all care groups to support and empower people to continue to live healthy, meaningful and more personally satisfying lives as active members of their community for as long as possible. To do this will show ambition and be innovative to develop and try new ways of providing services that haven't been done before, even that is difficult and sometimes more risky than the easy option.

5. Public Protection

We will work to ensure that people, particularly the most vulnerable children, adults and older people, are kept safe from harm, and that risks to individuals or groups are identified and managed appropriately. We accept that not all risks can be avoided entirely. However, risk can be managed effectively through good professional practice. By promoting health and well-being we aim to strengthen, safeguard and protect vulnerable people.

Achieving our strategic priorities

In order to achieve the Strategic Priorities for the HSCP a range of activity is planned or underway. During the life of the Strategic Plan there will be further activity that emerges which the HSCP will deliver with its partners. All of the activity which is progressed will be relevant to one or more of the Strategic Priorities identified in this Plan and will contribute towards meeting the 9 national health and wellbeing outcomes. The activity necessary to be completed within Glasgow City is informed by a number of factors.

- One is **what you tell us is important to you**. Some of the comments you made during the development of the Plan have been included in the next section.

- Another is the information that is routinely collected through the HSCP's **performance management** arrangements (such as locally defined performance indicators) and the national integration indicators which help tell the HSCP where there are possible issues that need to be addressed in local operational performance and progress with integration. You can read more about our performance management framework on page 42.

- And another is the information on the **population profile of the city**. This is captured from a wide range of sources and collated in a demographics report. This is used to carry out a needs assessment to help the HSCP see where the evolving profile of the city is going to result in areas of demand for services.

Examples of each of these sources of information have been included below for each of the strategic priorities. The tables below just give some examples to illustrate what is considered. They are not a full and comprehensive list. You can find much more information in our Annual Performance Report and the Demographic Profile.

Prevention, early intervention and harm reduction

What you told us
People only receive help from support services if they are in crisis therefore the above is not achievable until this changes
Make services more accessible so early intervention and prevention is actually possible
I feel that prevention is key here and if this is acted on much quicker, this would enable services already involved in the person's life to adjust and support them ensuring all needs are being met, rather than having to wait for months until someone is assessed.
In relation to primary healthcare, the model has been disease- centred rather than prevention-centred and hence this focus (and funding) has to shift.
More focus on identifying Adverse Childhood Experiences (ACE's) and working with staff teams to develop awareness of the impact of ACE's on accessing services and on experience of services.
Prevention needs to be the ultimate aim. If we can prevent the situation reaching crisis point in an individual's life we can achieve so much more. This will also be more cost effective, as the level of initial service provision required may be far less than that which may be required farther down the line when the situation has progressed and developed.
More investment in self-management needs to happen if early intervention is an aim of the HSCP
People are not being signposted to the services they need quickly enough and as a result we are not intervening early, we're waiting until we get to crisis point
Referrals to appointments are taking too long and sometimes appointments are getting cancelled at very short notice. This has to change as it makes early intervention very difficult
We should have a yearly GP check-up, similar to a 6-month dentist check-up, as some people have not been to their doctors in years. This would support the idea of prevention, especially for certain health conditions such as diabetes

What we know?
Glasgow City's premature mortality rate has fluctuated from 634 per 100,000 in 2015 to 607 per 100,000 in 2009 and stood at 678 per 100,000 in 2020. In all years since 2015 the rate has been significantly higher than the rate for Scotland as a whole
Life expectancy for Glasgow woman (78.3 years) is longer than a Glasgow man (73.1 years) but less than the respective Scottish averages (76.8 years) and (81.0) years
The percentage of people seen within the 18-week target by specialist Child and Adolescent Mental Health Services (CAMHS) was 59.4% (target 100%)

Healthy Life Expectancy is 1.4 years higher for Glasgow females (57.4) than males (56.0) but is lower than the Scottish figures (61.8 and 60.9 years respectively)
Alcohol-related deaths are 53% higher in Glasgow (31.9 per 100,000 population) than Scotland (20.8).
The uptake of Mumps, Measles and Rubella (MMR) Vaccinations at 24 months and 5 years is 93.7 and 96.2 respectively (target 95%)
170,000 adults live with a limiting long-term illness or condition
3 in 5 people will be a carer at some point in their lives
The numbers of Glasgow S1-4 pupils who consume the recommended 5+ portions of fruit/veg per day range from 32.4% in North East to 41.6% in South and 49.5% in North West
Only the North West locality of the city is meeting the target (90%) for % of people starting Psychological Therapy treatment within 18 weeks of referral (92.4%)
94% of service users commenced alcohol or drug treatment within 3 weeks of referral (target 90%)
The rate of women smoking in pregnancy is 9.5% (target is under 12%)
Breastfeeding rates at 6-8 weeks (28.3%) are lower than the target (33%)

What we plan to do to change people's lives

Activity	Objectives	Timeframe
Progress work with Police Scotland to ensure better information gathering at the initial point of contact with members of the public	To identify and address the root causes of presentations to the Police, ensure appropriate and timely interventions, signposting and referrals to the correct agencies and prevention of repeat presentations to the wrong agency for support	TBC
Launch the HSCP's new Single Point of Access Service. This new service will provide enhanced first point of contact arrangements for Adults, Older People, Children & Families and Homeless social care services.	Provide more robust signposting, information provision and redirection by utilising 3rd sector/ commissioned or community supports. Promote prevention and early intervention approaches that promote independence, reablement and rehabilitation at first point of contact.	Year 1

	Improved focus on homelessness prevention and housing options Increase the number of households seeking assistance from the HSCP to sustain their accommodation.	
Complete the switch from analogue to digital care at home services	Migrating telecare service users through equipment replacement including digital connectivity to enable and improve access to emergency assistance 24 hours a day	Year 1
Expand mental health awareness training opportunities for all HSCP all staff groups	Increase awareness and understanding of staff of mental health. Increased basic mental health support skills to support tackling issues such social isolation (for adults and older people), trauma informed care, Adverse Childhood Experiences awareness, one good adult, mental health first aid, suicide prevention.	Year 1
Suicide prevention	Continue to support suicide prevention training and multi-agency co-ordination and input to Suicide Prevention Partnership. Provide support for people bereaved by suicide, those who support people at risk of suicide and staff and volunteers.	Year 1
Carry out a comprehensive review of the homelessness Flexible Outreach Service, which provides housing support to homeless households.	Improve access to housing support for households at risk of homelessness. Ensure those in greatest need access housing support services.	Year 1

	Improve access to housing support for households in private rented accommodation.	
Continue to deliver the 100 actions within The Promise Plan for Glasgow	• Improve the following areas of supporting children and young people: • Planning for services • Advocacy and rights • Educational outcomes for our young people • Accessibility for our children and young people to participate in meetings • The development Young People's Advisory groups.	Years 1-3
Work in partnership with Who Cares Scotland to develop an online Sexual Health practice guidance toolkit for staff and carers working with care experienced children and young people	Improve the knowledge and understanding of staff and carers to offer better care and support to people accessing sexual health services	TBC
Develop and implement the Flexible Homelessness Prevention Fund	Provide funding that can be used flexibly to support small scale grants to people at risk of homelessness in order to sustain their existing accommodation.	Year 1
Develop a trauma informed, strengths-based practice model for family support, which can be accessed through universal services at the point that it is recognised that families could benefit from additional support	Work alongside families, understanding the impact of trauma, and seeing families as experts in their own lives Seamless pathways to accessing support for families, via universal services (thereby allowing early intervention)	Years 1-3 (subject to successful funding bid)
Delivery of Earlier Intervention Family Support Services	Crisis prevention through family asset building and support/ intervention with all family members	Years 1-2

	Consideration of all family members' needs, removing rigid eligibility criteria and responding to need flexibly.	
A healthy childhood	Meet the UNICEF Platinum Standard for breastfeeding and early nutrition Act to maximise the take up of childhood vaccination programmes Develop new mental health and well-being services with and for children and young people through Glasgow's Children's Services Plan Build the prevention confidence and skills of those that work with children e.g. Well-being App for evidence, information, training and resources on well-being for teaching and learning support staff in the city Advance the Youth Health Service for young people (12-18yrs) in Glasgow	Year 1 Years 1-3 Years 1-3 Year 2 Year 3
Mitigate poverty and health inequalities	Contribute to the delivery of the annual Glasgow Local Child Poverty Action Plan Enable the delivery of financial advice and welfare rights advice across health and care services including	Years 1-3 Years 1-3

	As a Local Employability Partnership member we will develop and extend the pathways for patients/service users to employability support	Years 1 & 2
Reduce reliance on harmful substances	Protection programmes to reduce uptake, exposure and cessation services for tobacco smoking Provide objections to licensing applications which pose a public health risk, support early interventions for harmful risks and enable those working with young people and those at risk to take action to prevent escalation.	Years 1-3 Years 1-3
Support healthy living	Work with community planning partners to progressively implement the Glasgow Food Plan Learn and implement changes from the Thrive under Five (TU5) pilot programme addressing good nutrition and food insecurity in early years. With partners, progressively implement the 10 best practices for physical activity Improve access to weight interventions for young people and those at increased risk of type 2 diabetes	Years 1-3 Year 2 Year 3 Year 2

What success will look like

- People will be supported to access the right services at the right time to meet their needs

- We will have earlier and realistic, frank conversations with people about the kind of care they want and need, instead of waiting until a point of crisis in their lives, when it's difficult for everyone involved to think straight about the options available to them
- Health inequalities within the city will significantly reduce
- Fewer people will need to be admitted into residential or long-term care
- Children and young people will achieve positive physical and emotional health and wellbeing outcomes
- Families will receive support at an earlier stage of their support journey based on a trauma-informed and strengths-based model of support to prevent crises
- Where people are diagnosed with a life changing health diagnosis, carers will be identified early in their caring role and provided with the support and information they need to help maintain and improve their health and wellbeing so that they can continue to care, if they so wish, and have a life alongside caring
- People will have access to good quality and appropriate housing that matches their needs and is responsive to the needs of the changing demographic profile of the city
- People at risk of homelessness will be supported into suitable accommodation with the appropriate supports to sustain the accommodation provision
- Community Planning partners across the city will be working better together in partnership to correctly identify health and social care needs at the earliest opportunity and to signpost vulnerable citizens to the correct supports at the correct time
- People that require support from the HSCP have a clear, simple to understand and efficient means of accessing advice and support to ensure they receive the support they need in a timely manner
- Staff working across the HSCP will be suitably trained to identify the signs and root causes of mental ill-health and equipped to offer supports to reduce its impact.

Providing greater self-determination and choice

What you told us
I think when dealing with changes to services good quality information is essential. This is to reduce anxiety and also to ensure that services are used appropriately.
As a person with multiple health issues, I must look after my own health. I have received some support to enable me to stay well and look after myself but would like to have more.
There is not enough help for people that need care as there is not anywhere to go 24 hours a day.
Ensure more staff and good signposting services so people know where to get help.
Clear pathways and information for people who need extra support would be helpful. Recently I have been trying to access day care for my Mum and this has been more difficult than it should have been because of confusion within the HSCP over which service my Mum requires. Her needs have changed over time and the system appears not to have much in place to support us at these points of need.
We need to look at the services that we are providing for people with most complex needs. As a result of their experiences growing up and significant trauma they are often mistrusting of services and struggle to engage in the 'traditional' way. We need to change our services to help them to build trust and get the support, care, and treatment they require.
There is a lack of choice in relation to housing options (for example lack of; options for larger families; adapted housing; specialist housing for those with particular health needs; housing designed for older people and; housing with private outdoor space.

What we know?
At March 2022, a total of 3,244 adult service users were in receipt of a personalised social care service - an increase of just under 6% since March 2021 (3,063)
The number of children in receipt of personalised services has risen from 117 in 2016 to 382 in 2022
The proportion of service users receiving a Direct Payment has risen from 14% in 2016 to 19% in 2022
57.2% of Glasgow adults aged 18+ who have high levels of care needs, are cared for at home or have a direct payment for personal care. This is lower than the Scotland rate of 62.9%
The percentage of adults supported at home who agreed that they had a say in how their help, care or support was provided (75.5%) compares with the national figure (75.4%)
87% of people receiving home care support think it allows them to get up and go to bed at times that suit them
93% feel that they are listened to and their wishes are respected

98% feel the home carers treat them with dignity and respect
86% feel home care staff/managers always respond to concerns they have
99% of unpaid carers feel valued and respected by their worker

What we plan to do to change people's lives

Activity	Objectives	Timeframe
Carry out a review of Self-Directed Support policies, processes and procedures for Adult and Older People & Primary Care social work services	Identify development opportunities to promote the use and effectiveness of SDS in enabling service users to meet their personal outcomes	Year 1
Carer Services will develop their approach to improving the carers experience of hospital admission, stay and discharge for the person they are or will be caring for	The intention is to fully involve unpaid carers at all stages of the journey through hospital of the person they are or are going to be caring for as equal and expert partners	TBC
Evaluate and consider extending the pilot of Recovery Peer Support Workers	Recovery Peer Support Workers who are people with lived experience of mental health issues will use their own experiences to offer social, emotional and practical support, helping those about to come out of hospital to prepare for being back in the community and those already in the community to continue their recovery	Year 1
Expansion of Cognitive Behavioural Therapy (CBT) and computerised Cognitive Behavioural Therapy (cCBT)	• Provide assistance to people in making sense of overwhelming problems by breaking them down into smaller parts and stopping negative thought cycles • Support people to feel better and stay better • Offer alternative models of accessing CBT for those who do not require support on a face to face basis with a clinician or who are unable to	TBC

	travel, leave their homes or get away from work to attend daytime appointments	
Patient Initiated Follow Up	Patient Initiated Follow Up will give patients and their carers the opportunity to initiate their own appointments as and when they need them. This might be when they have a flare up of their symptoms or there is a change in their circumstances. This helps avoid unnecessary routine appointments and makes it easier to book appointments when they are really needed. People who might benefit from PIFU in particular are those: · who no longer require the same level of support from their Community Mental Health Team but who have been with the team for a long time · who are at a positive point in their recovery, but might be at risk of relapse · who have conditions where it is likely that relapse might occur but has long periods of stability	TBC
Bipolar Hub	Provision of a single source of up-to-date information, advice and support will be made available for carers and people with Bipolar Disorder, offering: · Self-management training (run by Bipolar Scotland)	TBC

	· Peer support groups (run by Bipolar Scotland) · Group therapy for patients and carers · Physical health checks and lifestyle advice which will include diet, stopping smoking, family planning and pregnancy · Access to a pharmacist for support with medicines · Advice and information about additional resources such as housing, benefits, carers support and employment support	
Launch the 'Awkward Moments' campaign, developed on behalf of a national partnership, with film clips and toolkit on what positive enthusiastic sexual consent looks like for young people	Improve the understanding of positive sexual consent	TBC
Redesign temporary accommodation	• Improve the range and quality of temporary accommodation to enhance people's experience of homelessness and enhance choice • Meet statutory and regulatory requirements in relation to the provision of temporary accommodation • Improve placement management	Year 1
Improve access to information and advice across a range of media platforms to prevent homelessness	Ensure access to high quality information & advice that will assist people to avoid homelessness and access support when it occurs	Year 1
Develop a Children and Young People's Networking Team to help children, young people and families to	The aim of this work is to move away from passive signposting in order to more proactively engage families in the range of supports available	Year 1

navigate the system of supports and to promote engagement		

What success will look like

- We will have open and effective channels of communication with service users, carers, stakeholders and the public to understand and have honest conversations about what they want future services to deliver
- The information that people need to understand their support options and make choices about which supports to engage with will be provided in formats which are accessible and provide clear pathways to support services where needed
- We will achieve a shift away from people 'being assessed 'by a health and care professional to having an active and equal role in discussions and decisions about their care based on what matters to them
- Carers will be involved in the hospital discharge process of the person they are or are going to be caring for
- We will offer a range of housing options for people to choose from to meet the needs of citizens who experience multiple and complex needs
- We will achieve the cultural shift to in how we work together, as partners in care rather than as people who **give** care and people who **receive** care
- People will be enabled and empowered to exercise greater choice of how and when they require to engage with services, based on their expertise in understanding their own support needs
- People will feel like they have more say in the decisions that affect them, so they can live independently, healthily and safely for as long as possible
- People who need extra support will be provided with clear and accessible information on how to access the services and support they need at the appropriate time in their care journey

Shifting the balance of care

What you told us
We need more central locations to provide care in community. Some elderly patients have to travel quite far to receive care at community hubs
If services are to be delivered in the community then they should be community led and not hospital/medically led. More engagement with Scottish Government to ensure services that area already in community stay within community HSCPs
Community link workers should be increased and valued. These members of staff are in deep and able to relay information of lived experience from their patient contacts.
Increase required in community services as not enough staff to deliver care, particularly in district nursing and mental health services
Due to the pressure on hospital beds there is pressure to refer and discharge people at earlier and earlier stages. This results in the provision/creation of greater numbers of commissioned beds in care homes. This actively works against shifting the balance of care. This requires a level of self-examination and willingness to address areas where performance is poor
We need to ensure that we have the resources in the community to do this. Completely agree hospital is not the best place, however, struggle to support in the community with current services available
Carers don't always have the time or capacity to find and accept help due to their caring role. Having someone identified and a support worker reaching out to the carer would make a massive difference
The plan to provide more care in people's homes raises lots of questions around staffing levels of carers, the amount of time a carer gets to spend with each service user, travel to and from different homes, etc.
Too many people stuck in their homes in solitude and lonely. There should be more sheltered and supported accommodation to support this choice
Funding should be increased to enable people to be maintained at home. Equipment for example enhanced telecare, adaptations need to be done timeously
A shift towards collective responsibility at all levels of society and the government supporting agenda. Increase use of volunteers across the board with view to building connections to tighten the support around people living in the community
Priority is to keep people living at home for as long as they want to. Ideal is to have a blend of support from family and support from services/HSCP as needed
Community involvement and linking people in with their local community has been really helpful in supporting recovery/addiction issues. During the pandemic, whilst people were working from home and had more time there was more availability of volunteers, but as we 'return to normal', there is a reduction in capacity. How do we generate those community links naturally? Getting people into their communities more has huge benefits

What we know?
The Housing First Service secured over 51 households with settled tenancies in 2021, meaning it has achieved 250 settled tenancies for people with complex case histories over the duration of the service
The number of people requiring hotel and bed and breakfast type accommodation has risen over the course of 2021/22, from 286 (Q1) to 414 (Q4)
The rate of emergency admissions per 100,000 adults has reduced from 14,816 in 2015/16 to 11,066 in 2020/21
The rate of emergency bed days per 100,000 adults has reduced from 144,254 in 2015/16 to 115,812 in 2020/21
Readmissions to hospital within 28 days of discharge per 1,000 admissions was higher in 2020/21 (116) than in 2015/16 (98)
89.4% of people in 2020/21 spent the last 6 months of life at home or in a community setting, compared with 86 in 2015/16
57.2% of adults with intensive care needs received care at home in 2020, lower than the Scotland rate (62.9%)
42.8% of Glasgow's older people aged 65+ who have high levels of care needs, live at home. This is higher than the 35.0% for Scotland overall
In 2020/21 the number of days people aged 75+ per 100,000 of the population spent in hospital when they were ready to be discharged was 644, increased from 627 in 2015/16
The number of children looked after and accommodated away from home has reduced from 1352 in 2016 to 733 in 2022. The number looked at home has reduced from 545 to 365 in the same period
The number of children in placements outwith their local authority of residence has reduced from 126 to 31 between 2016 and 2022

What we plan to do to change people's lives

Activity	Objectives	Timeframe
Borderline Personality Disorder Network	Roll out training across mental health teams to increase awareness amongst staff and provide them with knowledge and tools to better help people with this disorder. Utilise dedicated teams that will ensure that people can be offered at least one form of evidence-based therapy within their own	TBC

	community to avoid unnecessary hospital admissions and help people leave hospital more quickly than before	
Carry out engagement with key stakeholders to understand and inform the impact of shifting the balance of care to community services	Seek people's views on the principles that should be considered for any shift of resource from inpatient care to community based work.	Year 1
Develop and tender for an enhanced community living service for adults with a learning disability	Provide an intermediate bridge in service provision between those people assessed as suitable for discharge from NHS hospital care, but for whom existing community accommodation is at present unlikely to be a suitable or sustainable option. In particular, the enhanced community living service will aim to: • Support individuals in positive ways • Help people to find good and safe ways to manage their challenging behaviours • Help people to develop independent living skills and self-management skills • Over time, support people to move on to less intensive services, such as supported living, wherever possible and in line with assessed need.	Year 1

Continue to deliver the Rapid Rehousing Transition Plan	• Support people to sustain their accommodation • Reduce the time households spend in temporary accommodation by speeding up the time it takes to secure settled accommodation	Years 1-3
Review provision of emergency accommodation for homeless households leaving hospital	• Ensure access to accommodation that meet people's needs • Minimise delayed discharge for homeless households	Year 1
Initiate a Test of Change to administer small grants to community/ neighbourhood services and organisations supporting children, young people and families to address their mental health and wellbeing needs	• Supporting local community organisations to provide easy access and a range of support options to meet a range of wellbeing needs • Achieve an increase in family support and mental health and wellbeing supports accessed through universal services	Year 1
Create a single system of support for families, aligning poverty, mental health and family support pathways to ensure seamless access at a neighbourhood level	• Ensure that families' immediate distress is addressed in order to help to build families' readiness for meaningful change work • Engagement in approaches which will be able to address longer term outcomes in relation to building resilience and employability	Year 1
Develop and deliver an accessible, patient-centred, equitable, centralised abortion care service across Greater Glasgow and Clyde.	The majority of care will be delivered to women in the community, supporting them to self-manage their abortions at home. This will include: • Full transition to EMAH (Early Medical Abortion at Home) service for all women who opt for this (and who are eligible)	Years 1 & 2

	• A community based Manual Vacuum Aspiration (MVA) service allowing women to access a safe method of surgical abortion • Rationalising provision of in-patient abortion care • Ensuring that all women requiring abortion up to 20 weeks gestation are able to access this	

What success will look like

- Families and communities will have a major and active role in supporting people to live independently
- We will achieve a move away from thinking about statutory services as the default first response to meeting a person's needs, to looking much more widely and using all the assets within their community
- People with complex needs will be able to live in their own homes and communities for as long as possible
- We will have explored and embraced the opportunities presented by new technology available to us
- We will be working well with partners to provide access to a range of housing options that cater for a variety of needs and will have reduced the reliance on temporary accommodation options
- Support services will be provided at a community/neighbourhood level wherever possible
- Our health and social care 'contract' with the public will change to ensure a sustainable health and care system that meets the needs of Glasgow's diverse communities now and in the future.

Enabling independent living for longer

What you told us
The HSCP needs to be more robust in ensuring that families understand what enabling independence means
There needs to be more emphasis on the psychological aspects of health behaviour change or maximising wellbeing, and the psychological factors that impact on their independence (e.g. anxiety or fear of falling leading to reduced activity and over-reliance on carers)
Look at more independent living for people with learning disabilities. Have their own homes, but with some support from carers and assistive technology
Need to increase equipment and adaptations budgets
You seem to equate independent living with old age and give no consideration to the appalling lack of accessible housing for disabled people
There needs to be increased funding for tenancy support services for vulnerable households and better engagement around technological interventions, particular for older people's housing
Aids/adaptations remains a priority along with new build accessible housing, but technology enabled care is also important
Technology can have a positive impact on helping individuals be more independent. Being connected to the Internet and learning some digital skills could enable someone to shop online which is often cheaper and easier or access learning courses online. New technologies can really open your eyes to a multitude of opportunities

What we know?
81.5% of adults supported at home agree that they are supported to live as independently as possible compared with 80.8% for Scotland
74.8% of adults supported at home agree that their health and social care services seemed to be well co-ordinated (73.5% for Scotland)
79.2% of adults supported at home agree that their services/support are improving/maintaining their quality of life (80.0% for Scotland)
89.7% of adults are able to look after their health very well or quite well (92.9% for Scotland)
81.6% of adults supported at home agreed they feel safe (82.8%)
96% of people that receive a home care service feel safe at home
96% feel the contact they have with home carers improves their quality of life

94% feel the service enables them to maintain the standard of personal care that they want
Unpaid carers reported that the carers service has; improved their ability to support the person they care for (97%); improved the quality of life of the person they look after (86%) and; improved their quality of life (87%)

What we plan to do to change people's lives

Activity	Objectives	Timeframe
Implement the priorities and activities outlined within the housing contribution statement, digital housing strategy and Glasgow's Housing Strategy to meet the housing, health and social care needs of people in the city	Provision of housing and support for people with complex health needs; tenancy sustainment; securing long term funding of Care and Repair Service; support people seeking asylum/refuge living in Glasgow; deliver the required supply and type of housing stock	Years 1-3
Widening the scope of day opportunities for people with a learning disability and improving the model and standard of services	• Transition towards a model for LD day services that has a greater focus on community and alternative supports for individuals who are assessed as not requiring a building-based service • Service users' assessed needs for day support are met, whether that be in a building-based service, community supports or a blended combination of both • Improve the environment for service users within building-based day services, as well as better access to other supports, such as on-site healthcare clinics	Years 1-3
Build on the work undertaken to date to explore further, the opportunities that technology enabled supports (TECS) can bring to support independent living	Ensure service users and practitioners can make informed choices around the use of TECS to better support independent living, where appropriate and compatible with assessed need.	Years 1-3

	This will include: • Integration of the consideration of TECS as a core element of the assessment process • Training for staff in the uses and availability of TECS solutions • Expanding and evolving the availability of TECS solutions across the City. This will include the potential for greater use by young people in transition to adult services, as well as mainstreaming the consideration of TECS within service redesigns and future commissioning • Clear and timely information for service users, carers and families to help make informed choices on TECS.	
Work with partners to ensure commissioned accommodation and housing is future-proofed for TECS availability and accessibility.	Ensure the housing stock of the future is ready to embrace innovation and provide modern solutions to meet people's housing and social care needs	Years 1-3

What success will look like

- People who need support in the City will be helped and supported to make choices that enable them to enjoy the best quality of life possible
- Preventative and effective early intervention services and supports will be available to support people to live independently in their communities
- We will be able to offer a range of housing stock options that enable citizens to live as independently as possible with support where required
- Investment in the development of stronger communities will provide the appropriate levels of support to individuals to enable them to live in their communities for longer and drive decisions about how they manage risk
- The HSCP will have harnessed the opportunities available through the use of technology and innovation to support independent living in communities where this is appropriate and enables risk management

- Housing options provided by our partners that are available to individuals can support technology-enabled care solutions to facilitate independent living in the community.

Public Protection

What you told us
Some housing in Glasgow is substandard. When we provide substandard housing to families we are essentially devaluing their self-worth and enabling poor health and outcomes
Call out landlords, including social landlords, who provide poor quality accommodation and devise a minimum standard that is not just about the basics. Housing that is damaging to health must finally be outlawed.

What we know?
The rate of adults assessed as homeless or threatened with homelessness is more than 50% higher for Glasgow (9.8 per 1,000 population) than Scotland (6.1).
There were 2,668 households in temporary accommodation in Glasgow in 2020/21. This is 20.1% of the national total of households in temporary accommodation, compared to Glasgow's 11.8% share of all Scotland's households
The number of children on the child protection register has reduced from 314 to 303 between 2018 and 2022
The rate of new registrations has fallen from 415 to 366 in the same timeframe
During 2020/21, there were 4346 Adult Support and Protection referrals and 281 formal investigations completed
Number of households reassessed as homeless/ potentially homeless within 12 months was 526 in 2021/21 (target is under 480)
Percentage of Community Payback Order (CPO) unpaid work placements commenced within 7 days of sentence has increased from 64% in 2015/16 to 87% in 2021/22
Percentage of live homeless applications over 6 months duration at the end of the quarter was 48% across the city in Q4 of 2021/22 (target is less than 40%)
The average number of weeks from assessment decision to settled accommodation was 45 weeks at the end of 2021/22 (target 26 weeks or less)
Number of households reassessed as homeless or potentially homeless within 12 months stood at 526 at the end of 2021/22 compared with a target of 437

What do we plan to do to change people's lives

Activity	Objectives	Timeframe
Explore requirements for the provision of housing for people on release from custodial sentences	Ensure adequate housing provision for people being released from custodial sentences to support reintegration into society and the prevention of re-offending	TBC
Implement the housing contribution statement, digital housing strategy and Glasgow's Housing Strategy to meet the housing, health and social care needs of people in the city	Provision of housing and support for people with complex health needs; tenancy sustainment; securing long term funding of Care and Repair Service; support people seeking asylum/refuge living in Glasgow; deliver the required supply and type of housing stock	TBC
Expand the Housing First service to undertake a Mental Health Test of Change	Working to secure tenancies with the Mental Health Unit at Stobhill Hospital, an approach which will now be rolled out to the Leverndale unit	TBC

What success will look like

- People with health and social care needs will experience better housing-related supports and outcomes as a result of strong partnership working with the housing sector
- People re-entering the community having served custodial sentences will be able to access appropriate housing to support their re-integration into society

Monitoring performance and measuring progress with integration

Glasgow City Integration Joint Board (IJB) and Health and Social Care Partnership (HSCP) have integrated performance management arrangements to monitor, report and scrutinise the performance of health and social care services.

A comprehensive Performance Framework is in place and routine performance management arrangements established within the HSCP, which facilitate scrutiny of performance in relation to delivery of our Strategic Plan and against a range of local and national Key Performance Indicators (KPIs). Within this Strategic Plan, we seek to highlight a selection of key indicators of progress in relation to each of our Strategic Priorities from this Performance Framework. Full details can, however, be found within the Quarterly and Annual Performance Reports, along with the Demographics Profile which can all be accessed on the HSCP.

A detailed Quarterly Performance Report is produced which includes a wide variety of Health and Social Work KPIs and provides information on how services are responding to areas of under-performance. All KPIs have been aligned to the HSCP's Strategic Priorities as set out in our Strategic Plan and to the National Health and Wellbeing Outcomes specified by the Scottish Government. This Performance report is shared with and scrutinised by HSCP senior management groups and teams and is presented to the Integration Joint Board's Finance, Audit and Scrutiny Committee. At each of their meetings, specific service areas are focused upon and relevant strategic leads are invited to discuss performance and demonstrate how they are impacting upon the HSCP's Strategic Priorities.

In addition to this Quarterly Report, we publish an Annual Performance Report (APR) in line with the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014. Within this, we highlight progress in delivering our Strategic Plan commitments and consider performance over a longer period of time including in relation to the Core Suite of National Integration Indicators which have been published by the Scottish Government to measure progress in relation to the National Health and Wellbeing Outcomes. These are derived from national information systems as well as the biennial Scottish Health and Care Experience Survey. This APR also contains information from local surveys conducted by individual services such as Homecare and Carers, as well as user/carer feedback and case studies, in order to demonstrate progress in taking forward our Local Priorities.

The IJB and HSCP Management Teams also regularly receive updates on delivery of our Strategic Plan commitments through individual service reports, as well as financial updates on budgetary performance and the delivery of agreed savings programmes. They will also review and respond to any reports produced by NHS/Council Internal Audit teams, Audit Scotland, Healthcare Improvement Scotland, the Care Inspectorate and the Ministerial Strategic Group for Health and Care.

In addition to the above performance management arrangements, a Demographics Profile for Glasgow City has been developed to support needs analysis, service planning and service delivery within the HSCP and is updated annually. It includes general population estimates by age, gender and ethnicity at HSCP locality, city and national level, as well as population projections by age-band at city and national level. It also includes a profile of health in the city with information on life expectancy and mortality, patterns of illness and disease, as well as information on factors that can impact upon health and wellbeing, including lifestyle and behaviours, social capital, poverty and deprivation, education, employment and crime.

Our understanding of how health is changing for particular groups in Glasgow and how we plan to meet changing needs is informed by a range of population health surveys and needs assessments, including:

- The School Health and Well-being survey (12-18year olds) and the introduction of the national school census undertaken through education in Glasgow City Council in 2022/23
- NHS Greater Glasgow and Clyde Health and Wellbeing Surveys, with bolstered sampling within localities and some neighbourhoods in Glasgow, for more localised reporting
- The Health Needs Assessment of people who are lesbian, gay, bisexual, transgender or Non-binary (LGBT+) in Scotland undertaken with Lothian Health Board (2022)
- Health Needs Assessment of prisoners within the Greater Glasgow and Clyde prison estate (2022)
- The Scottish Health Survey
- The Scottish Crime and Justice Survey
- The Scottish Household Survey
- The publications of the Glasgow Centre for Population Health.

Finance and resources

What you said: ***"The vision definitely still applies, and everyone is doing a great job in trying to make this happen, however I think there are challenges including financial constraints which limit the implementation of the vision"***

Budget Position

Glasgow City HSCP delivers a range of services to its citizens and in 2022-23 has funding of £1.4bn to spend on services. This is funded through budgets delegated from both Glasgow City Council and NHS Greater Glasgow and Clyde. As in previous years, savings will be required to be identified to enable the HSCP to meet demand and cost pressures whilst remaining within the funding that is made available from the Council and Health Board.

The HSCP is committed to delivering services within the financial resources that are available and strives to do this while transforming the services which it delivers. A number of core programmes have been put in place to support this.

Financial Framework

The Medium-Term Financial Outlook is an essential piece of the strategic planning process which underpins the delivery of the ambitions and priorities as outlined in IJB's Strategic Plan. A robust medium term financial outlook will support strategic planning, balancing the financial impact of IJB policies and objectives whilst ensuring stability and continuity of service delivery.

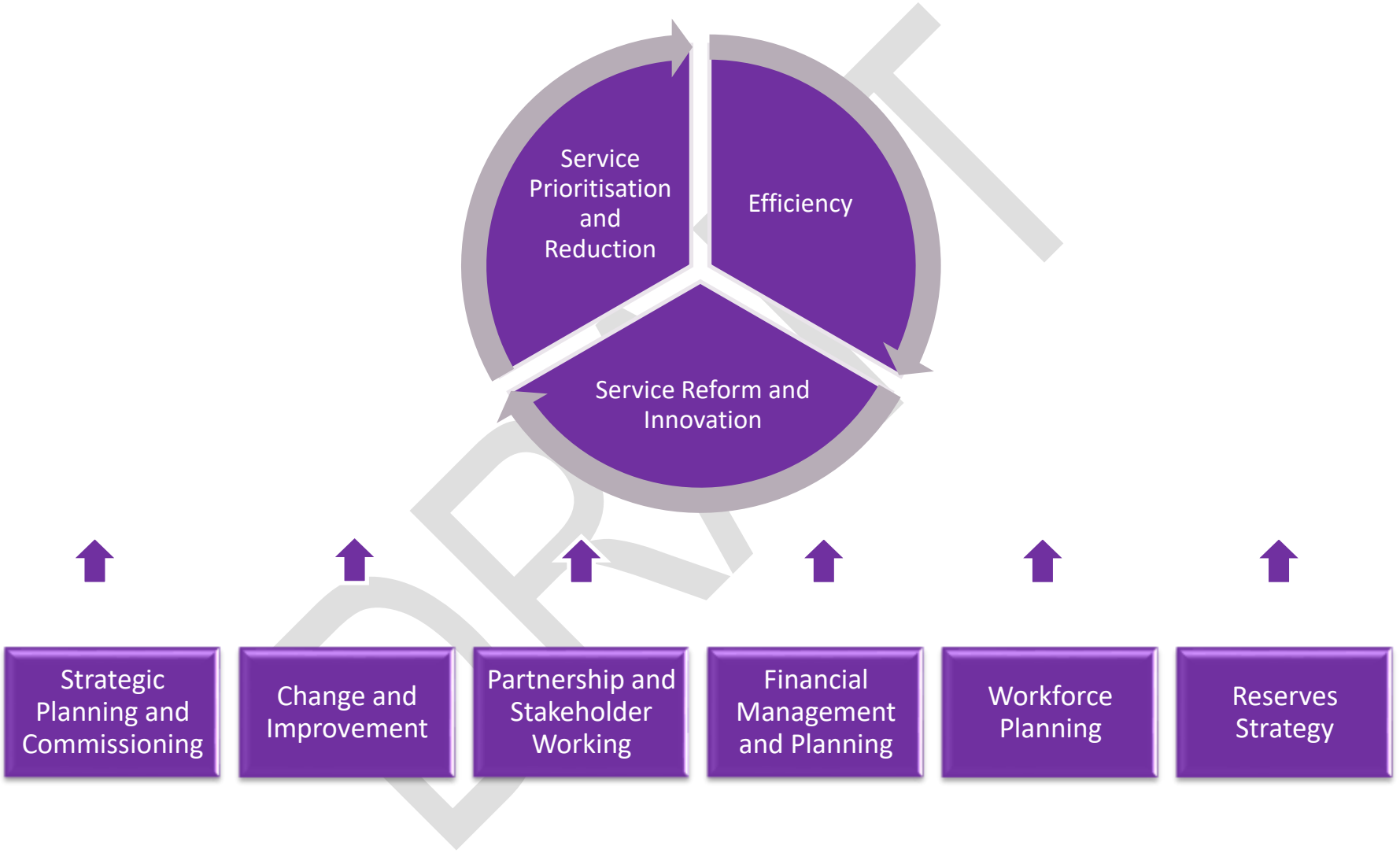
The IJB is operating in an increasingly challenging environment with funding not keeping pace with increasing demand for services and increasing costs linked to delivery. Our response to the pandemic has also brought with it a number of challenges as well as opportunities to deliver services in a different way. The financial impact of implementing the required changes to services and service delivery models (e.g. to support social distancing requirements, support staff with the appropriate protective equipment and manage the new and changing levels of need and demand) is significant and likely to be ongoing and evolving. The IJB continues to respond to the pandemic and there is no doubt that the full impact of the pandemic will not be fully known for years to come. However, we can already see the impact it is having on people's health, wellbeing and the economic impact including income, employment and housing. COVID-19 has exacerbated the existing inequalities and challenges we face within the City and we are seeing this translate into an unprecedented increase in demand for our services.

Glasgow City IJB is clear about the challenges which are ahead and its aspirations for its services. The IJB continues to have a clear transformation agenda which will focus on delivery of a sustainable health and social care service for the City. This will have a focus on prevention and early intervention approaches and will encourage individuals and communities to support each other. This recognises that the best health and care outcomes are associated with the highest possible levels of self-management and independence.

This creates a challenging environment in which to operate, managing demand within the financial constraints, whilst planning for recovery and transformation of services as we continue to navigate our way through the pandemic. A clear financial strategy is required to ensure the IJB remains financially sustainable over the medium term. The IJB will continue to be ambitious about the delivery of this plan and will use the Medium-Term Financial Outlook to support the IJB as it continues to respond to the pandemic whilst transforming services.

The Medium-Term Financial Outlook estimates a financial gap of £**60m** over the medium term which will require to be met from savings. It highlights a number of financial pressures which contribute to this financial gap and more detail on these can be found within the Medium-Term Financial Outlook.

Our Medium-Term Financial Strategy has 3 core components which collectively support the transformational change required to deliver financial balance whilst delivering safe and sustainable services. This strategy is set out in the diagram below and cannot be delivered without working closely with all our partners and stakeholders to secure a future which sustainable and meets the needs of our communities. This is underpinned by strategic planning and commissioning, robust financial management, a prudent reserves policy and workforce planning to ensure our resources are used in the most effective way to deliver services and deliver the vision for the IJB.


Service Prioritisation and Reduction
Efficiency
Service Reform and Innovation
Strategic Planning and Commissioning
Change and Improvement
Partnership and Stakeholder Working
Financial Management and Planning
Workforce Planning
Reserves Strategy

Transforming Our Services

The HSCP has put in place a transformational change programme, outlined earlier in this Strategic Plan, which spans the entirety of the HSCP's business and seeks to deliver transformational change that will deliver innovative services for the people of Glasgow and realise financial savings to support a balanced budget.

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 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.

Investment Priorities and Plans

Implementing the transformation programme requires the HSCP to look at what services are delivered, how they are delivered and where they are delivered from. Fundamental to these programmes is the partnership investment programme and how it supports this transformation.

The HSCP has set out its investment priorities in its Property Strategy 2019-2022 **(NB: Property Strategy is currently subject to review and consultation in 2022)**. The main objectives of the strategy are:

- to gain best value from our use of property
- to ensure that health and social care services are provided in and from fit-for-purpose, modern buildings
- to enhance provision of health and social care services in local communities
- to maximise opportunities to work with other services, agencies and communities to establish optimum service needs and delivery models
- to rationalise our estate in order to reinvest savings into frontline services.

The Property Strategy has already delivered significant investment to support transformation, including the opening of the new Gorbals Health and Care Centre, the Woodside Health and Care Centre, completion of the investment in Older People Residential and Day Care Centres and continued investment in Children's residential accommodation.

Work has commenced on a new £72m North East Health and Care Hub to replace Parkhead Health Centre and will also include a Library facility on behalf of Glasgow Life. Funding of £20m has been provided for the refurbishment of the Church Street Social Work property to provide a key centre for the provision of services in the North West of the City, and there is programme of Health Centre upgrades and refurbishments underway across the City to ensure we are maximising the use of the space to ensure the delivery of the primary care improvement programme. All these projects will accommodate a range of health and social care services, delivering integrated services for these local communities.

The HSCP is also working jointly with partners to rationalise property bases and a number of opportunities are being explored to provide integrated services at a number of locations across the City.

Staffing and Workforce Plan

Staff within Glasgow City HSCP– our people – are integral to our success and particularly the success of our transformational journey.

As at April 2022, Glasgow City HSCP has a workforce of 10,956 Whole Time Equivalent (WTE) staff, made up of 6,220 WTE employed by Glasgow City Council and 4,736 WTE employed by NHS Greater Glasgow and Clyde. The significant majority of staff work directly with patients, service users, carers and their families to support them. The breakdown of staff across care groups and between Council and Health Board is outlined within the following table.

Breakdown by Care Groups							
Staff Group	**Head Count**			**WTE**		**Totals**	
	Council	**NHS**		**Council**	**NHS**	**Head**	**WTE**
Adult	469	2690		440	2456	3,159	2,896
Care Services	3972	n/a		3070	n/a	3,972	3070
Older People	315	1132		297	967	1,447	1,267
Primary Care	n/a	286		n/a	240	286	240
Children	1073	1077		999	928	2,150	1,927
Public Protection and Complex Care	655	n/a		602	n/a	655	602
Resources / Other	998	182		812	145	1,180	957
Totals	**7482**	**5367**		**6220**	**4736**	**12,849**	**10,956**

To support Glasgow City HSCP's workforce through service redesign, integration and transformational change programmes, our organisational development approach is fundamental to building a culture of shared objectives and close partnership working. An Organisational Development Plan (as part of the Workforce Plan) for Glasgow City HSCP is in place, focussing on four strands:

- culture
- service improvement and change
- establishing integrated teams and
- leadership development.

Glasgow City HSCP is required to develop and publish a workforce plan setting out the strategic direction for workforce development, service redesign and any resulting changes to our workforce.

Our Workforce Plan 2022-25 is designed to achieve the five key priorities for Glasgow City IJB / HSCP for health and social care. Success in achieving these aims is underpinned by the commitment to support and nurture our workforce, looking after mental and physical wellbeing as well as offering roles and development opportunities that staff find rewarding and fulfilling. The Workforce Plan sits alongside the Strategic Plan and acts to support the fundamental objective of the HSCP to develop a relationship with citizens based on helping them to help themselves where appropriate, be informed by the views and the preferences of individuals, and the importance of family and community resources in meeting the health and social care needs of the city.

The key service level priorities are:

- Remobilisation and recovery including addressing backlogs
- Finding solutions to challenging recruitment situations, eg Prison Health Care, Nursing including District Nursing and Health Visitors, Care Homes and Care at Home, Mental Health Officers (MHO), Medical Consultants
- Redesign of services, in particular Urgent Care, Homeless, and Addiction and Recovery Services
- Delivery of local policies and strategies such as Maximising Independence, Hospital at Home, Primary Care Improvement Plans (PCIPs), Single Point of Access, Vaccination Programmes, Carers Strategy
- Mental Health Services – development of community-based services, inpatient services and Child and Adolescent Mental Health.
- Development of staff to meet changing needs of service users, particularly in Care Homes and Care at Home Services.

- Recognition and understanding of the crucial interdependencies within the health and social care system, ensuring that our approach strengthens these vital connections (e.g. Urgent Care, Hospital Discharge)
- Prepare for the introduction of the National Care Service.

The Workforce Plan also takes account of the Scottish Governments requirements in the National Workforce Strategy for Health and Social Care in Scotland and as such the plan includes our ambitions around Recovery from Covid, Growth and Transformation of Services and the Workforce. The Plan includes actions required around the 5 Pillars of the workforce journey Plan, Attract, Train, Employ and Nurture.

The Workforce Plan is a three year plan to 2025 and describes the short-term workforce drivers focused on recovery and remobilisation during the next 12 months, and the medium-term workforce drivers focused on sustaining growth and supporting longer term transformation in the 12-36 month timeframe. The plan details the establishment gaps, the workforce challenges, comparing the future staff demand with our current workforce numbers and skills. It will also profile the numbers of staff and new roles require to achieve all of this.

Partnership working and involving others

What you said: ***"The longer-term goal is achievable with full participation from everyone involved"***

"Services should be working more collaboratively and innovatively with the HSCP to consider new ways of joint working to do tests of change, for example around providing incontinence care"

Glasgow City Health and Social Care Partnership does not and should not operate in isolation. Planning and delivering quality health and social care requires a range of different people, organisations, professionals and groups (our partners) to share the responsibility to ensure people receive the types of support they need, where they need it and at the appropriate point in time. Central to this will be working with the people who know the services best. People who have used services have a unique perspective on how they need to change to meet the needs of others throughout the City. These people are often referred to as people with "lived experience". People with lived experience are one of a range of different partners that have a role in shaping service delivery in the city.

The key partners we will work with to plan and deliver health and social care services include the following:

- People with lived experience (including patients, service users and carers)
- Local communities (individual citizens and community organisations and groups)
- Other services and teams within the Council (e.g. Housing, Education)
- Voluntary (or third) sector service providers
- Independent sector service providers
- Providers of housing services
- Community Planning partners
- Other Health and Social Care Partnerships within Greater Glasgow and Clyde.

Involvement

The IJB and HSCP make better decisions when people affected by those decisions are involved, meaningfully and at the appropriate point in time. Whether by being consulted on what a new service should look like or what changes should be made to existing services, involving others in ways which genuinely influence what happens next is vital. There are a number of ways the HSCP encourages and describes its approach to involving others in the process of influencing services and service delivery. All are designed to give a voice to those with a contribution to make in ways that make contributing as accessible as possible. The diagram below shows examples of the how involvement is supported by the IJB/HSCP.

Principles of meaningful involvement

Meaningful involvement doesn't just happen because you have certain groups set up or certain policies or strategies in place. Successful implementation of these policies and strategies, and the effectiveness of groups and forums, relies on a genuine and fundamental commitment to working together to develop new ways of doing things as partners.

In order to make the best use of the involvement structures and opportunities within the HSCP and make best use of the expertise and experience of our health and social care partners, it's important that we have some basic principles that inform how we involve others in designing and developing integrated services that help to tackle inequality within the city. We have developed a set of principles that we believe are vital to achieving meaningful engagement:

- Achieving our priorities requires **joint working and full participation** from partners
- Meaningful involvement is a **two-way** process and requires the full commitment of each partner
- Services must be **co-produced**
- Decisions about services must be **informed by people with experience** of those services or an interest in them
- Access to involvement should be **equitable** and informed by a commitment to **equalities and human rights**
- Involvement should be **empowering**
- Involvement should be driven by **locality planning** that starts with the community, not senior management
- Communication must be **effective, targeted and proportionate**
- Involvement must be occur at an **appropriate time** to enable maximum influence

- Those involved should be informed by realistic expectations and provided with feedback on **outcomes of their involvement**.

How we will know involvement is meaningful:

- We will be working in partnership with a network of voluntary and independent health and social care providers, groups and individuals and people with lived experience of health and social care services (our stakeholders)
- People with lived experience will feel that the IJB recognise the value of involving them in the decision-making process
- All stakeholders will feel that they are working together towards joint goals
- Decisions about health and social care services will be influenced by our stakeholders
- Stakeholders will be respectful of one another's views and feel that their views are being listened to and acted upon
- New services and changes to existing services will be designed jointly (co-produced) with our stakeholders
- Opportunities to be involved will be equitably open to people with protected characteristics and communities of interest, place or identity
- Stakeholders will recognise their input and suggestions in the decisions that are taken, irrespective of the outcome
- Stakeholders will not feel like an afterthought in the engagement and decision-making process but will feel actively involved and empowered.

Mainstreaming equalities

What you said: ***"we would really love to see more information about equalities as well as intersectionality".***

The Equalities (Scotland) Act 2010 identified a number of general and specific duties for Integration Joint Boards as the legal public body responsible for planning health and social care services. The general duties set out in the Equalities Act are:

- to eliminate unlawful discrimination
- to advance equality of opportunity
- to promote good relations.

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The legislation in Scotland also outlines a range of specific duties for public bodies (such as IJBs) to:

- Report progress on mainstreaming the equality duty
- Publish equality outcomes and report progress
- Assess and review policies and practices
- Publish equality information in a manner which is accessible.

Equalities Mainstreaming

Mainstreaming equality refers to the efforts made by Glasgow City HSCP to integrate equality into the day-to-day working of all our services. This recognises that in some cases this requires a specially designed response and a long-term commitment to ensuring that equality and diversity is part of the structures, behaviour and culture of Glasgow City HSCP. One of the ways we describe and meet our duties under the Act is by publishing our Equalities Mainstreaming Report and equality outcomes. The HSCP's most recent report on progress in implementing its equality outcomes can be found on the HSCP website https://glasgowcity.hscp.scot/equalities and focusses on three priority areas:

- to foster good relations and remove discrimination
- to contribute to closing 'gaps' and
- to listen to, and work with, people and communities.

The key mainstreaming challenges in the last two years relate to the pressure to introduce response services and move to remote delivery for many services while also managing the workforce challenges during the pandemic. The pandemic has brought a clearer focus to equalities practices, however it is widely acknowledged that particular protected characteristic groups have been more negatively impacted upon during the pandemic (e.g. the triple 'whammy' experiences reported by women with a disability in Glasgow). How the HSCP acknowledges and addresses the differential impacts of the pandemic on groups with protected characteristics will be considered by the relevant Strategic Planning Group and other planning and governance structures.

The IJB set seven outcomes with clear actions, which are:

1. That family support strategy beneficiaries report good person-centred support and delivery that improves children's outcomes across those with protected characteristics and experiencing poverty
2. Through the Maximising independence Programme more users report that they are supported to live an independent life in a homely way, via the delivery of supports and advice
3. Improved patient experience of primary care for people with protected characteristics and experiencing poverty
4. Improved use and experience of Mental Health Services of BME patients in need
5. Improved care and health outcomes through advancing equalities practice across all HSCP services
6. The planned 'Parkhead Hub' (the integrated social and primary care, mental health and community hub) will be developed to have equalities at the heart of its culture and design.
7. The IJB members and Senior Management Team provide leadership in progressing the equalities culture of the organisation.

Equality Impact Assessments

Equality Impact Assessments (also known as EQIA's) are a key way for us to influence designing services and making decisions in ways that take account of the impact on different groups across the city. EQIAs are our way of considering what the impact will be of what we are considering doing on certain groups of people (referred to as people with protected characteristics). These characteristics might include having a disability, their sex, their sexual orientation or their ethnic identity.

The HSCP acknowledges that further activity and commitment is required to fully implement a culture where timely and detailed consideration is given to how different groups will be affected by decisions being taken by the IJB. The HSCP is also increasingly aware of the importance of understanding and considering the combined impact of multiple characteristics. For example the

combined effect for people with a disability who are female. Or on people who are in older age groups and of black or minority ethnic background. The interconnected nature of social categorisations such as race, class, and gender as they apply to a specific individual or group can have the effect of creating overlapping or multiple experiences of discrimination or disadvantage. We refer to this as ***"intersectionality"*** and this will be actively considered as part of the decision-making process with partners.

Equality impact assessments have a strong human rights element and help us to identify and reduce or remove negative impacts. EQIAs, though the involvement of relevant and affected groups, influence service design and help to reduce discrimination in service development and delivery to remove barriers to accessing services. EQIAs undertaken and published by the HSCP can be viewed on our website: https://glasgowcity.hscp.scot/equalities-impact-assessments.

Fairer Scotland Duty

In 2018, a Fairer Scotland Duty was brought into legislation, requiring the IJB to actively consider ('pay due regard' to) how they can reduce inequalities of outcome caused by socio-economic disadvantage, when making strategic decisions. These requirements are included in the mainstreaming report and update report, and consideration of the duty forms part of the Equalities Impact Assessment process used by the HSCP.

Some of the ways that we have sought to mitigate and reduce poverty as a community planning partner and for our service users and patients include: (further details can be found within the mainstreaming update report on the website)

- Continuing and extending our income maximisation services for service users and patients through our welfare advice and health improvement teams
- Undertaking specific poverty mitigation measures during the pandemic
- Including assessment of the impact of socio-economic disadvantage in our Equality Impact Assessments and resultant mitigation measures
- Being an active community planning partner challenging the fundamental causes of poverty and the system changes required to prevent poverty, including our leadership of the Cities Challenge Child Poverty Partnership
- Expanding the provision of financial advice services within GP practices from 30 practices to 84
- Securing funding for a community food-nurturing programme with families of pre-school children, focussing on food insecurity, healthy eating and physical activity in three Glasgow neighbourhoods: Ruchazie, Garthamlock and Cranhill (North East); Drumchapel (North West); Priesthill, Household wood, Nitshill and Pollok (South).

Other mainstreaming priorities and enablers

Glasgow City HSCP Equalities Working Group

The group works to support the development, delivery and progress of Glasgow City HSCP's mainstreaming duties. Members of the group represent all services and areas of work reflected in our equality outcomes such as: Health Improvement, Primary Care, Family Support Strategy, Maximising Independence, Mental Health Strategy, and Organisational Development. The Group also includes representatives from Glasgow City Council, Glasgow Equality Forum and NHS GGC's Equality and Human Rights Team.

Benchmarking Progress

In 2021, Glasgow City HSCP took the opportunity to participate in the Employers Network for Equalities and Inclusion (enei) Talent Inclusion and Diversity Evaluation (TIDE) exercise. The TIDE mark allows organisations to assess the status of their organisational practice in equalities and inclusion across eight mainstreaming domains.

Training and Development

Promoting the completion of relevant equalities training amongst staff and senior management working within the HSCP, and promoting the mainstreaming plan to ensure staff understand the need to adopt an equalities and human rights approach in the work they do.

Procurement/Commissioning

Working with NHS Greater Glasgow and Clyde (NHSGGC) on a new project that aims to diversify NHSGGC's supply chain to include businesses led by, for, and with people with protected characteristics as defined by the Equalities Act Scotland & Fairer Scotland Duty.

Further examples of activity to

Identifying opportunities for mainstreaming service delivery within the services and functions supported by the HSCP, examples of which can be found within the most recent mainstreaming update report

Commissioning within Glasgow City HSCP

Glasgow City HSCP is committed to meeting the health and social care needs of Glasgow's citizens by providing access to high quality, flexible and responsive support services delivered by partners that share our values and principles and promote good practice standards. These may be provided directly by NHS Greater Glasgow and Clyde or by Glasgow City Council (Social Work Services) or be delivered by voluntary and independent sector care providers on our behalf.

Commissioning within Glasgow City HSCP plays a crucial role in enabling the vision and priorities, supporting our aspirations and the delivery of transformational change. Working in partnership with provider organisations and service users we aim to deliver a wide range of support services that promote choice and independence and that enable individuals and families to be supported in their own homes and local communities for as long as possible. Glasgow City HSCP recognises and values the knowledge and experience our partner providers have of the communities we all serve, and work together to meet the needs, personal outcomes and aspirations of patients, services users and their carers.

Glasgow City HSCP's commissioning activity (i.e. **how we do it**) is governed by procurement legislation, and follows the core principles of the Scottish Government Procurement Journey commissioning cycle (analyse, plan, do and review). Commissioning teams within the HSCP ensure a balance between quality and cost of services (Best Value) is achieved from purchased services through the application of a contract management framework that promotes safeguarding users of services and a culture of continuous improvement, efficiency and effectiveness.

The approach to contract management was interrupted during the Covid-19 pandemic, and partner providers and commissioning officers had to adapt to a range of new requirements in respect of quality assurance. The restrictions placed on us all during the pandemic also meant that relationships were built and maintained on new virtual approaches. During this next strategic planning cycle and as we move into recovery from Covid-19 the commissioning service plans to work with partner providers to review the contract management framework to adopt the learning from the pandemic.

The Commissioning Service has developed and published an Action and development Plan that is kept under constant review and revision, and will help position the service to continue to grow the knowledge and skills of staff to contribute to the achievement of strategic objectives and transformational change.

The commissioning priorities for the duration of this Strategic Plan (i.e. **what we commission**) is informed by a number of factors. The Strategic Plan itself continues to drive health and social care commissioning activity, influenced by the priorities identified by stakeholders and by the activity laid out earlier in the Plan to achieve the strategic priorities. Those priorities and the activity that

follows is informed by the strategic needs assessment referred to earlier in this Plan. Activity is further influenced by strategic programmes including Maximising Independence, the Children's Services Family Support Strategy, Carer's Strategy, Domestic Abuse Strategy and Mental Health Strategy.

Activity is also driven by external factors such as increasing demand, reducing resources and changing legislation and policy (such as the implementation of the National care Service). All of these contribute to an environment where flexible and innovative solutions must be developed and delivered at pace. The Commissioning Service prepares a plan for upcoming commissioning activity for the Integration Joint Board and the plan for 2022/23 can be found on the HSCP website.

We will continue to be innovative in our approach to commissioning and to firmly embed engagement and participation from partner providers, users of services and people with lived experience when we plan commissioning exercises to ensure the services purchased and delivered on behalf of the IJB reflect the needs of the communities. During the life of this Plan the HSCP will supplement the information that drives commissioning priorities referred to above with the development of a plan to ensure there are a range of providers and types of support available within the city for supported people to choose from, based on projected need. This will be called our Market Facilitation Plan. We will also consider whether joint strategic commissioning plans should be developed at care group level to inform the commissioning priorities based on an understanding of need at that local level.

Delivering sustainable procurement will be a key focus for commissioning throughout the lifetime of this Strategic Plan. Consideration of Fair Work First in tender exercises, and prompt payment in keeping with the commitments for the Living Wage is already embedded in our commissioning approach but work is needed on other aspects of sustainable procurement to ensure compliance with the Sustainable Procurement Duty and to secure wider social, economic and environmental benefits for the City. Work in this area will include a review of our approach to community benefits and identifying improvements in our approach and processes to maximise opportunities for local small and medium sizes enterprises (SMEs) and third sector organisations.