Glasgow City HSCP
Health and Social Care Partnership

ANNUAL PERFORMANCE REPORT

2018/19

NHS Greater Glasgow and Clyde

Glasgow City Council

FOREWORD

We are pleased to provide this foreword to the third annual report by Glasgow City Integration Joint Board (IJB) on the performance of integrated health and social care provision within the city.

The annual report can only ever provide a snapshot of the overall performance of the IJB in delivering its Strategic Plan and its aspirations to transform how health and social care is planned, delivered, received and experienced. The size, scale, complexity, history, culture, expectation within and across a city the size of Glasgow necessarily means that it would be impossible to produce an all-encompassing definitive report that establishes unequivocally that the IJB is delivering the nine National Health and Wellbeing Outcomes.

Within this report, however, we endeavour to demonstrate the significant progress made by the IJB and the operational vehicle reflecting the Partnership, the Health and Social Care Partnership (HSCP), in working towards delivering not just the nine National Health and Wellbeing Outcomes; but also the spirit and principles behind the Public Bodies (Joint Working) (Scotland) Act, through the fostering of a culture of joint working and partnership across all HSCP services and partner agencies.

We seek to achieve the above by highlighting key service developments in the last 12 months and reflecting upon how we have delivered our key priority of transforming the way in which services are planned, delivered and accessed.

We also describe some key operational highlights and achievements in respect of our performance, while identifying areas where we fell below our expectations and will be seeking improvements going forward over the course of the next year.

It is also worth noting that over the course of the last year, Audit Scotland have undertaken a second performance audit of health and social care integration, which has aimed to examine the impact public bodies are having as they pursue integration. In addition, the Ministerial Strategic Group for Health and Community Care have undertaken a review of progress and made a number of progressive and challenging recommendations relating to effective integration.

The IJB has recently undertaken an analysis of our position in respect to both reports and is developing an Action Plan. This will be a key focus for us going forward over the next 12 months and will be an area we will reflect on within our Annual Performance Report for 2019/20.

Susanne Millar
Interim Chief Officer

Simon Carr
Chair, Glasgow City Integration Joint Board

Councillor Mhairi Hunter
Vice Chair, Glasgow City Integration Joint Board

PERFORMANCE REPORT
2018/19

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1. INTRODUCTION

1.1 PURPOSE 0F REPORT

The Public Bodies (Joint Working) (Scotland) Act 2014 requires Integration Joint Boards to publish an Annual Performance Report, setting out an assessment of performance in planning and carrying out those functions for which they are responsible.

This is the third report for the Glasgow City Integration Joint Board (IJB) and within it we look back upon the last year (2018/19). Within it, we review our performance against agreed local Key Performance Indicators, as well as in relation to the National Integration Indicators and those indicators specified by the Ministerial Strategic Group (MSG) for Health and Community Care.

We also consider progress in delivering the priorities set out in our first **Strategic Plan** which covered the period 2016-19.

During the course of the last year, we have revised this Plan and produced an updated version for the period **2019 - 2022**. This will be used as the basis for reporting within future Annual Performance Reports.

1.2. PARTNERSHIP OVERVIEW

i. Organisational Profile

The Glasgow City Integration Joint Board is a distinct legal entity created by Scottish Ministers and became operational in February 2016. In response to the Public Bodies (Joint Working) (Scotland) Act 2014, Glasgow City Council and NHS Greater Glasgow and Clyde agreed to integrate children and families, criminal justice and homelessness services, as well as those functions required by the Act, delegating these to the Integration Joint Board.

The IJB is, therefore, responsible for the strategic planning and/or delivery of a wide range of health and social care services in the city. These include the following:

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

More information on the health and social care services and functions delegated to the Glasgow City IJB are set out within Glasgow City's Integration Scheme

The Health Board area for NHS Greater Glasgow and Clyde is larger than Glasgow City's boundary, spanning 5 other Health and Social Care Partnerships. As a result, Glasgow City also has responsibility for planning and delivering some services that cover the entire Board areas, for the other HSCPs. These include sexual health and continence services.

Across all services, as at December 2018, the Health and Social Care Partnership (HSCP) has a workforce of 10,058 Whole Time Equivalent (WTE) staff, made up of 5,795 WTE employed by Glasgow City Council and 4,263 employed by NHS Greater Glasgow and Clyde.

In addition to directly providing services, the Partnership also contracts for health and social care services from a range of third parties including voluntary and independent sector organisations. Within primary care services, a range of independent contractors, including GPs, dentists, optometrists and pharmacists are also contracted for by the Health Board, within the context of a national framework.

Within the Partnership's area, there are 145 GP practices providing general medical services to their practice populations. There are also 161 dental practices including 5 orthodontic practices, 164 community pharmacies and 109 optometry practices.

GLASGOW CITY HSCP

10,058 Staff

£1.1 billion budget

Range of third party partnerships

ii. Locality Management Arrangements

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

iii. Performance Management Arrangements

Routine performance management arrangements are in place within the Partnership, with regular operational performance reports, covering all HSCP services, produced for internal scrutiny by HSCP management teams on a quarterly basis.

These reports are also scrutinised by the Integration Joint Board's Finance, Audit and Scrutiny Sub-Committee, which has introduced arrangements whereby they focus on specific services at each meeting, with relevant strategic leads invited to attend and discuss the performance of their respective areas. An overview of performance is also maintained by the Integration Joint Board, which receives a quarterly performance report that focuses upon a smaller set of more strategic performance indicators.

There are, therefore, a range of mechanisms in place within the Partnership in order to monitor and scrutinise performance on an ongoing basis, with service leads identifying and reporting upon how they are responding to any areas of under-performance.

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

The IJB and HSCP Management Teams also receive care group specific reports and will review and respond to any reports produced by NHS/Council Internal Audit teams, Audit Scotland, Healthcare Improvement Scotland and the Care Inspectorate.

1.3. AREA PROFILE

Key demographic characteristics of the city are summarised below. A list of additional information sources where further information can be found are listed in Appendix A.

Population

The 2017 estimated population of Glasgow City is 621,020, 11.4% of the total population of Scotland (Source: National Records of Scotland - NRS). The breakdown of population by age-band is shown in the following chart.

621,020

(2017 National Records of Scotland), which is **11.4%** of the population of Scotland

THIS COMPRISES:

99,137 *(17.9%)*
children aged 0-17

437,911 *(68.5%)*
adults aged 18-64

83,972 *(13.6%)*
older people aged 65

The population of Glasgow City is projected to increase by 7.1% over the period 2016-2041 (NRS 2016 population projections). The table below shows estimates of projected population by age-band at five year intervals over this period and also shows the change at 10 and 25 years:

2016-based principal population projections for Glasgow City by age-band at 5 year intervals (NRS) and % change 2016 - 2026/2041

	Population						% change	
age-band	**2016**	**2021**	**2026**	**2031**	**2036**	**2041**	***2016-2026***	***2016-2041***
0 -15	98,487	103,188	105,088	103,541	102,642	101,044	*6.7%*	*2.6%*
16 - 64	432,793	442,515	438,723	435,096	433,239	437,741	*1.4%*	*1.1%*
65+	83,790	86,964	95,846	107,995	117,385	120,193	*14.4%*	*43.4%*
Total	**615,070**	**632,667**	**639,657**	**646,632**	**653,266**	**658,978**	***4.0%***	***7.1%***
75+	39,009	37,631	40,136	44,159	51,810	60,372	*2.9%*	*54.8%*

The child population (0-15) is projected to increase by 6.7% between 2016 and 2026, after which it is likely to decrease steadily giving an expected overall rise between 2016 and 2041 of 2.6%.

Deprivation

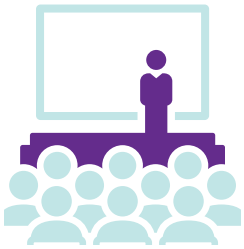
- Glasgow City contains 4 in 10 of the 15% most deprived data zones in Scotland, the highest proportion for any local authority, according to the 2016 Scottish Index of Multiple Deprivation (SIMD 16). 127 of these most deprived data zones are in the North East of the city, while the North West has 87 and South 106. More than 40% of Glasgow's entire population live in one of these 320 data zones, with 59% of these people living in the North East of the City (SIMD 16).
- Almost a fifth (19.7%) of Glasgow's overall population is "income deprived" compared to more than a tenth of Scotland's population (12.2%) (SIMD 16).
- Just under half (48.6%) of Glasgow young people aged 0-25 years live in the 20% most deprived data zones in Scotland, more than double the national average (21.5%) (SIMD 16).
- At school age, more than 30.1% of Glasgow children (14,385) are registered for free school meals, almost twice the rate of 15.6% for the whole of Scotland (Scottish Government Feb 2018).
- At February 2016, more than 30,000 children in Glasgow or 27.4%, were living in low income households, compared to 16.7% across Scotland (HMRC 2019).
- Deprivation among Glasgow's older people population is also far higher than the Scottish average as indicated by the rate of people aged 60+ claiming pension credits (10.7% in Glasgow compared to the Scotland rate of 5.5%) (DWP May 2016).

- During 2017/18 more than 27,000 people in Glasgow applied for a Crisis Grant from the Scottish Welfare Fund, representing 15.7% of all applications across Scotland. This compares to a population share for Glasgow of 11.4% (statistics.gov.scot 2018).
- 30% of adults surveyed said they had difficulty in meeting essential living costs such as rent/mortgage, utility bills, food, and clothes/shoes. This was far higher for people living in the 15% most deprived data zones at 38% compared to 25% for people from other areas (Glasgow Adults Health and Wellbeing Survey 2017/18).

Economic Activity

- 15.5% of the working age population of Glasgow is "employment deprived" compared to a national rate of 10.6%. 53% of adults surveyed indicated they are 'economically active' (in full, part-time or self-employed work or on a zero hours contract). This varies across areas with 46% of people living in the 15% most deprived areas economically active compared to 58% in other areas. It also varies by age group, with 49% of 16-24 year olds economically active, compared to 72% for the 25-34 years age group and 52% for those 55-64 years (Adults Health and Wellbeing Survey 2017/18).

Education



- 19% of adults surveyed have no qualifications. The rate rises significantly with age: 5% of 16-24 year olds; 23% of 45-54 years olds; and 49% of people aged 75+. The rates also vary by area with 28% of people in the 15% most deprived areas having no qualifications compared to 13% more generally(Adults Health and Wellbeing Survey 2017/18).

Life Expectancy and Mortality

- Life expectancy (LE) at birth for a Glasgow male is 73.3 years compared to 77.0 years for a Scottish male. For females, it is 78.7 years for Glasgow and 81.1 for Scotland.
- Glasgow males living in the 20% least deprived data zones (LE = 80.2 years) can expect to live 12 years longer than those living in the 20% most deprived data zones (LE = 68.3). A narrower gap exists for Glasgow females with those in the 20% least deprived data zones (LE = 83.2 years) living 8 years longer than those in the 20% most deprived data zones (LE = 75.0) (National Records Scotland (NRS) 2015-17).

- Healthy Life Expectancy (HLE) at birth for males in Glasgow is currently 57.2 years and for females 58.9 years, both far lower than the Scottish averages of 62.3 years for males and 62.6 years for females.

- There is a 20 year differential in HLE between Scottish people living in the most and least deprived (SIMD) quintiles. HLE ranges from 50.3 (Quintile 1 – most deprived) to 70.6 (Quintile 5 – least deprived) for males; and 52.3 to 70.6 for females (NRS 2015-17).
- Glasgow has a higher rate of people dying early from all causes than Scotland. During the period 2015-17 there were 126.1 deaths from all causes of people aged 15-44 per 100,000 population in Glasgow compared to a national rate of 105.8 (NRS 2015-17 3 year aggregates).
- Early deaths (under 75s) from specific causes also tend to be higher in Glasgow than Scotland overall. In Glasgow, there were 206.8 deaths per 100,000 population for cancer, compared to 160.2 for Scotland for the period 2015-17. Similarly there were 79.2 early deaths per 100,000 population from Coronary Heart Disease (CHD) for Glasgow compared to 53.0 in Scotland overall (NRS 2015-17 3 year aggregates).
- Alcohol related deaths have increased between 2015 and 2017 (from 186 to 206), and have a higher rate per 100,000 population than NHS Greater Glasgow and Clyde and Scotland as a whole (NRS annual death registrations).
- Drug related deaths have increased between 2015 and 2017 (from 157 to 192), and have a higher rate per 100,000 population than NHS Greater Glasgow and Clyde and Scotland as a whole (NRS annual death registrations).

Illness and Disability

- 10% of adults surveyed indicated that they have bad or very bad health. While 73% of adults are positive about their health, this declines with age and deprivation. (Glasgow Adults Health and Wellbeing Survey 2017/18).
- 29% of adults surveyed indicated they had a limiting long term illness or disability. Of these, 58% have a long term illness; 52% have a disability; and 28% have a mental or emotional health problem (note – some have multiple conditions) (Glasgow Adults Health and Wellbeing Survey 2017/18).
- The numbers living with a limiting long term illness vary across areas with 35% in the 15% most deprived data zones compared to 24% people in other areas. They also vary by age, 14% for 16-44; 40% for 45-64 and 60% for 65+ (Glasgow Adults Health and Wellbeing Survey 2017/18).
- More than 50,000 Glasgow people claim incapacity benefit/ severe disablement allowance/ employment and support allowance representing 9.8% of the 16+ population, compared to a Scottish rate of 6.1% (May 2016 Department of Work and Pensions (DWP)).
- There are an estimated 8,000 people in Glasgow with dementia (2017 Alzheimers Scotland).

- Glasgow has a far higher rate of emergency hospital admissions (all ages) at almost 9,400 per 100,000 population compared to 7,600 per 100,000 population for Scotland (Information Services Division (ISD) 2015/17).
- Similarly, the rate of people aged 65+ with multiple emergency hospitalisations of almost 7,400 per 100,000 population for Glasgow is far higher than the comparable rate for Scotland of 5,400 per 100,000 population (Information Services Division (ISD) 2015/17).

Mental Health

- 21% of adults in Glasgow are estimated to suffer from common mental health problems compared to 16% of Scottish adults. Females are more likely to be affected (24% for Glasgow and 17% for Scotland) than males (18% for Glasgow and 14% for Scotland) (2017 Scottish Health Survey (SHeS) GHQ12).
- A higher rate of people in Glasgow experience more severe mental illness than nationally. More than 2,000 Glasgow people were hospitalised for psychiatric reasons between 2015 and 2018 equivalent to a rate of 345.1 per 100,000 population compared to the Scotland rate of 261.9 per 100,000 population. (ISD 2015/16 – 2017/18 3 year aggregate).

Lifestyles

- The rate of alcohol related hospital stays for Glasgow is almost double the Scottish average. In 2017/18 there were 1,230 stays per 100,000 population in Glasgow compared to a national rate of 680 per 100,000 population (ISD 2018).
- There were more than 1,500 drug related hospital stays in Glasgow during the period 2014/15 – 2016/17, equating to a rate of 242.1 per 100,000 population, compared to the Scottish rate of 146.9 per 100,000 population (ISD 2014/15 – 2016/17 3 year aggregates).
- It is estimated that 21% of Glasgow men aged 16+ are obese (BMI≥30) – less than the comparable rate of 28% for Scottish men. The rate of obesity in females of 31% is slightly higher than the Scottish rate of 30% (SHeS 2017).
- Of those adults surveyed, 39% eat the recommended 5 portions or more of fruit/veg per day. This varies by gender with females at 45% compared to 32% for males. It also varies by area, with 31% in the 15% most deprived data zones compared to 44% people in other areas (Glasgow Adults Health and Wellbeing Survey 2017/18).
- Of those surveyed, 65% of adults indicated they were moderately active for the recommended 150 mins or more per week. This was higher for males (68%) than females (62%) (Glasgow Adults Health and Wellbeing Survey 2017/18).

- Of those adults surveyed, 24% are smokers. Rates are higher for males (30%) than females (19%) and vary by area, with 32% in 15% most deprived data zones compared to 19% people in other areas. (Glasgow Adults Health and Wellbeing Survey 2017/18).
- There were 660 teenage pregnancies (under 18) in Glasgow during the 3 year period 2014 to 2016. These have been falling and have reduced from 1019 in the period 2010 to 2012. Rates are, however, higher than NHS Greater Glasgow and Clyde and Scotland as a whole (NRS birth registrations).
- 31% of adults surveyed indicated that they had spent money on gambling in the past month (36% of males compared to 27% females). Lottery/scratchcards were the most common form of gambling, followed by betting at the bookmakers (Glasgow Adults Health and Wellbeing Survey 2017/18).

Carers

- Of those surveyed, 14% of adults were unpaid carers (16% of females and 13% males) (Glasgow Adults Health and Wellbeing Survey 2017/18).

Homelessness

- During 2017/18 there were 4,185 homelessness applications that resulted in a homeless/threatened with homelessness decision in Glasgow. These represent 14% of all such decisions in Scotland, above Glasgow's population share of 11.4% (Scottish Government Statistics 2018).
- Almost 2,000 of the households in Glasgow assessed as homeless/ threatened with homelessness had one or more support needs identified within the household (eg. health problem, condition or disability; addiction problems; lacking independent living skills). These represent 15% of all such households identified nationally (Scottish Government Statistics 2018).
- At March 2018, 2,150 households were living in temporary accommodation in Glasgow. These accounted for 20% of all such households in Scotland.

Social Care

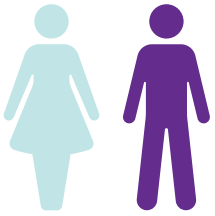
- Glasgow generally has higher rates of children/young people with social care needs than Scotland overall. At July 2017 Glasgow had more than 2,800 looked after children & young people, a rate of 25.5 per 1,000 population compared to 14.3 for Scotland. More than 400 children were on the Child Protection Register at this point equating to a rate of 3.6 per 1,000 population, higher than the Scotland rate of 2.5 per 1,000 population (Scottish Government Statistics 2018).
- There were 426 referrals for offence reasons in Glasgow to the Scottish Children's Reporters Administration (SCRA) during 2017/18: this equated to 9.5 per 1,000 of 8-15 population, higher than the Scottish rate of 6.7 per 1,000 population (SCRA 2018).

- The rate of referrals to SCRA for care and protection reasons was less in Glasgow than Scotland – Glasgow had a rate of 10 per 1,000 of 0-15 population, compared to 12.3 per 1,000 for Scotland (SCRA 2018).
- Glasgow has a greater proportion of people aged 65+ with high levels of care needs being cared for at home than the Scottish average (39.2% compared to 35.2%) (Scottish Government Community Care Statistics 2017).

Crime/Anti-Social Behaviour

- All crime rates are higher in Glasgow than Scotland. For 2017, these were 48.1 per 10,000 population for Glasgow compared to 30.5 for Scotland (all crimes) (Scottish Government Statistics 2017/18).
- Domestic abuse crime rates were 144.5 per 10,000 population for Glasgow compared to 108.8 for Scotland (Scottish Government Statistics 2017/18).
- Violent crime rates were 25.0 per 10,000 population for Glasgow compared to 13.3 across Scotland (Scottish Government Statistics 2017/18).
- Drug crime rates were 103.7 per 10,000 population for Glasgow compared to 59.7 for Scotland (Scottish Government Statistics 2017/18).
- 13% of adults surveyed indicated they were victims of crime in the past year. This was higher for males (15%) than females (11%) (Glasgow Adults Health and Wellbeing Survey 2017/18).
- 7% of adults surveyed said they had experienced discrimination in the past year. Most commonly this discrimination occurred by an unknown person in a public place (46%). Most people experiencing discrimination said this was related to their ethnicity (30%) (Glasgow Adults Health and Wellbeing Survey 2017/18).

Social Capital



- 20% of adults surveyed indicated they lived alone. This increased with age: 16-24 year olds (4%); 45-54 year olds (22%); 75+ (55%). It also varied across areas with 24% in the 15% most deprived areas compared to 18% in other areas (Glasgow Adults Health and Wellbeing Survey 2018/19).
- 15% of adults surveyed feel isolated from family/friends (Glasgow Adults Health and Wellbeing Survey 2017/18).
- 20% of adults surveyed said they had felt lonely at some point within the last 2 weeks. This was highest for those aged 75+ (28%) and lowest for young people aged 16-24 (14%) (Glasgow Adults Health and Wellbeing Survey 2017/18).
- 20% adults surveyed indicated they had volunteered in the last year. The highest proportion of any age-band volunteering was 16-24 year olds (30%). Less people in the 15% most deprived areas volunteered (13%) compared to those in other areas (25%) (Glasgow Adults Health and Wellbeing Survey 2017/18).

1.4 STRATEGIC VISION AND PRIORITIES

i. Strategic Plan

As indicated earlier, in accordance with the Public Bodies (Joint Working) (Scotland) Act 2014, we prepared a **Strategic Plan** for the delivery of those functions which have been delegated to the Integration Joint Board by Glasgow City Council and NHS Greater Glasgow and Clyde.

This plan, which covers the period from 2016-19, sets out the following vision and priorities for health and social care services in Glasgow. Within this report, we capture some of our key achievements in relation to delivering these priorities and the nine National Health and Wellbeing outcomes (See Appendix B).

ii. Our Vision

We believe that the City's people can flourish, with access to health and social care support when they need it. This will be done by transforming health and social care services for better lives.

We believe that stronger communities make healthier lives and we will seek to achieve these by:

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

iii. Our Priorities

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

We believe that more of the same is not the answer to the challenges facing Glasgow, and we will strive to deliver on our vision through the following strategic priorities:

1.4 STRUCTURE OF THE REPORT

In chapter 2, we describe progress which we have made over the course of the last 12 months for each of our agreed strategic priorities. Where relevant, performance indicators and trends affected by these developments are highlighted, along with user/carer feedback and case studies which seek to demonstrate our impact on the nine National Health and Wellbeing Outcomes.

In chapter 3, we provide an overview of our three localities. We describe the locality management arrangements and planning processes in place and highlight some of the key developments progressed over the last year in each area. We also describe the engagement mechanisms and highlight how these have been used to involve local stakeholders in a range of city wide and locality developments, with the feedback obtained shaping decisions and plans.

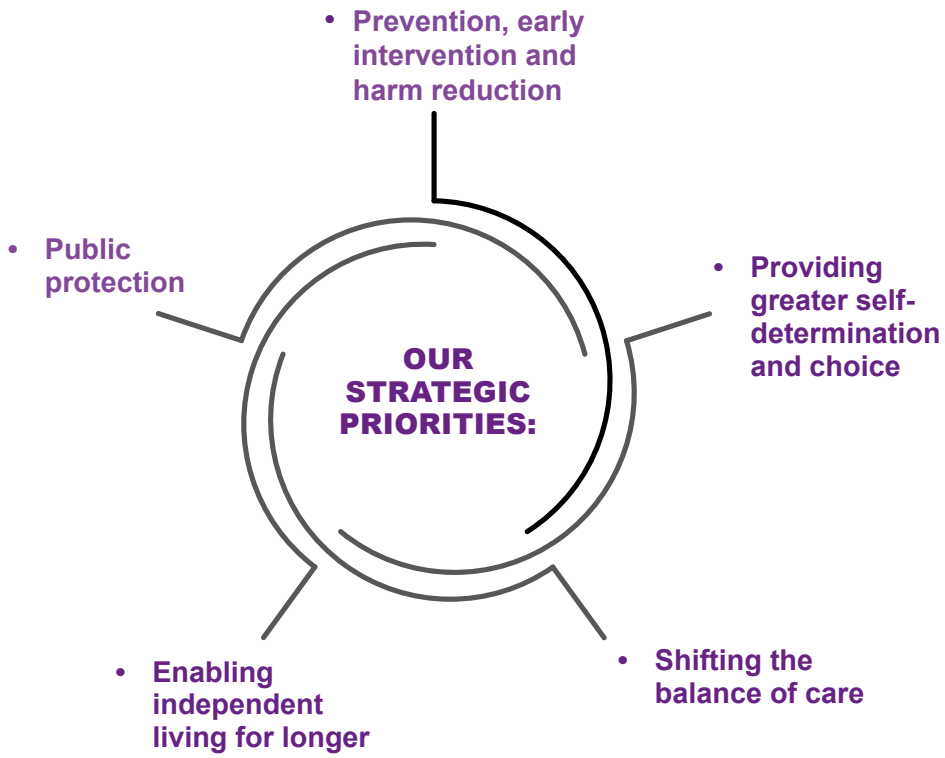
In chapter 4, we provide a summary of our financial performance for 2018/19. We also describe some of the key transformation programmes and resultant savings that have been achieved as a consequence. Key capital investments are also summarised and the financial outlook for 2019/20 considered.

Finally, in chapter 5, we provide a more comprehensive overview of performance, drawing on a range of sources including our agreed local key performance indicators, National Integration Indicators, national inspections and key survey findings. Where available, performance in relation to our local performance indicators is shown for the end of 2018/19, with comparisons made across the period since the Partnership was established.

2. DELIVERING OUR KEY PRIORITIES

2.1 INTRODUCTION

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



In sections 2.2 to 2.6, we highlight some of the key service developments and improvements undertaken in relation to our Strategic Priorities over the last year.

We also describe any associated activity or performance trends and where relevant, draw upon some of the local Key Performance Indicators which are reported quarterly to the Integration Joint Board. A comprehensive overview of performance in relation to all local Key Performance Indicators is provided in chapter 5.

Under each of the Strategic Priorities, we have also included any relevant user/ carer feedback and case studies which help to demonstrate the impact being made by our services upon these Strategic Priorities and the nine National Health and Wellbeing Outcomes (Appendix B).

In section 2.7 we then focus upon our staff and how we have engaged with and supported them over the last 12 months. Finally, in section 2.8, we consider how we have taken forward our statutory duties and responsibilities in respect to equalities.

Within this chapter, we focus upon the impact upon Outcomes 1 to 8. Chapter 4 on Financial Performance is used to demonstrate our progress in relation to Outcome 9 'Resources are used effectively and efficiently in the provision of health and social care services'.

2.2 PREVENTION, EARLY INTERVENTION AND HARM REDUCTION

Within this section, we profile some of the key developments progressed in relation to our strategic priority of Prevention, Early Intervention and Harm Reduction.

We have continued to work with a wide range of partners across the City to improve overall health and wellbeing, prevent ill-health, increase healthy life expectancy and reduce health inequalities and the impact of deprivation.

This work is underpinned by agreed priorities for Health Improvement which focuses the health improvement workforce on reducing health inequalities and changing the culture in relation to health behaviours in the city.

The activities described in this section have contributed to a range of the 9 National Health and Wellbeing Outcomes, most notably those shown below. Other related activities including those addressing poverty and recovery, and those specific to each locality within the context of the Thriving Places approach, are also described in later sections of this report.

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

i. Alcohol Brief Interventions (ABIs)

During 2018-19, we have continued to promote the delivery of ABIs. These are short, structured, evidence based interventions aimed at reducing an individual's risk of alcohol related harm when they are identified as having potentially hazardous alcohol consumption.

This work is carried out in primary care and wider settings including prisons, police custody suites, smoking cessation groups and by other community based HSCP services.

ABIs are delivered in partnership with a number of voluntary organisations including Drink Wise, Age Well, Addaction and Glasgow Council for Alcohol (GCA). In addition to delivery, GCA also provide practitioner and 'train the trainer' sessions.

ii. Smoking Cessation

Smoking Cessation Service
The Glasgow City Tobacco Group was set up in October 2017, led by the Health Improvement Team, to develop a consistent, evidence based and cost effective approach for the delivery and development of tobacco work.

At Q4, performance in relation to ABIs was slightly below target but classified as GREEN (5055 against a target of 5066). This compares with 6470 last year. Recorded numbers are believed to be lower than they should be as a result of changes in the GP contract which has had an impact on the recording of ABIs in primary care. To address this, work has been undertaken with the Health Board GMS Contract team to develop a new, simplified template for recording ABI delivery on NHS information systems and work is ongoing with GP clusters to raise awareness of this issue. Going forward, it is hoped this will ensure all ABIs delivered are recorded.

Key priorities progressed over the last year have included the following:

- Improving joint working with primary care e.g. 29,000 texts were sent via GP practices to patients who are current smokers to offer them support from the Quit Your Way community service.
- The use of targeted social media marketing campaigns e.g. the Quit Your Way Facebook page has been used to publish case studies and messages aimed at driving people towards services. Targeting by age, gender and geographical locations has been used with the aim of engaging 'harder to reach groups'.
- The HSCP signed Scotland's National Charter for a Smokefree Generation, alongside a range of organisations including schools, colleges, universities, dental practices and pharmacies, which pledges them to work towards making non-smoking the societal norm. A range of activities are being progressed to support this, including the promotion of smoke free playgrounds.
- The Quit Your Way Pregnancy Service incentives programme which involves the provision of store card vouchers to pregnant women following initial engagement and completion of successive smoking cessation milestones. This pilot service commenced in summer 2018 and is evidencing increased referrals, engagement and successful quit outcomes.

The Scottish Government target for smoking cessation remains the primary focus for smoking cessation services. At Q3, performance is approximately 24% above the target for quits at 3 months from the 40% most deprived postcodes (943 against target of 761).

At Q4, 10.4% of women in the general population were smoking at their time of booking (target of 13% or less); and 18.9% of the most deprived quintile (target of 19% or less). These compare to 10.6% (general) and 18.7% (most deprived).

USER/CARER FEEDBACK

Helen and Stuart quit smoking with our support. Their motivations were health concerns and saving money:

"The support has been amazing. We couldn't have done it without them"

"What I was paying on cigarettes pays my mortgage every month. I say that to people – if that's not an incentive what is?"

CASE STUDY

Research on Smoking Cessation services was published in July 2018. This report features a case study involving a woman aged 55-64 who works full time (over three jobs) and lives in Cadder, close to Possilpark. She was smoking 20 cigarettes per day and after an unsuccessful quit attempt using Champix, she heard about the Smoking Cessation service and felt that this offered a better chance of a successful quit.

She made an initially successful quit attempt with the support of the service, but subsequently lapsed. She did not know that she could use the service again until she received a telephone call from the Smokeline service advising her of this. She stopped for a second time with their support, but again lapsed, citing family problems and stresses as the trigger for returning to cigarettes. However, she returned for a third time and the latest quit attempt has been successful and she feels confident she will maintain it. She felt that the support and advice she received has been crucial to her eventually succeeding:

"They were very helpful. I can sit and talk away to the advisor and I don't hold anything back. If I've had a bad day, she'll talk me through it. I'm putting on weight and that's worrying me, so she talks to me about it. She talks to you about everything. So you can see she's interested. And she gives me wee ideas about things I can try. I always go away feeling that I like being there and I like going back again... knowing that I have the support from the clinic has been a big, big, help".

Smoke-Free Prisons

Prison healthcare services across NHSGGC are hosted by Glasgow HSCP. Prior to the introduction of smoke-free prisons in November 2018, there was an expansion of smoking cessation services (Quit Your Way) in the three establishments in NHS Greater Glasgow and Clyde, including Barlinnie in Glasgow. This enhanced service provision has contributed to a smooth transition to smoke-free establishments.

Across NHSGGC during the period April – Sept 2018, there was a 125% increase in the number of people in prisons setting a quit date (435 v 193) compared to the same time period in 2017; a 193% increase in quits at 4 weeks (157 v 81); and a 66% increase in the number of people quit at 12-weeks (83 v 50).

Since November and the introduction of smoke free prisons, engagement with the service has increased again, with a 210% increase between Dec 2018 (83) and Feb 2019 (257).

iii. Sexual Health Services

Free Condom Service
The Free Condom Service provides free condoms to anyone aged 13 or over living, working or studying in the Greater Glasgow and Clyde area. In addition to bars and clubs and colleges/universities, they are made available from a range of locations including NHS premises, housing providers, employability services, addiction services, needle exchange pharmacies, homelessness accommodation and outreach services.

Over the last year, the service has been raising awareness of sexual health issues and distributing condoms and lubricants at a range of festivals, including the Glasgow Pride festival; TRNSMT; the Fresher's Festival; and the youth zone at the 2018 European Championships.

The number of condom distribution venues increased from 470 in 2017 to 492 in 2018 and the number of condoms ordered rose from 1,347,078 to 1,397,390 in the same time period.

Preventing HIV transmission
The HIV pre-exposure prophylaxis (PrEP) programme has been delivered since 2017 to people who are HIV negative but who are most at risk of HIV transmission. In 2018, over 2,700 individuals were prescribed these medicines in order to reduce their risk of becoming infected.

Screening
The cervical screening programme is managed by the Health Board's Public Protection Unit. The HSCP is not, therefore, directly responsible but works with partners to promote awareness and encourage uptake. In the last twelve months, Saturday morning cervical screening drop-in sessions have been introduced at the Sandyford clinic.

This initiative has been introduced to target mainly difficult to reach women whose smear test was overdue and it has been supported by a successful grant application to the Scottish Government.

Across the Health Board area, key United Nations 90/90/90 targets have been achieved. The proportion of people with HIV who have been tested and had a diagnosis is over 90%; with over 90% of those diagnosed being on antiretroviral treatment; and of this group, over 90% have evidenced a suppressed virus.

CASE STUDY

Sandra is a Scottish woman in her mid-40s who lives in the East End of Glasgow. Her smear test was "very, very overdue" so her GP did opportunistic screening when she was in for another appointment. Her results showed abnormalities so she was asked to come back in 6 months.

Her main barrier is time and access – she works full time in a demanding job and has to take annual leave for appointments. After 6 months, she received a letter recalling her for screening, but she had no more annual leave left. "I thought – what am I meant to do now?!" She called up her GP practice and the receptionist told her about the Sandyford Saturday drop in. She attended and at the clinic, was able to chat to a Jo's Cervical Cancer Trust staff member about cervical abnormalities and took some information home with her.

The clinic was perfect for her and she believes the flexibility of the clinic could help her stay on top of her future appointments. "Something like this would help, absolutely". She is going to tell her friends and family who live locally about the clinic if they're overdue for screening. "I hope this is funded in the future. If women were aware of this, this could make all the difference".

Prison healthcare services have also been targeting women prisoners at HMP Greenock, in light of national evidence which indicates the need to improve screening uptake and sexual health amongst this client group. Screening procedures and processes have been improved in response and routine sexual health enquiries are now made on admission.

A specialist sexual health clinic is also now held monthly. Pre-liberation consultations have also been introduced including contraceptive advice, cervical screening dates and sign-posting to local services. HMP Greenock now has 100% compliance for cervical screening and efforts to maintain this continue.

CASE STUDY

Patient A had been non-compliant with cervical screening for many years prior to receiving a custodial sentence. Through routine sexual health enquiry, they were identified as falling into a high risk category in relation to sexual health.

Having been contacted by the Sexual Health link nurse, they were invited for cervical screening and attended. During this screening an irregularity was noted and they were fast tracked for a follow-up hospital assessment, with a subsequent treatment plan initiated.

iv. Breastfeeding

UNICEF's Baby Friendly Initiative accreditation continues to be maintained across all localities. During 2018/19, each sector progressed work towards achieving the UNICEF UK Baby Friendly Achieving Sustainability (Gold Award).

This evidences that UNICEF standards are embedded within the culture of the organisation and that all the relevant structures are in place to support its ongoing maintenance and progression. All localities have now achieved this award with 865 staff attending courses related to this over the last year.

North East Glasgow achieved this award in December; with the North West and South passing the award in March 2019. Health Improvement staff also supported 96 other organisations in the city to attain or maintain Breastfeeding Friendly awards.

Over the course of 2018/19, 874 mothers attended the breastfeeding support groups which operate across the city, accounting for a total of 2086 attendances.

Exclusive Breastfeeding rates at 6-8 weeks for the general population was 30.4% in 2018, rising from 26.9% in 2017 and 25.7% in 2016. Rates for the most deprived population were 21.2% in 2018, compared to 20.3% in 2017 and 18.2% in 2016.

USER/CARER FEEDBACK

As part of UNICEF Baby Friendly Standards maintenance, an ongoing audit cycle is in place in each locality to establish the quality of care and information received by mothers about feeding and caring for their baby. Feedback from the audits are collated and shared with staff and managers and the results are used for ongoing staff training and updates. Comments include the following:

"Happy with support provided. Baby Café very good - didn't have this with my older child, it has made a big difference this time round."

"I feel I have had good support, I had lots of issues… the health visitor focused on what info was needed at each point in time and was always there if needed."

"Support was exceptionally good. Health visitor was great, also provided good support with other things, they were very approachable, I feel I can call anytime."

"Health visitor has been very supportive, very encouraging. When I moved to formula I was worried what the reaction would be but they were very supportive."

"The health visitor supports me with the whole family, not just the baby."

v. Weigh to Go Service

The HSCP, working alongside partners, delivers a range of programmes to improve diet and lifestyle choices and to mitigate the effects of food poverty. These include the 'Weigh to Go Service', which targets 12-18 year olds, supporting them to manage their weight, increase their physical activity levels, develop skills to enable them to prepare healthy, nutritious meals, and build confidence and self-esteem.

Over the last year, staff have worked with young people and their parents to co-produce a range of multi-purpose digital media resources which have been used within a pilot social media recruitment campaign using Facebook, Instagram and YouTube. This ran between May and October and included ten 'paid for posts'. The total reach of these was 68,572; there were 2,145 'post clicks' and 489 'reactions, comments and shares'. 60 young people expressed an interest in the programme and 35 went on to become engaged in it.

Overall, during 2018/19, the target of 100 was exceeded with 127 young people participating in the programme in Glasgow City, compared to 102 in 2017/18 and 100 in 2016/17.

77% of participants were from SIMD 1 & 2, demonstrating the impact of the programme in addressing inequalities.

CASE STUDY

One of those engaged by the service in the last year was a 14 year old with Down's Syndrome. They were referred by their GP in December 2018 due to sleep apnoea which had been exacerbated by their unhealthy weight. On presentation, their weight was 13st 6 lbs with a BMI of 49.19 (healthy BMI should be under 25).

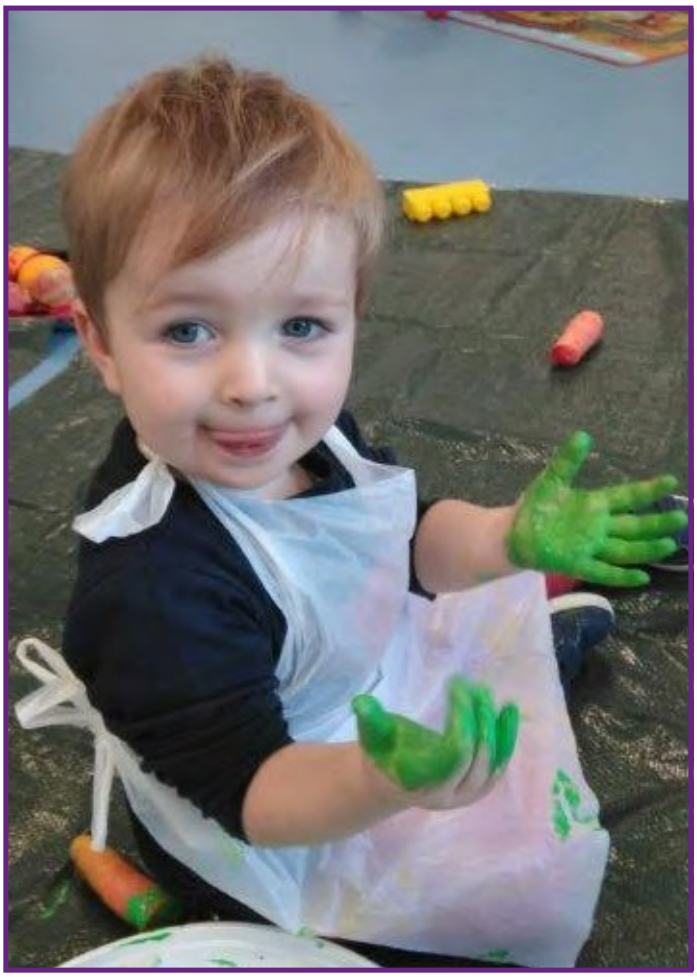
The young person's family were very supportive, with their parents actively involving them in choosing, preparing and cooking healthy meals. They also supported and encouraged them to engage in physical activities alongside the programme. The programme is delivered in partnership with Slimming World, with the programme leader providing visual support materials to help the young person to follow their eating plan. Wrap around support was also provided by the Weigh to Go outreach nurse, who liaised with the school and respite care provider to ensure the healthy eating plan was adopted there too.

Following participation in the programme, the young person was voted Slimmer of the Year by fellow class members and has a current weight loss of 3 Stones and a BMI of 40. Their sleep apnoea has also improved.

vi. Early Years

The development of every child in Scotland is assessed by Health Visitors at set intervals from pre-birth until the point they are due to start school so that help can be provided as required.

The "Ready to Learn" assessment prioritises each child's language, speech and emotional development as part of their preparation for nursery and then school.



This is a core part of the Scottish Child Health Programme and invitations are issued to all children when they are approximately 27 months old, with the assessment to be completed by 33 months.

In March 2019, the percentages of children who received a Ready to Learn assessment were 93% (NE), 90% (NW), and 89% (S). Although there have been increases since April 2018, when the corresponding figures were 88% (NE), 87% (NW) and 89% (S), performance remains below the Scottish Government target of 95%.

Unique challenges have been identified in Glasgow as a result of a disproportionately high number of families in the City who have newly moved in or out; who are part of the student population; or who are asylum seekers, for whom the target can be difficult to achieve.

Improvements have occurred as a result of action by Health Visiting teams to identify areas of low completion rates and to initiate corrective action. Efforts will continue going forward, to achieve ongoing improvement.

vii. Mental Health

Heads Up Website

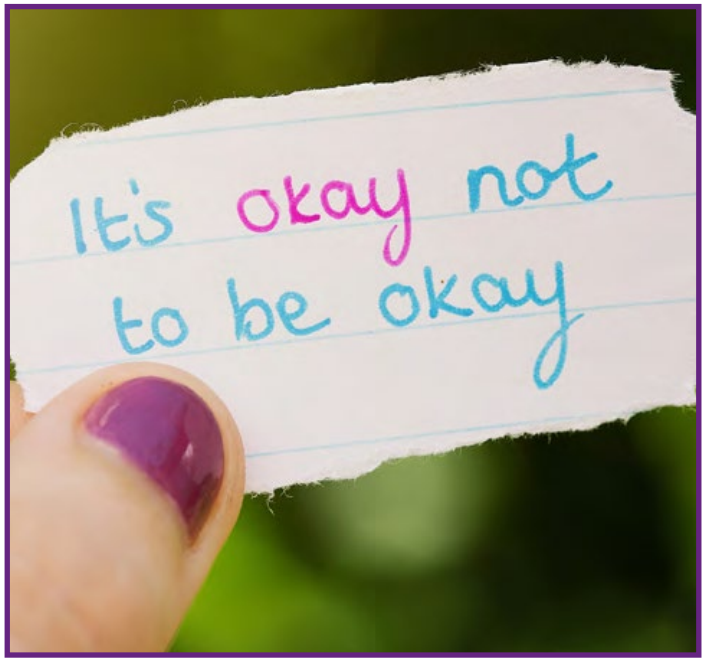
There is recognition at HSCP, NHS, Local Authority and Scottish Government level of the importance of harnessing technology in promoting self-management and supporting our focus on prevention and recovery. Within Mental Health, the **Heads Up** website was launched in 2018/19 to support this agenda. The design has been co-produced with inputs from staff and local user and community representatives and it was taken forward as a Glasgow School of Art Centre for Design Innovation project. This website provides a range of information about mental health conditions, including what helps; how to live with them; and how to care for someone experiencing them. Real life stories are also included in video, audio or written form, along with members of staff sharing information on what someone can expect when they care seen by care professionals.

Aye Mind

We have also continued to work with partnerships across NHS Greater Glasgow and Clyde to support and promote the 'Aye Mind' programme for youth mental health, which shares a range of digital resources to promote youth wellbeing (**www.ayemind.com** and on Twitter @ ayemind99). A suite of training materials has also been developed including the "On Edge" school curriculum resource; and the "What's the Harm" training programme which has been attended by more than 250 professionals from multiple backgrounds across the Health Board area.

Computerised Cognitive Behaviour Therapy Service (CCBT)

CCBT offers evidence-based psychological interventions for people who are experiencing mild to moderate anxiety and/or depression, and is referred to primarily by GPs. It comprises eight one-hour self-help sessions, which adopt a cognitive behavioural therapy (CBT) framework and can be completed at home. The service recently won the Accessing Mental Health award in the Holyrood Digital Health and Care Awards held in Edinburgh in February 2019. Over the period April 2018-March 2019, Glasgow HSCP generated 1234 referrals, with an uptake in 76% of GP practices across the city.



Suicide Prevention

All partners continue to work together to try and reduce deaths by suicide, with efforts being overseen by the multi-agency Glasgow City Choose Life Strategy Group, led by Glasgow HSCP. Activities are being informed by the new national suicide prevention action plan, Every Life Matters.

These activities include a range of suicide prevention training courses - including ASIST and SafeTALK - which are targeted mainly at NHS, social work and voluntary sector staff; and SuicideTALK, targeted more at community groups and other partners.

We now have a bank of over 20 SuicideTALK leaders in the city from a wide range of organisations, who are linking with third sector, business and community organisations to deliver these sessions.

In the past year, SuicideTALK sessions have been delivered to staff from bank call centres, the Department of Work and Employment, Job Centres, Land and Environmental services, housing associations and taxi drivers.

During the last year, there has been an increased number of courses delivered. This year's figures are shown below, with last year's shown in brackets:

- 339 ASIST courses (273)
- 331 SafeTALK (240)
- 302 SuicideTALK courses (81)

There has been a slight reduction in suicide deaths between the last two reportable periods, falling from 91 in 2016 to 88 in 2017.

viii. Glasgow Well-being for Longer Fund

The Glasgow Well-being for Longer Fund (GWLF) was established two years ago with approximately £520k funding from the HSCP and Impact Funding were successful in securing the tender to manage it on our behalf. The funding is available to local organisations across the city to support them to work with local people to improve their health and wellbeing, reduce isolation and inequalities, with a focus on prevention and early intervention. The funding has been secured for a further two year period 2019-2022.

During 2018/19, 28 organisations have been funded and there have been over 3400 beneficiaries. Feedback reported across the projects in line with the key aims and intended outcomes of the Fund include reduced social isolation and finding new friends; increased confidence and self-esteem; improved health & wellbeing; reduced stress and anxiety; new skills & knowledge; and increased independence.

2.3 PROVIDING GREATER SELF-DETERMINATION AND CHOICE

We are committed to ensuring that service users and their carers are supported and empowered to make their own choices about how they will live their lives and what outcomes they want to achieve.

Within this section, we profile some of the key developments progressed in relation to our strategic priority of Providing Greater Self-Determination and Choice. Activities undertaken have contributed to a range of the National Health and Wellbeing Outcomes, most notably the following:

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

i. Learning Disability Services

We have continued to extend Self Directed Support (SDS) services across the city and recently developed and implemented the 2019 Framework for selected purchased social care supports. This will assist all those involved in SDS care planning by providing the HSCP, service users and legal representatives with a range of quality assured providers who can deliver supported living, day opportunities, employability services and respite/short breaks. This Framework also aims to facilitate the further extension of Technology Enabled Care and support, as a new and innovative way to help service users meet their assessed needs and desired outcomes. A transformational change project is underway reviewing overnight supports which will explore the use of these technology options.

During 2018/2019, work has been undertaken to refurbish our two day centres in Riddrie and Calton. We also undertook a review process to consider how to improve joint working across health and social care learning disability teams and how to deliver services within an integrated model. As a result, team leader roles have been strengthened and a test of change pilot is underway in the North East locality where health and social work learning disability staff have been co-located. The learning from this pilot will inform the roll out of integrated working practices across the city.

ii. Listening to Children and Young People

The Children's Rights Service (CRS) offers rights information, support and advocacy to children and young people from Glasgow who are looked after and accommodated, and to young people people in continuing care and aftercare.

During 2018, 152 children and young people were supported by the service, with 664 reasons for support being identified by them. Other examples of work that the Children's Rights Service have supported in the last year include the following:

Digital Resilience Group

Young people in our residential houses have, for some time, been raising the issue of access to wi-fi and highlighting the inequalities associated with their lack of access to it. In response, the Digital Resilience Group was set up and has been working on the development of a digital resilience strategy and plan for looked after and accommodated children and young people. The underlying aim has been to ensure that as access is opened up, young people are 'digitally resilient' meaning they are able to make the most of the opportunities that technology offers, are aware of the risks and are able to recover from any setbacks they encounter online.

14 young people were supported to work with SNOOK (A service design and digital agency) to co-produce a framework that supports safe and appropriate access to digital and online services.

Online surveys and consultation events were held and over 100 children and young people aged 7 to 19 provided feedback upon their digital requirements, their use of digital technology and the internet, and any issues they had experienced. As a result of this work, wi-fi has begun to be installed across Glasgow's provided residential children's houses.

Young People's Champions' Board

Glasgow Young People's Champions' Board, PAC (People Achieving Change), has been in operation since February 2018 and is supported by a development worker from *Who Cares? Scotland*. It aims to ensure that the voices of children and young people are at the forefront of how we plan and deliver services for care-experienced children and young people. 22 young people have attended PAC on more than once occasion in the last year. The group have identified mental health as the key area they want to focus upon with corporate parents in the coming year.

USER/CARER FEEDBACK

Young people involved in PAC were asked about what they enjoyed about the group and feedback included the following:

"Having people listen to us."
"Knowing this is our group."
"Having corporate parents come to us."
"Being comfortable to speak within the group."
"Having power to make change."

Residential Worker Interviews

Young people have been supported to participate in interviews for children's residential care workers. 27 young people have joined interview panels where they asked candidates questions and took part in the decision making process.

The young people involved valued having an input into deciding who was working with them and were appreciative of the experience it gave them.

USER/CARER FEEDBACK

Social Workers use several tools to help children and young people to express their views and encourage participation. One such tool is Viewpoint, which allows the child or young person to complete a questionnaire linked to the GIRFEC (Getting It Right For Every Child) Wellbeing Indicators: Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible and Included. The table below presents a selection of questions taken from the Viewpoint Survey, along with the percentage of children who responded positively. Some of the questions are not applicable to both categories of children shown, so this is denoted as "not applicable (n/a)."

Viewpoint Question	% responding positively in 2018/19 (17/18 figures shown in brackets)		Children's Wellbeing Indicator
	Children Looked after away from Home	Children on the *CP Register or subject to *VYP procedures	
Would you describe yourself as happy?	**90%** (92%)	**93%** (85%)	**HEALTHY**
Do you feel safe where you live now?	**83%** (96%)	**N/A**	**SAFE**
Do you feel safe in your home?	**N/A**	**96%** (91%)	**SAFE**
Are things going well for you?	**100%** (89%)	**N/A**	**ACHIEVING**
Is your Social Worker someone you can talk to?	**96%** (85%)	**96%** (94%)	**RESPECTED**
Do you enjoy school?	**91%** (78%)	**81%** (82%)	**ACHIEVING**
Are you treated fairly where you live now?	**100%** (95%)	**N/A**	**RESPECTED**
Do the people or person looking after you notice when you have done well at something?	**100%** (98%)	**N/A**	**NURTURED**
Do you think your views are listened to?	**96%** (88%)	**97%** (74%)	**RESPECTED**
Do you take part in regular activities you like doing?	**90%** (92%)	**67%** (82%)	**ACTIVE**
Do you help out with the chores where you live now?	**85%** (78%)	**N/A**	**RESPONSIBLE**
Do you see your friends when you want to?	**82%** (80%)	**60%** (68%)	**INCLUDED**

*** CP - CHILD PROTECTION**
*** VYP - VULNERABLE YOUNG PERSON**

iii. Family Group Decision Making

During the last year, Family Group Decision Making (FGDM) progressed from an initial pilot to being established across the city. FGDM is based on the principle of family and community empowerment.

With support from an independent facilitator, families work together to develop a realistic plan that meets the child's needs and keeps them safe.

This process transfers control from professionals to the family group, and aims to reduce the need for long term statutory social work intervention and for children to come into local authority care.

2018 has also seen the completion of the first year of the Lifelong Links Trial, a 3 year UK-wide study sponsored by The Family Right Group across 10 UK sites.

The trial is evaluating a model that renews and develops relationships between children (up to age of 5) who are looked after and accommodated, and their friends and family who may have become estranged.

The model adopts a process similar to FGDM and asks family and friends to commit to renewing or forming a relationship with that young person. This service will be extended to a wider group after this year's successful pilot.

In the last 12 months, the FGDM team received 831 referrals which has so far culminated in 163 family meetings (compared to 415 referrals and 58 meetings in 17/18).

Extended Family Network Searches (EFNS) have also continued alongside FGDM. These seek to identify extended family members of children and young people, enabling relationships to be built or rebuilt and support an increase in the number of kinship carers and placements in the city, as alternatives to foster or residential care.

To date, since it started 374 EFNS have been completed and in total, 6000 family members found who had not been known to Social Work Services previously (rising from 170 and 3084 in 2017/18).

CASE STUDY

A referral to the FGDM team concerned the unborn baby of a young woman who had been removed from her family at an early age and had been looked after and accommodated since. With the breakdown of her final placement in a children's unit, followed by homelessness and pregnancy, her route out of care was chaotic. The young woman was now involved with a fairly aggressive, hostile man, who was not the father. There was some urgency to the case, as the referral came in just before the pre-birth conference, and only a few weeks before the baby was due.

At the pre-birth meeting, there were concerns as the young woman prioritised her partner's needs over those of her future child. There was also evidence of chaotic behaviour, and the risk of domestic violence by the partner. The young woman was asked to consider going into a mum and baby unit, or living with her mum, but she refused and it was decided the baby would be removed from her at birth.

The FGDM team arranged a family meeting with the hope of drawing the family around this young woman. Given that she had been removed from her own mother and father, the area team had reservations about the grandparents as potential carers given they has experienced addictions issues themselves. The FGDM worker met the grandmother and discovered she had changed her life completely. The grandmother acknowledged she had not looked after her own children, but indicated that she had not used drugs in ten years, was not involved with criminal justice and had maintained a tenancy. Although separated, she remained friends with the grandfather.

The family meeting went ahead and the resulting family plan noted that on discharge from the hospital after the birth, the baby would go to the grandmother. When the mother visited for contact, they wanted this to be at the grandmother's house, as it was as "*a familiar space and not social work*". As the daughter could be aggressive and violent, the grandfather offered to be there to help manage things. Overall, they came up with a "fantastic contact plan".

Once the baby was born, the mum no longer wanted the baby to go to the grandmother. The area team had to request a Child Protection Order (CPO) from the Sheriff Court, which was granted and the child was placed with the grandmother. The mum did not maintain the contact and at a subsequent Children's Hearing, this was terminated. The baby remains in her grandmother's care and remains safe, "*when the destination probably would have been foster placement*" if FGDM had not been in place.

iv. Employability

Continuing Care Team
Social Work Services deliver four employability support services to young care leavers (16-25 years old): Care Leavers Employment Service (CLES), Coreskills, Launchpad and the Housing and Employment Service (HES). These deliver a range of holistic employability supports for care leavers across the five stages of the employability pathway.

Project Search
Project Search is a service is for young people from Glasgow aged 18-25 years who have a learning disability or autistic spectrum condition and want to start their journey into employment.

The service is delivered by a multi-agency partnership including Glasgow City Council, NHS Greater Glasgow and Clyde, Glasgow Clyde College, City of Glasgow College and Autism Network Scotland.

When they have completed their work with Project Search, the Glasgow Supported Employment Service supports successfully participants into a first paid job.

During 2018/19, the project supported 31 people into full time employment, a slight increase on the 29 that were supported in 2017/18.

CASE STUDY

Despite applying for over 100 jobs and securing 20 interviews, E struggled to find a job. Nerves got the better of him during interviews and he clammed up when quizzed about his abilities.

After completing Project Search, Glasgow's Supported Employment Service were able to set him up with a work trial at a golf club. He has since moved from kitchen porter up to sous chef in the club restaurant. He is described by his manager as "*a model employee and an asset to the company, with a strong work ethic.*".

His resilience was recognised in February when he was presented with both the Outstanding Award for Employment and the overall prize for Outstanding Journey and Achievement at the Glasgow City Council's Leaders awards, which recognise the achievements of looked after and accommodated young people.

v. Glasgow Recovery Communities

Recovery communities encourage people using drugs and/or alcohol into recovery, by offering them opportunities to engage with others who have achieved this.

Around 600 - 800 people participate in these communities on a weekly basis. The initiatives offered include alternative therapies, talking groups and social activities, all of which complement services offered through Alcohol and Drug Recovery Services and other statutory agencies.

These recovery communities are managed and organised by volunteers and aim to develop the volunteers' confidence, skills and knowledge which should ultimately prepare them for employment or further education.

A partnership with Glasgow Kelvin College has resulted in 58 volunteers completing the Community Achievement Award; 35 volunteers accessing SVQ and HNC courses; and 2 volunteers securing university places.

In recognition of their valuable work Glasgow Recovery Communities were finalists in Glasgow's 2018 Inspiring Cities Award, in association with People Make Glasgow and Glasgow Chamber of Commerce. In November 2018, they also won the Healthier Lifestyles Award at the 2018 Scottish Health Awards.

CASE STUDY

"I first came into recovery in May 2018. I was broken with no self-esteem, no confidence and no hope. I was referred to a recovery programme and started attending North West Recovery. At first I would just watch, as I'm not very good with people but I was slowly encouraged to join in. The arts and crafts were really therapeutic and my skills and self-esteem grew and I felt better within myself. Being a part of something is worthwhile and rewarding. Getting to know people, having easy conversations and a laugh with everyone, is great for your mental health and spirit. I've sustained my recovery, built confidence and skills, and rebuilt relationships with my family. I'm in a good place. I couldn't do this without the recovery support backing me up. I didn't imagine life could be this good."

"I started using drugs age 14 and was in and out of prison from the age of 16. I had mental health issues and family relationships had broken down. Following a long period of chaotic drug and alcohol use, I was referred to Glasgow Addiction Services and started to engage with services where I learnt basic life skills and was introduced to voluntary work. I became involved with South Recovery Communities creating a platform for my recovery. The stability this brought enabled me to rebuild relationships with my children, sustain a tenancy and embark on a course which led to me achieving a diploma in Social Sciences. I then achieved further qualifications and secured full-time employment with Glasgow HSCP Alcohol and Drug Recovery Services."

"Aged 12, I started drinking and soon afterwards I found drugs. I ended up in and out of prison a lot, lost my job and when my kids were removed to foster care, I reached rock bottom. I was fortunate to be offered treatment and got the chance to realise that I could live my life without drugs and alcohol. I started to socialise and went to my first recovery cafe in the North East. I learned how to build positive relationships and be a better person and after time I started volunteering. My life has now flipped and is totally different. I secured a good tenancy through Recovery Housing. My children were returned to my care and I have a great relationship with them. I have a new job as a trainee support worker in the treatment centre I attended and have achieved a SVQ Level 3 in Social Services and Healthcare. Every day is a great day to wake up to when you realise you have a purpose. Life is great."

vi. Personalisation

Personalisation, as outlined in the Social Care (Self-directed Support) (Scotland) Act 2013, has now been widely adopted across the City and is used as appropriate according to individual needs and circumstances.

This provides people with greater choice and control over the nature of the support they receive.

At the end of March 2019, a total of 3,208 adult service users were in receipt of personalised social care services, an increase of 7.1% since March 2018 (when was 2,994). Children with disabilities in receipt of personalised services rose by 44.6% over the same period (from 184 to 266). Between March 2018 and March 2019, there was no change in the proportion of service users who chose to receive their personalised budget as a direct payment, which remained at 15%.

2.4 SHIFTING THE BALANCE OF CARE

Services have been transformed over recent years, with the balance of care shifting away from institutional, hospital-led services, towards those that support people in the community, promoting recovery and greater independence wherever possible.

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

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

i. Children's Services

Glasgow's **Transformation Programme** for children's services aims to deliver a sustainable shift in the balance of care for Glasgow's children, young people and families, by strengthening local community infrastructure and emphasising the role of prevention. There is also a commitment to spend more of the HSCP's resources in the city, to ensure that where possible children and young people are helped to stay at home, in their local neighbourhoods and attending their local schools.

The Centre for Excellence for Looked after Children in Scotland (CELCIS) is supporting this programme, and has introduced a coaching approach across teams to strengthen supervision and practice, share learning and encourage collaboration.

They are also providing practical learning and development opportunities for leaders, managers and practitioners.

Glasgow Together Consortium
The above changes are supporting the increased investment and enhancement of family support services and will be critical in sustaining the shift in balance of care in the longer term. A new model called the Glasgow Together Consortium was piloted in the North East in the last year and will now roll out across Glasgow. This has involved the HSCP and 6 third sector organisations (Rosemount Learning Centre, Barnardos, Woman's Aid, Geezabreak, Homestart and Quarriers). Funding of £800,000 has been secured through a Big Lottery grant for the next 3 years, with an additional £200,000 being provided by the HSCP.

The agencies involved interact with families when they are first referred to Social Work and agree which services would be most appropriate to help them.

The aim is to support families at an early stage, preventing further deterioration and a crisis developing, which may require statutory social work intervention and result in children being looked after away from home. The pilot project indicated that as many as one family in three who eventually received Social Work support would have been helped by this type of consortium arrangement.

High Cost Placements
Over the last year, the number of high cost placements for young people fell to 51, slightly above the year-end target of 47. This has, however, fallen from 111 in March 2017 and 67 in March 2018 and the reduction in our use of these placements has been a major success story, generating savings and opportunities to re-invest in prevention and earlier intervention.

Accommodated Children
The number of children and young people being looked after by the Council also continues to fall. At the end of 2018/19, the total recorded number of children accommodated was 1006, falling from 1125 (2017/18) and 1227 (2016/17). The number of children being looked after at home also fell to 1572 from 1614 (2017/18) and 1627 (2016/17).

Foster Care
Purchased foster placements are also reducing as planned. At the end of March 2019, there were 267 children and young people in purchased foster care placements, compared to 319 (March 2018) and 426 (March 2017).

ii. Older People

Through the **Transformation Programme** for Older People, the HSCP is aiming to support a shift in the balance of care away from institutional care (hospital and care homes) towards enabling more people to live within the community, with the support of community based services and supports. Alongside this, there is an intention to enable and support people to enjoy the best quality of life possible, informed by their own choices and wishes.

We have also developed a three dimensional programme of Unscheduled Care aimed at preventing admission to hospital and supporting more people to live at home.

Work progressed over the last year has included the following:

Prevention and Early Intervention
Actions to prevent admission and better support people in the community have included:

- Implementing anticipatory care plans within specific patient groups e.g. COPD, residential care home clients etc.
- Introducing a frailty screening tool to better manage frailty within the community.
- Working with care homes to reduce hospital admissions including rolling out the red bag scheme (see below).
- Working with the Scottish Ambulance Services to reduce the number of falls conveyed to hospital as part of a wider falls prevention strategy.
- Continuing to develop the palliative care fast track service.
- Extending the community respiratory service to provide a service over weekends.

Hospital Discharge
Actions to improve hospital discharge and better support people to transfer from acute care to community have included:

- Implementing the Home is Best team.
- Developing the Intermediate Care Improvement programme (see below).
- Extending intermediate care capacity as part of the winter planning arrangements.
- Purchasing additional Red Cross transport and support.
- Continued robust performance management of delays.

Primary/Secondary Care Interface
Actions being taken forward jointly with acute to better manage patients in the most appropriate setting include:

- Reviewing acute assessment unit referrals discharged on the same day, to explore scope for managing this activity as part of planned care.
- Reviewing repeat A&E attenders to explore scope for an early intervention approach to reduce attendances.
- Introduction of condition specific re-direction policy at Glasgow Royal Infirmary.
- Introduction of a test of change involving consultant geriatricians and GPs to better manage care home patients.
- Introduction of consultant connect at the Queen Elizabeth Hospital to improve GP- Consultant communications.

Progress in these areas continue to be reported nationally to the Ministerial Strategic Group for Health and Community Care (MSG), who request a MSG plan from each Partnership. These Plans are required to cover a number of unscheduled care indicators, with progress in relation to some of these key indicators set out below. (see also chapter 5).

A continued gradual rise in the number of new A&E attendances, from 203,819 (16/17) to 206,596 (17/18) and then 212,516 (18/19), above the intended 18/19 target of 197,542.

These have contributed to ongoing challenges in meeting the four hour A&E waiting time target (95%), with performance below target at both acute hospital sites (81% at GRI and 83.2% at QEUH for Mar 2019).

Emergency Admissions (all ages) have increased slightly to a monthly average of 5925 but are so far meeting the 2018/19 target (6312). These have been falling over time from 6304 in 2016/17 and 5808 in 2017/18. (Apr 18 – Jan 19).

There has been a reduction in the number of Unscheduled Hospital Bed Days (all ages). These have fallen to a monthly average of 40,014 (18/19) from 42,097 (17/18) and 43,763 (16/17), although they remain above the 18/19 target of 37, 857. (Apr 18 – Jan 19).

There has been an increase in Delayed Discharges and associated Bed Days Lost for over 65s. Bed Days Lost have risen to 15,288 (18/19) from 10,982 (17/18), having fallen prior to that from 21.888 (15/16) and 15,557 (16/17).

Red Bag Scheme

The Red Bag Scheme involves the provision of a transportable red bag to care homes which is used to store information, medication and property for care home residents who require unplanned acute attendance and/or admission. If the resident is admitted, the Red Bag follows the resident through their journey into acute and back to the care home.

Staff in each sector use it to provide key information on transfer, which speeds up processes and supports decision making. Glasgow City HSCP has led the implementation of the scheme across the Health Board, covering 70 care homes in Glasgow and a further 200 homes across the Board area.

This process began with a pilot in July 2018 and has been fully implemented from December 2018.

The HSCP has worked with partners including acute and the Scottish Ambulance Service to raise awareness and ensure this bag is clearly identifiable to all staff, patients and carers alike.

Initial board-wide performance suggests reduced attendances and admission from care homes, with further gains anticipated as the Red Bag scheme becomes more fully established.

USER/CARER FEEDBACK

Initial feedback from stakeholders including residents, relatives and carers has been very positive. Care Homes see it as simple and have reported benefits such as:

- Quicker processes in support of the transfer to acute.
- Reduced unnecessary calls from acute.
- Higher return rate of key information and resident property.

Acute colleagues have noted:

- Information now available to support decision making that wasn't previously, reducing the need to make time consuming calls to care homes.
- Improved dialogue with care homes.
- Benefits of visual impact of Red Bag at Assessment Unit or Ward level.

Qualitative evaluation has also noted where further work is required including raising awareness across acute colleagues; and improving processes when a resident may not return to their original care home, to enable the Red Bag to be returned to the original home.

Intermediate Care
During 2018/19, we have been implementing an improvement programme in response to an internal audit undertaken in 2017/18, with the aim of improving throughput, reducing length of stay and increasing the number of people being discharged home.

Aspects of the programme which have been taken forward include consideration of good practice from other areas and how this might be applied locally; the hosting of three practice development sessions that brought together staff from across localities to share best practice and encourage joint working; the development of an Intermediate Care assessment report and home care ordering pathway; and the production of risk enablement practice guidance.

There is a target of 30% plus for the proportion for the numbers of older people returning home from intermediate care. Performance in relation to this fluctuates and having met the target for the majority of the first part of the year, performance has been below target for the last five months and was 24% in March 2019.

iii Adult Services

A broad range of areas come under the banner of Adult Services in Glasgow City HSCP. These include mental health; sexual health; homelessness; criminal justice; alcohol and drugs; and disability.

The Adult Services **Transformation Programme** sets out the aim of shifting the balance of care and delivering more effective community based services. It signals a clear intention to shift the focus to enabling and supporting those that require support to enjoy the best quality of life possible, informed by choices they make for themselves.

Key aspects of the programme which have been progressed over the last year include the following:

Mental Health Strategy
Glasgow City HSCP has a lead co-ordinating role on behalf of all six HSCPs in NHS Greater Glasgow and Clyde in relation to mental health services. Over the course of the last year, Partnerships have continued to work together to deliver the 5 year strategy for mental health (2018-23). Funding has been allocated across the Health Board area, with Glasgow City receiving £1.3 million for 2018/2019. We have developed a local **Implementation Plan** which outlines our priorities for the city and how we will contribute to Board wide initiatives. Examples of how this funding will be used include:

- Development of Mental Health Support Training for staff - the commissioning of accredited training for staff working across mental health services including those working within the third sector.
- Computerised Cognitive Behaviour Therapy (CCBT) - roll out with the service being actively promoted across community and primary care mental health teams.
- Development of a Recovery Orientated System of Care - peer led model delivering effective supports and routes to training and employment for services users going through the recovery journey.

Sexual Health Strategy
In March 2018, the IJB approved a Transformation Programme and direction of travel for **Sexual Health** services.

Over the last 12 months, the service has been working towards a new 3 tiered service model, which aims to improve access to services and the quality of the overall care journey. Key aims have been to increase the engagement of young people and further develop self-management approaches and opportunities. Developments have included:

- An online platform on which clients can be triaged; order a home-delivered test for chlamydia, gonorrhoea, syphilis and HIV; receive their results; and if required be referred to appropriate clinical services.
- Work to enable clients to order their contraceptive pills and then pick these up at a local pharmacy.
- Redesign and user testing of the website which has made information much more accessible.
- Introduction of an Early Medical Abortion at Home (EMAH) option. This reduces delays and the number of clinic visits required and lowers demands on acute services. This has proved to be a popular choice for women. Monthly numbers have risen to around 120 women per month and are expected to rise further as awareness grows.

Rapid Rehousing Transition Plan (RRTP)

During 2018/19 the HSCP participated in the formulation and worked to implement, the Scottish Government's Homelessness and Rough Sleeping Action Group (HARSAG) recommendations. This has involved moving to a Rapid Rehousing and Housing First response to homelessness as the default approach, if homelessness cannot be prevented.

Glasgow's 5 year **Rapid Rehousing Transition Plan** (RRTP) has been approved during the last year which renews the focus on the Housing Options and Housing First approaches; and work has been undertaken to improve internal assessment and referral processes. These supported the successful decommissioning of Clyde Place and the re-provisioning of Rodney Street, completed in September 2018, which involved 84 service users.

Homelessness Services have continued to work with partners to improve service responsiveness and outcomes for homeless individuals presenting with complex needs. During the last year, we have been taking forward the development of a rapid response multidisciplinary hub service for homeless adults with complex needs, within which a range of interventions will be delivered, from advocacy to treatment and care. Agreement on budget has been achieved and plans progressed with the intention of the service becoming operational by mid-2019.

Criminal Justice

Personal/Unpaid Work Placements

One of the Scottish Government's main justice commitments is to extend the presumption against short prison sentences to 12 months. Personal placements are integral to the Unpaid Work (UPW) Process which support this aim.

In Glasgow there are 60 personal placement providers incorporating charities and other services and 34% of UPW hours are completed in these placements.

In June 2018, the HSCP Criminal Justice service and Criminal Justice Glasgow hosted a visibility event for personal placement providers in order to recognise and thank them for their contribution to making Glasgow a safer city.

Another event was held in March 2019 for unpaid work purchased placements. This explored the use of Community Payback Orders and Unpaid Work Requirements and highlighted the advantages and outcomes for both individuals and communities, with the aim of increasing judicial confidence and encouraging their use as alternatives to prison sentences.

Drug Court/Alcohol Court:
The Glasgow Alcohol Court - introduced in February 2018 - is a partnership between Glasgow Sheriff Court, Criminal Justice Social Work and Alcohol and Drug Recovery Services. It deals with individuals appearing at Glasgow Sheriff Court who have pled guilty to, or are convicted of, charges in which alcohol abuse has significantly contributed to the offending.

It seeks to provide individuals with an alcohol assessment and immediate access to community based interventions, as part of a Community Payback Order (CPO) or Structured Deferred Sentence (SDS). The aim of the court is to deliver sentences which are tailored to influence an individual's behaviour and hold them accountable, with progress being subsequently rigorously monitored.

There were 108 unique cases dealt with by the Alcohol Court in 2018 and 11 new cases since 1st January 2019. The court is now averaging 2 to 3 new cases each week and an additional Sheriff was recruited in October 2018 in response to the increase in numbers. In 2018, 41 CPOs and 26 SDSs were made. Only 8 warrants were issued throughout 2018. This is substantially lower than other courts considering there were 337 individual court appearances throughout this period. The HSCP have agreed to further support the court in 2019 by having a social worker and addiction team leader present to provide advice to the sheriff and initiate referrals into treatment.

CASE STUDY

M was given an Unpaid Work Order. At the start, she was really anxious about doing her hours. She hadn't worked in a long time and had spent her time caring for her husband who is disabled and helping to look after her grand-children.

She got a placement in Barnardos and completed the programme successfully. She actually undertook more hours than was required and is now continuing to work on a voluntary basis. She has been trained to operate the tills and works with and supports new starts. HSCP staff have commented how the difference in her is amazing and how she is much more confident and positive about things.

2.5 ENABLING INDEPENDENT LIVING FOR LONGER

Work has continued to be progressed across all care groups to support and empower people to live healthy, meaningful and more personally satisfying lives as active members of their community, for as long as possible. Within this section, we profile some of the key developments progressed in relation to our strategic priority of Enabling Independent Living for Longer.

Activities undertaken have contributed to a range of the National Health and Wellbeing Outcomes, most notably the following:

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

i. Integrated Older People's Teams

Progress has continued with the development of integrated health and social care teams across 10 local neighbourhoods in the city which are broadly aligned with GP clusters. HR (Human Resources) processes have been concluded and each neighbourhood has a management and leadership team comprising a service manager and team leaders for community nursing, social work and rehabilitation and enablement. As a result, we are now beginning to see progress in how services working together in an integrated way, can support people to remain at home and maintain their independence.

Alongside this, we have developed a single HSCP Hospital discharge function, moving away from locality based services. A service manager has been appointed who has worked to develop consistent processes and ways of working. The service aims to improve delayed discharge performance and enable the smoother transition of patients from acute hospital care to intermediate care and other community based care settings.

ii. Home Care and Reablement Services

Home Care services were transferred from Cordia LLP to Glasgow City HSCP in October 2018. These services aim to provide care and support to enable people to live as independently as possible in their own home.

All service users who require a home care service are initially screened for suitability for reablement.

This service provides tailored support to people in their own home for up to six weeks and aims to build confidence and help them to regain skills to do what they can for themselves at home.

USER/CARER FEEDBACK

Just prior to the transfer of Cordia LLP to the Health and Social Care Partnership, Cordia conducted a service user consultation on the Home Care service.

The headline figures for the 2018 survey are presented below along with the figures for the 2 previous surveys (2016 and 2017) for comparison. The 2018 figures are based on the results from 1,631 completed questionnaires.

The results of the 2018 survey are consistent with the previous years' results. The figures continue to demonstrate a high degree of satisfaction with the service in general, for example 86% of service users agree that they feel safer at home, and 84% agree that their home carers have improved their quality of life.

The professionalism of home carers was again highlighted during 2018, with 98% agreeing that their home carers are helpful and friendly, and 98% agreeing that their home carers treat them with dignity and respect.

Statement	% who "strongly agree" / "agree" with statement			National Health and Wellbeing Outcome
	2016 Survey	2017 Survey	2018 Survey	
The home care service I receive has made me feel safer at home	**84%**	**86%**	**86%**	**Outcome 7**
The contact I have with home carers has improved my quality of life	**81%**	**86%**	**84%**	**Outcome 4**
I get up and go to bed at times that suit me	**84%**	**85%**	**84%**	**Outcome 3**
I feel that I am listened to and my wishes respected	**85%**	**86%**	**85%**	**Outcome 3**
The home care service enables me to maintain the standard of personal care that I want	**87%**	**91%**	**90%**	**Outcome 4**
My home carers are helpful and friendly	**97%**	**98%**	**98%**	**Outcome 3**
My home carers treat me with dignity and respect	**97%**	**97%**	**98%**	**Outcome 3**
My home carers are thorough at what they do	**88%**	**91%**	**91%**	**Outcome 4**
I feel that my right to confidentiality is respected by my home carers	**92%**	**93%**	**94%**	**Outcome 3**
I am confident that my home carers have the training and skills to support me	**89%**	**90%**	**91%**	**Outcome 8**
Telephone calls to the Cordia office are always answered promptly	**76%**	**82%**	**78%**	**Outcome 3**
The Cordia office staff are always polite and helpful	**86%**	**90%**	**87%**	**Outcome 3**
Cordia managers and staff respond to any concerns I have about the service	**73%**	**78%**	**76%**	**Outcome 8**

iii. Supported Living Services

A key strategic aim is to shift the balance of care by enabling greater numbers of older people to be supported at home with enhanced packages of care, while reducing the numbers going into residential or nursing care. To this end, the Partnership has been working with care providers to expand the number and range of Supported Living options in line with our wider accommodation based strategy.

The HSCP has exceeded its 2018/19 target (830), with 842 packages in place at the end of March 2019. This has risen from 734 at the end of 2017/18. In 2019/20, we will seek to build on this, in order to maximise the number of older people in the city who can access and benefit from these enhanced packages of support.

CASE STUDY

A is a 94 year old widowed lady who lives on a second floor privately let tenement flat. She has two sons, one who has Power of Attorney both welfare and financial. In 2012, the lady was admitted into hospital after a fall and on discharge was offered mainstream support. In April 2017, staff reported concerns around the lady staying at home on her own with poor memory and high incontinence levels. Subsequently a referral was made to the Supported Living Service and a care plan was put in place to assist with all aspects of her personal care, including food preparation and social support. Her carers felt multi-agency involvement was required and contacted her GP who prescribed antibiotics and arranged for a district nurse visit. An OT assessment was also requested for a more suitable chair to meet the client's needs. A review was held after 4 weeks from start date and the care plan was changed to add an additional visit for toileting. This reduced the time in between visits, as there was still some issues in relation to her incontinence.

In terms of outcomes, the lady engaged well with the service and her son was very happy as his mum was benefiting from the additional time and social support provided by the carers, including reminiscence. He said his mother wanted to remain living independently within her own home and that the service had exceeded his expectations and was providing reassurance for the family in terms of the lady's safety. His mother was now more alert and animated during his visits, and frequently spoke of quality time spent with carers during her social time.

USER/CARER FEEDBACK

Research was undertaken in the last year specifically with clients of Cordia's Supported Living Service (SLS) which involved service users, carers, home carers and Social Work staff. Key findings were:

- 100% service users rated the service as satisfactory compared to 73% unpaid carers.
- 100% service users and unpaid carers said SLS staff had treated them with respect and dignity.
- 100% service users said the SLS homecare staff had spent quality time with them and 93% unpaid carers said the same.
- 90% service users said they had been listened to regarding their care packages and getting things done the way they wanted. 93% unpaid carers said the same.
- 80% service users and 76% unpaid carers said they were notified of changes to their care package.
- 90% service users and unpaid carers said SLS had made it possible for the cared for person to stay in his/her own home.
- 80% service users and 87% unpaid carers also said the cared for person felt more comfortable and safer in their own home.
- Areas where rating was 70% or less included: being in control of their own life, feeling independent, feeling happier, and/or feeling more confident.
- 90% service users and 86% unpaid carers were able to shape the care package.
- 89% service users and 97% unpaid carers knew who they could contact related to the care package.
- 80% service users knew who their home carer was.
- 60% service users knew what was in the care plan. There is evidence that the lower percentage score could be related to service user's age, frailty and physical/ mental condition(s).

"The girls are fabulous and go out of their way to make their client safe and comfortable. The service is 100% better than our previous package". (unpaid carer)

"I think that if this had not been put into play, I would be the one that is ill. Delighted with the team and my brother gets to stay at home and keep his independence". (unpaid carer)

"But when I am not feeling well, they help me to do the things that I am not able to". (service user)

iv. Telecare

The dedicated Telecare Reform Team, established in March 2017, has continued to work towards developing improvements to the HSCPs Telecare Service throughout 2018/19. The Localised Responder Service is now delivered by HSCP Care Services, having successfully transferred over after initial pilot projects. A more efficient referral process, including an online referral pathway and an improved GOLD training module has also been developed over the last 12 months and will be launched Summer 2019.

There is increasing recognition of the challenges that the analogue to digital switchover will bring and the Telecare Reform Team have been participating in the 'Can Do' Challenge, which is a new Small Business Research Initiative (SBRI) competition launched by the Scottish Government in association with Scottish Enterprise, and Innovate UK.

The aims are find innovative new solutions within public sector areas and involves working with SMEs (Small and Medium-sized Enterprises) with a view to develop products which ultimately can be marketed nationally. The Partnership's 'Technology Enable Glasgow' bid was one of the 6 selected bids (from a total of 44). The first phase of the award was for £150k and is nearing completion, and we have been working with 5 companies on this.

A further £300k is available for phase 2 and if successful will involve us working with a maximum of two companies. The Scottish Government have been very supportive of our application and have advised that they will be seeking to use this project as an exemplar for future funding in this area.

Over the course of 2018/19, targets have been met for the number of referrals for traditional basic telecare equipment (2706 against target of 2248), although there has been a slight reduction from 2017/18 (2771).

The target for more sophisticated advanced technology have also been exceeded (1337 against target of 304), with the numbers rising since 2017/18 (1222). This includes technology designed to track older people's movements and provide families with peace of mind when an older relative is at risk of wandering as a result of dementia.

v. Supporting Carers

Supporting carers is a key aim within the Strategic Plan and all care groups have agreed to assume responsibility for identifying, referring and supporting carers, and monitoring their performance in respect to referrals and the completion of Adult Carer Support Plans and Young Carer Statements.

Activity to identify carers have included:

- Significant work has been undertaken to raise awareness of carers within the new GP cluster structures. This included the distribution of over 1300 carer booklets and the introduction of the SCI-Gateway (Scottish Care Information) electronic referral route in July 2018.
- Distribution of almost 1900 booklets to services in contact with carers as part of the hospital discharge process.
- Over 250 young carer awareness raising sessions delivered in partnership with education, including school assemblies, which reached approximately 13,000 young people.
- During the year, there were also 564 calls to the Carers Information Line.

All services involved with the Carers Partnership continue to ensure that adult and young carers are identified earlier in their caring role and 68% of new referrals were for anticipatory support.

Over 2018/19, 1984 new carers have been identified and offered an Adult Carers Support Plan. 110 new Young carers were identified in the period and 70 completed a Young Carer Statement. Combined, the total of 2054 plans/statements exceeded the annual target of 1650, and was slightly above the 2017/18 figure of 2016.

USER/CARER FEEDBACK

Feedback forms are sent to carers after their assessment has been undertaken and services are in place. Returns show that the percentage who believe the support they received has improved their ability to support the person they care for, has consistently been above 80% throughout the year, in excess of the 65% target.

vi. Income Maximisation

Income maximisation services are in place across health and social work services as below:

Social Work Clients
The HSCP Welfare Rights service visit people in receipt of a range of chargeable social work services to ensure that they are receiving all relevant benefits to which they are entitled.

During 2018/19, £4.55m (£2.87m ongoing and £1.68m in arrears) has been generated in successful claims for benefit for service users receiving a chargeable service. This compares to £4.19m made in the same period in 17/18.

During 18/19, the service also represented 1,392 clients at social security tribunals (mainly for adult disability and incapacity for work benefits), compared to 1715 last year. Analysis of the results for the concluded appeals show a 81% success rate with an average financial gain per successful appeal of £7340.

This compares with a success rate of 73% in 2017/18, when there was an average financial gain of £ 8,244 per successful appeal. These last two years have exceeded expectations, as prior to this, the average was in the region of 65%.

Health Clients
The HSCP also supports a Financial Inclusion Partnership which, along with Glasgow City Council and the Wheatley Group, offers a range of local advice services for NHS HSCP staff to refer patients to. Health Improvement Teams across this city are engaged in raising awareness of, and promoting this service, which has a strong child poverty focus.

This area of work continues to see year on year increases in referrals, individuals seen, amounts raised and debt supported. During 2018/19, across the Financial Inclusion Partnership, there were 5128 referrals (compared to 4,311 in 17/18) and 3721 individual clients seen (3,246 in 17/18). Financial gains were just over £8.7m (£7.3m in 17/18), with over £1.5 million of housing and non-housing debt managed (£750k in 17/18).

Over the last year, two GP clusters have been operating embedded money advice staff as part of the primary care team. The client financial gain for these two clusters was over £2.4m and expansion of this service to two other clusters is planned for 2019/20. An evaluation from **Glasgow Centre for Population Health** offers a detailed review of one of the clusters.

USER/CARER FEEDBACK

"This has been one of the most successful projects that I have been part of in 20 years in General Practice. To be able to offer a practical solution to address the financial causes and consequences of both physical and mental illnesses has been invaluable. The burden of illness often impacts on the patient's ability to work, which can in turn lead to debt which further exacerbates mental health issues. The benefit of having an expert money advisor has been enormous."

Health Improvement staff have also been taking forward a pilot project in response to the Child Poverty Act (2017). The 'Poverty in the Early Years' pilot project has engaged with parents and carers to understand the financial pressures of a child engaging with early years education.

It also provided early years staff with training on the impacts and causes of poverty and included a section on raising the issue of money worries with families. Enhanced training was also developed which encouraged nurseries to consider the additional costs of engaging in nursery activities, and to develop actions which would reduce or eliminate these pressures.

A referral pathway for nursery establishments to refer parents for money advice through the Wheatley Group MyMoney Service has also been introduced. During the last twelve months, 17 establishments received training with an additional 3 sessions planned. A final project report is due in summer 2019.

2.6 PUBLIC PROTECTION

We have continued to 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. Within this section, we profile some of the key developments progressed in relation to our strategic priority of Public Protection.

Activities undertaken have contributed to a range of the National Health and Wellbeing Outcomes, most notably the following:

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

i. Adult Support and Protection

During 2018/19, there were 302 Adult Support and Protection Investigations completed, a decrease from 2017/18 (361) and 2016/17 (372). New recording arrangements were introduced in November 2018, however, which may cause fluctuations in figures until they become fully embedded.

Self-Evaluation

Adult Support and Protection work in the city is overseen by the multi-agency Glasgow Adult Protection Committee (APC), which has various sub-groups, including a specific service user sub-group. This Committee undertakes regular monitoring of our Adult Support and Protection processes, interventions, policies and procedures.

A joint self-evaluation was carried out in September 2018, led by the HSCP, with multi-agency involvement from primary and acute health services and Police Scotland. This involved scrutiny of a random sample of 30 cases which went to full case conference, in relation to two key outcomes: i) adults at risk are safe from harm, supported and protected; and ii) key processes are appropriately followed through. This found that:

- 87% of individuals saw an improvement to their circumstances in relation to safety, support and protection.
- Choices of individuals were respected, and a small percentage of individuals chose not to take the support offered to them.
- 90% of carers felt appropriately involved and consulted with throughout the ASP process.

Work has also been progressed in the last year to develop a service user evaluation form which was launched April 2019 and will enable information to be gathered, regularly analysed and responded to.

Training
Within Glasgow City HSCP we have continued to raise awareness of the importance of Adult Support and Protection. This has included internal as well as multi-agency training and development sessions for managers and front line staff.

During the course of 2018/19, 27 sessions were offered to HSCP staff, with a total of 286 people attending. 11 multi-agency sessions were offered which were attended by 226 people. In addition to these, specific work has been undertaken with housing associations, with 94 people attending ASP briefing sessions and 11 attending a Training for Trainers session.

ii. Child Protection

At the end of March 2019, there were 389 children on the child protection register, an increase of 80 from March 2018. 45% of these children were aged 0-4, 39% aged 5 to 11, 14% aged 12 to 15, and 2% aged over 15.

Between April 2018 and March 2019, there were 511 new child protection registrations, compared to 412 for the same period in 2017/18. The number of de-registrations fell from 583 to 435 over the same period.

The average number of days on the register before deregistration fell slightly from 317 to 285.

Neglect
During 2018 there have been a number of key initiatives to support professionals to identify and address issues of child well-being and protection. Glasgow continues to prioritise neglect and the toolkit for assessing neglect has been updated and multi-agency training delivered on it. In March 2019 a neglect summit was also held, with 185 participants representing all key statutory agencies and the third sector.

Sexual Exploitation
Glasgow continues to gain experience in the investigation and management of Child Sexual Exploitation (CSE) which continues to be a priority. Multi-agency training has been delivered and awareness raising activities continue across the night-time and business community. Glasgow has also been involved in the national pilot of Stop to Listen (StL), the focus of which was to review and reflect on how we engage with young people who are at risk of/or are victims of child sexual abuse and CSE. This was concluded in the last year but the StL approach continues to be used and is giving children and young people a stronger voice.

Trafficking
The Trafficking Work Group continues to engage in practice and policy discussions at a national level and local procedures and practices have been updated in response to new legislation. The link between CSE and Trafficking is a key priority for the group and further locality learning sessions are being delivered.

African Families
Following on from previous work undertaken with the black African community and AFRUCA (Africans Unite Against Abuse), a training for trainers programme has been developed to equip HSCP children's services staff to recognise the cultural needs of African families. Workshops were held with local communities which were positively received by parents, carers and professionals. Work has also commenced to develop a child protection awareness programme which can be delivered by community representatives within local communities. In September, a public protection event for the third sector was held and the programme provided the opportunity to share learning and reflect on practice.

iii. MAPPA

MAPPA brings together agencies involved in the management of Registered Sexual Offenders (RSOs), restricted patients and Category 3 Offenders, to share skill and expertise and agree risk management plans to manage risk to the public in a co-ordinated way.

Over the last year, the Block Profiling pilot has been progressed, involving Glasgow City Council, Police Scotland and the Wheatley Group, in response to the recommendations highlighted within a previous significant case review undertaken in Glasgow. This has involved the RSL (Registered Social Landlord) sharing information on prospective tenants with designated personnel within Police Scotland and Criminal Justice Social Work when a property in close proximity to a RSO becomes void.

This enables more informed decisions to be taken in relation to whether or not a housing offer should be made to prospective tenants. The pilot has evaluated positively and will now be rolled out across all RSLs in Glasgow.

iv. Homelessness

The Winter Night Shelter (WNS), which is run by the City Mission, recommenced its service, operating for the period between the 1st December 2018 and 31st March 2019. It has a capacity for 40 individuals and ensures the most vulnerable have overnight food and shelter at the most difficult time of the year. It also offers significant opportunities for direct engagement with those most at risk, with a range of partners taking this up, including the HSCP's Welfare Rights and Homeless Healthcare Service.

During December 2018, 201 people stayed for a total of 380 nights; compared to December 2017 when 203 individuals stayed for 880 nights, a trend in line with the aim of reducing the length of stay, and moving people onto positive destinations. By the end of December, we had seen over 100 moving to positive destinations.

We have also been engaging with partners in a range of heightened "Winter Initiative Actions". These involve intensive interagency street networking and partners have been developing and maintaining named lists of the most vulnerable and at risk people.

These include work by the Simon Community Street Team, who have access to a £25k personalisation budget provided by the Scottish Government. This is helping to lift vulnerable people immediately off the streets by empowering front line workers to make on the spot decisions and expand the range of options available to them.

At Feb 2019, Glasgow had received 5180 homeless applications for 2018/19, a 7% increase from the same point in 2017/18.

During 2018/19, 3593 Section 5 Resettlement Plans had been processed, a 19% increase from the 2017/18 (3016), although this was below the target of 4000 (which had been increased from 3000 in 2017/18).

CASE STUDY

A 37 year old male service user lived with a friend for a year until the relationship broke down. He had no family supports or networks in Glasgow and has Organic Personality Disorder with a history of self-harming. He disclosed binge drinking and daily cannabis use and had been medically retired from his job. After a traffic accident he suffered inverse skull fracture and was also diagnosed as bi-polar. He was not always compliant with medication which results in paranoia and his emotional expressions being loud and unpredictable. He does not always look after himself especially when drinking and his accommodation quickly falls into a poor state.

Following a referral to Housing First via a commissioned service, he moved into his own tenancy in August 18 with a range of services and support provided by the HSCP and partners and has manged this successfully. Due to his mental state, he regularly discusses the difficult conditions he used to live in and compares this to the higher standards he now enjoys. He recently chaired his own Housing First Review in his flat and articulated very well, conveying his own personal history of mental health, hopes, fears and aspirations, in a very positive manner. He has a forte in performance arts has attended baking classes and wrote a poem for St Andrew's night. He has also enrolled in a short 12 week course at Glasgow University and travelled to spend Christmas with his family.

v. Domestic Abuse

The Caledonian System is an accredited integrated approach which represents a fundamentally different way of managing perpetrators of domestic abuse in the community. It involves a two year programme of intervention with men, as well as the provision of associated services to women partners, ex partners and children. Glasgow City HSCP were successful in securing funding during 2018/2019 to set up a centralised team to deliver this system. The team has now been established and work is being undertaken to raise awareness of it amongst partners and to take forward its development.

vi. Alcohol and Drugs Harm Reduction

The multi-agency Glasgow City Harm Reduction Action Group (GCHRAG) seeks to address the range of drug related harms being experienced by those injecting drugs in Glasgow city centre. 6 key priorities have been identified: Injecting Equipment Provider (IEP) outlets; wound care; naloxone; discarded needles; HIV; and developing information for clients. Progress made in the last year has included:

- Increase in sheets of foil distributed from IEP outlets suggesting a potential reduction in injecting frequency (8.5% increase from 214,354 to 233,405),
- Naloxone provision increased due to continued promotion by key staff, peers and services (130% increase from 479 to 1102).
- Large scale training events helped 'up skill' the workforce to identify and treat wounds, with over 80 people trained. The introduction of low threshold wound care services in IEPs has enabled these to be put to good use and from a baseline of 0 in 2017, over 80 people have been treated by IEPs in 2018.
- A 78% increase in blood testing for Blood Borne Viruses (from 151 to 269).
- New cases of HIV fell from 37 to 19, contributed to by the multidisciplinary approach taken to testing, treatment and harm reduction.
- Introduction of a mobile IEP van to cover the gap in out of hours, which now operates between 6 and 10pm 7 days a week.

Plans have also continued to be developed in relation to the Heroin Assisted Treatment facility. Final approval for the site is anticipated when renovation work is nearing completion, and staff and managerial appointments have been made. It is intended that service will operate daily between the hours of 8.30am and 6.00pm, 7 days per week and 365 days per year. Plans have also continued to be progressed in relation to Safer Drug Consumption Facilities, with UK government legislative changes required before these can be implemented.

2.7 ENGAGING AND DEVELOPING OUR STAFF

i. Communications

Effective communications enable the HSCP and IJB to engage with staff and other key stakeholders to increase awareness of its priorities for health and social care in Glasgow. It also assists in engaging them in the planning and delivery of health and social care services in the city. Communications activity has continued to reflect the priorities for improvement identified in the **Communications Survey** reported to the IJB Public Engagement Committee in March 2017.

Activities undertaken over the last year have included the following:

- Briefing sessions for key staff on HSCP management structures and further roll-out of the HSCP's **Good Practice Guidelines** for consultation and engagement activity, which aim to ensure a consistent approach to consultation that is good quality, supportive and effective so that individuals, groups, communities and organisations have opportunities to be fully engaged in an informed way.
- Further development of the **HSCP's Website** to improve information on health and social care integration and 'how to get involved'. During 2018/19 there were 32,079 visitors to this website with 155,361 page views. Each Locality Engagement Forum (See chapter 3) also has its own dedicated webpage, with meeting and event dates and papers posted upon it.
- Support to and delivery of the consultation on the draft Strategic Plan 2019-22 including:
    - Development and implementation of a consultation, engagement and communications strategy and plan.
    - Pre-consultation and engagement on the proposed vision and priorities.
    - Dedicated webpage on the GCHSCP's public website including the full and executive summary versions of the draft Strategic Plan and online survey. During the consultation period, the site had 3,585 views, of which 3,047 (85%) were unique and 538 (15%) were repeat ones. The draft Strategic Plan was downloaded 1,354 times with the executive summary version downloaded 227 times.
    - 7 consultation events which were attended by a total of 546 people including HSCP and third and independent sector staff; IJB members; and community representatives.
    - Web-based survey to participants to evaluate the consultation events.
    - Communications channels to promote the consultation including Twitter; Facebook; regular emails; the Glasgow City Council's Community Council Briefing webpage and the HSCP's public newsletter.

- Continued development and publication of a range of communications activity to keep internal and external stakeholders up to date on the work of the HSCP and IJB, including:
    - Ongoing publication of IJB Committee papers, strategies/ plans and consultation and engagement opportunities on the HSCP's website.
    - Continued publication of the HSCP's regular and special edition newsletters including the GCHSCP Healthy Working Lives staff newsletter.
    - Continued use of the GCH-SCP's Twitter profile, @gchscp, and Chief Officer's Twitter pro-file, @dwgchscp.

As at 31 March 2019, the HSCP's Twitter profile, @gchscp, had 1,859 followers, and 563 Tweets were made during 2018/19. The HSCP Chief Officer's Twitter profile, @dw_gchscp, had 781 followers, and 332 Tweets were made.

- Further development and promotion of Your Support Your Way Glasgow (YSYWG), the HSCP's public website which provides information on the social care supports that are available in Glasgow City. This has included redevelopment and re-launch of the area of the website that covers services previously delivered by Cordia; contacting additional community-based services inviting them to be added to the website; the addition of a section entitled 'Are you looking after someone?' to coincide with the launch of the Carers Act; the addition of a webpage for Homelessness staff; and the addition of a British Sign Language (BSL) introduction to the homepage of the website
- Development and support to the communications and engagement strategy and plan for the transfer of Cordia Care Services into the management of the HSCP. This included emails, letters and welcome briefings; a dedicated webpage with a Q&A and feedback form; and 14 staff engagement sessions for staff transferring, which were recorded and made available on the website
- Delivery of three Partnership-wide Leadership Sessions with the wider GCHSCP leadership staff group to keep them up to date on IJB work and priorities and to discuss challenges and opportunities across the health and social care system. In addition to these, wider staff engagement sessions were delivered on a range of topics including the new primary care contract and service transformation across older people, adults and children's services.
- Delivery of two provider events for external providers whom GCHSCP purchases social care and support from.
- Support to deliver consultation for the Carers Eligibility Criteria, Young Carers Statement, Carers Strategy 2019 – 2022 and Young Carers Strategy 2019 – 2022.

ii. Awards

During the last year, the Partnership have continued to recognise the efforts of staff through:

- Delivery of Social Work Services' Long Service Milestone Awards to recognise and celebrate staff for 25, 30, 35 and 40 years' service.
- Delivery of the HSCP's Staff Awards for Excellence to recognise and celebrate individual staff/teams/projects that have 'gone the extra mile' in their work. Details of award winners are given below.
- Submission of nominations for external awards. Successful nominations are detailed below.

HSCP'S STAFF AWARDS FOR EXCELLENCE

Our Patients, Service Users and Carers
Occupational Therapist (South Mental Health Services).

Our People
Working with Black African Families Project.

Our Leaders
Nurse Team Leader (Perinatal Community Service).

Our Resources
Kingsway Medical Practice.

Our Culture
Intensive Support and Monitoring Service.

EXTERNAL AWARDS

British Heart Foundation Alliance Awards
Crail Medical Practice won Team of the Year.

Strathclyde Institute for Residential Children's Care Awards
Plenshin Court Staff won the Dream Team award.

Scottish Health Awards
Glasgow Recovery Communities Team won the Healthier Lifestyle Award.

United Kingdom Innovation in Public Health Awards
Health Improvement Lead (Mental Health) won the Inspiring the Public Health Workforce to Achieve Excellence Award.

Care Inspectorate (Care About Physical Activity) Programme Awards
Cordia Services (Care at Home) won the Culture and Team Award.

Scottish Pharmacist Awards
Prescribing support Team (South Locality) won the Working in Partnership Award.

NHS Greater Glasgow and Clyde Celebrating Success Platinum Staff Awards
- Working with Black African Families Project won the Overall Winner Award.
- Dental Support Technician won the Patient Centred Care Award.

Holyrood Magazine Digital Health and Care Awards
NHSGGC Computerised CBT Team won Accessing Mental Health Care Award.

Scottish Sensory and Equality Awards
GCHSCP and NHSGGC Mental Health Project won the Outstanding Approach to Promoting Partnership Working Across All Services for People with a Sensory Loss and/or a Disability in a Specific Local Area.

Scottish Association for Social Work Awards
Asylum Roma Team member won the Best Practice Equality and Diversity Award.

iii. Developing Our Teams

iMatter

We have continued to implement iMatter, the national staff engagement questionnaire which measures staff engagement within teams and supports the production of team action plans. Response rates varied across the Partnership in 2018, with all areas apart from the North West falling slightly below the target of 60%.

In terms of action plans, there was an increase in the percentage of teams developing these in the North East and for citywide services in 2018. Efforts will continue going forward across the city to increase both response and action plan development rates.

USER/CARER FEEDBACK

"The whole iMatter *process allowed us the opportunity to have more reflective and planning time together, something we hadn't taken time to realise and implement until having discussed it in detail following iMatter."*

"In addition to team meetings, staff agreed to put time in to catch up and work better together away from the core team meetings."

Team Effectiveness Framework
After an initial pilot, we have rolled out the Team Effectiveness Framework process to all Core Leadership teams. This has been developed to support managers to review the areas of team purpose, roles and objectives, and provide opportunities for reflection with the aim of agreeing priorities and achieving a clearer sense of identity and links to broader organisational objectives and priorities.

Health Improvement Training
Glasgow City Health Improvement (HI) Teams deliver training and awareness raising sessions across the city on a variety of health improvement topics. In the last year, these have included community smokefree services; equalities; nutrition and food; gender based violence; cancer awareness; internet safety; parenting; and suicide prevention. Sessions are targeted at HSCP and partner staff and local communities.

These sessions are designed to raise awareness of health improvement messages, support lifestyle changes, and build capacity to enable participants to deliver training to their own service users and patients.

Over the course of the year, 857 sessions were held with 8378 people attending. This compares to 746 sessions with 6229 people attending in 2017/18 and 650 sessions with 5495 people attending in 2016/17.

2.8 EQUALITIES

As a public body, the IJB is required under the Equality Act 2010 to publish its own set of equality outcomes. These are available within the **Mainstreaming and Equality Plan**. It is also required to report on progress in taking forward the equalities agenda and is expected to review policies and practices to ensure these eliminate discrimination, harassment and victimisation, and advance equality of opportunity and access for people with 'protected characteristics'. Activities progressed over the last year have included:

- Continued to assess strategies and services using Equality Impact Assessment Tools (EQIAs). The IJB has approved the use of the NHS web-platform for tracking and publishing EQIAs and over the last year, 21 EQIAs have been undertaken which can be accessed **here**.
- Progressed work to achieve the LGBT Youth Charter Mark. At present, one service has achieved this, with two others in the process of submitting portfolios. Glasgow is the first HSCP in Scotland to achieve this.
- Organised and delivered master classes, events, information sessions and training on a number of equalities topics for HSCP staff members, partner agencies and third sector organisations. Last year 1065 people attended these sessions, comparable to the previous year (1100). These sessions have covered religions and beliefs, British Sign Language, unconscious bias, human rights and many other subjects.
- Delivered a series of workshops with refugee communities through the Integration Networks entitled 'Understanding Mental Health: A Community Conversation' in North West Glasgow. These seek to facilitate conversations with participants on what is mental health and wellbeing and what supports are available within the community.
- ESOL (English as a Second or Other Language) training for volunteers has been supported within North East Glasgow, enabling volunteers to deliver ESOL at both beginner and intermediate level locally.
- Work has continued in South Glasgow with the Govan Community Project (GCP) to build on existing peer education models of intervention for asylum seekers and refugees. A learning resource has been designed and delivered to facilitate discussion of the short film, 'We Journey Together'; capturing the individual experiences of people going through the asylum process. Together the film and learning resource will contribute to ensuring the voices of asylum seekers and refugees are heard, as well as increasing awareness and understanding of the issues and barriers they face across staff and communities.

- In conjunction with the EU Health Visiting Team, Oral Health Directorate and 'Childsmile', a whole family approach pilot has been undertaken with the EU community within Govanhill. This resulted in more families registering with and accessing a dentist and increased awareness of the importance of oral health.
- Safeguarding African Families work has been progressed, in partnership with African Challenge, the Kenyan Women in Scotland Association (KWISA), Saheliya and Community Info-source. During 2018, a one day multi-agency training programme was developed and delivered on this topic.
- Developed a suite of '**Positive Signs**' films on mental health for the deaf community, which have been co-produced by staff and British Sign Language (BSL) users. These films are designed as information and awareness raising resources for staff in order to increase their understanding of this community's needs and improve access and service responses. They also support self-management and promote positive mental health amongst service users themselves.

USER/CARER FEEDBACK

Positive Signs was launched at an event at Glasgow's Lighthouse attended by representatives from the deaf community and from a wide range of other agencies and services. It received a very positive response, with delegate reflections including:

"Relatable and should be available for Deaf people to use".

"Good education material for staff".

"Very impressed with Sam's story showing positive action and showing resilience".

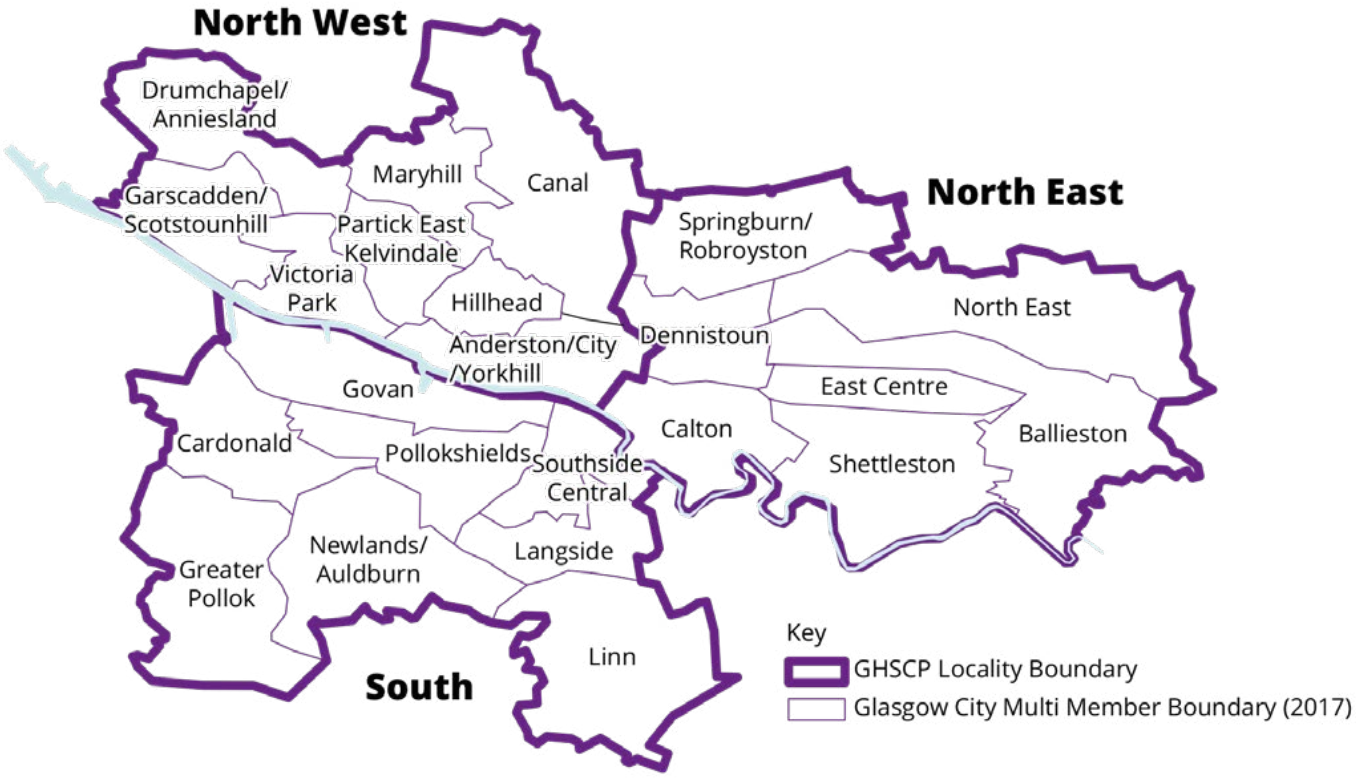
"Useful for voluntary organisations".

"Good to see the range of ages and kinds of activities being promoted in the wellbeing film".

3. LOCALITY PLANNING IN GLASGOW

3.1 LOCALITY AREAS

To make sure there is consistency in how local services are delivered, the Glasgow City Health and Social Care Partnership has adopted the same strategic areas as the Glasgow Community Planning Partnership. Services are managed and delivered within three local areas, known as localities. These localities - North West, North East and South - are shown on the city map and described in more detail below.



North East Locality
North East Locality covers the following wards:

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

The total population of North East Glasgow is 175,460 people and a breakdown by age is shown in the following table (Source: NRS Small Area Population Estimates for 2017).

Age Band	Number of People	% of Population	% of this age band in Glasgow City
0 to 15 years	29,823	17.0%	30.1%
16 to 64 years	120,714	68.8%	27.6%
65 years and over	24,923	14.2%	29.7%
All	**175,460**	**100.0%**	**28.3%**

North West Locality
North West Locality covers the following wards:

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

The total population of North West Glasgow is 219,838 people and a breakdown by age is shown in the following table (Source: NRS Small Area Population Estimates for 2017).

Age Band	Number of People	% of Population	% of this age band in Glasgow City
0 to 15 years	29,826	13.6%	30.1%
16 to 64 years	162,908	74.1%	37.2%
65 years and over	27,104	12.3%	32.3%
All	**219,838**	**100.0%**	**35.4%**

South Locality
The South Locality covers the following wards:

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

The total population of South Glasgow is 225,722 people and a breakdown by age is shown in the following table (Source: NRS Small Area Population Estimates for 2017).

Age Band	Number of People	% of Population	% of this age band in Glasgow City
0 to 15 years	39,488	17.5%	39.8%
16 to 64 years	154,289	68.4%	35.2%
65 years and over	31,945	14.2%	38.0%
All	**225,722**	**100.0%**	**36.3%**

3.2 PLANNING AND MANAGEMENT ARRANGEMENTS

Management Teams
Each locality is managed by an Executive Team responsible for the overall delivery of health and social care services in that area. This team is also responsible for ensuring that the partnership's policies and plans are put into practice at a local level; and working with partners, including the third sector, service users, and carers, to improve health and well-being. Individual care group management teams in each locality are responsible for overseeing their own service's activity and delivery. Wider locality planning arrangements are also in place which involve a range of partner agency representatives, service user and carer networks and groups, GPs and other primary care professionals.

Community Planning
Links with Community Planning partners are maintained at a strategic level through the Community Planning Area Senior Officers Group and the Community Planning Partnership Board. At a neighbourhood level, locality teams support the development of Thriving Places with community planning partners and others, as described in more detail in section 3.5 below.

Locality Engagement Forums (LEFs)
Across the City we have established Locality Engagement Forums in each of the Partnership's localities, which feed into local management arrangements and city-wide networks. The Locality Engagement Forums are made up of a range of stakeholders, mostly patients, service users and carers from local communities. They have an important role to play in linking to the governance, decision-making and planning structures of the locality and HSCP, ensuring that feedback and the opinions of patients, service users and carers are heard. These form a key role in our local participation and engagement arrangements, in line with the HSCP's **Participation and Engagement Strategy**. During 2018/19 these continued to flourish, providing opportunities for members and the wider public to engage and comment on the services provided by the HSCP.

Primary Care Implementation Groups
Each locality has a Primary Care Implementation Group engaging with primary care contractors, which link to the overall city wide Primary Care Steering Group. General Practice 'clusters' have been established to take forward the quality agenda in primary care. There are 21 GP clusters, 7 in each locality, with an average patient population of 34,000. Each of the clusters has identified a Cluster Quality Lead and a development programme has been implemented to support their learning needs, with a specific focus on using quality improvement methodology.

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

3.3 LOCALITY PLANNING

Each locality has developed a locality plan, which details how localities are taking forward the HSCP's Strategic Plan and responding to locally identified needs and priorities. These plans are reviewed and updated annually and those for the current year include the following:

- Health and social care needs and any changes year on year.
- Service priorities: progress made during 2018/19 and key actions for 2019/20.
- An assessment of performance against key targets, identifying where they have done well and areas for improvement.
- Locality budgets and savings.
- Community engagement mechanisms and development.
- Equalities activity and priorities.

Implementation of locality plans is monitored on an ongoing basis and reported to locality and citywide management teams, as well as to the Integration Joint Board. The detailed plans for each locality can be accessed **here**.

3.4 PARTICIPATION AND ENGAGEMENT

Each locality has mechanisms for participation and engagement in place. During 2018/19 over 35 Local Engagement Forum meetings/events and 24 city wide sessions were held across the city, attended by over 1,900 people.

These have been complemented where appropriate, by a number of other engagement mechanisms and methods including:

- Focus groups.
- Face to face interviews.
- Public meetings and presentations at Community Councils and Community Groups meetings.
- Pop up stalls and 'drop-in' information sessions and wider community events such as Summer Fetes and Health Days etc.
- Senior manager inputs to user/ carer networks and forums.
- Targeted sessions for key stakeholders e.g. GP's, 3rd Sector, Housing partners.
- Written and online questionnaires/ surveys.
- Information leaflets and posters translated into several community languages.
- Use of the HSCP website and HSCP and Chief Officer Twitter profiles.
- Quarterly South Locality Engagement Network Newsletter, Woodside Health and Care Centre Newsletter and North East Hub News.

Over the course of the last year these mechanisms been used to consult extensively on a number of key citywide and locality developments, with the feedback shaping management decisions and plans. They include the following:

- Draft Glasgow City IJB Strategic Plan 2019 – 22.
- Review of Diabetes Specialist Nursing Team Service.
- Review of Greater Glasgow & Clyde Out of Hours Services.
- Primary Care Improvement Plan.
- Locality Plans 2018-19.
- Moving Forward Together.
- Self-Directed Care.
- Review of Overnight Care Support.
- **Draft Carer Strategy 2019-22** and **Young Carer Strategy 2019-22**.
- Distress Collaborative - developing Crisis Cafes Engagement.
- Mainstreaming Equalities Event.
- Opening of Gorbals Health and Care Centre.
- Woodside Health and Care Centre.
- North East Hub developments.
- Pop-Up Information Road Shows during July 2018 to coincide with the 70th NHS Anniversary.

Examples from above, one from each locality, which help to illustrate the work being done to involve key stakeholders, communities and service users and carers, are described below.

North East – Development of the North East Hub

Proposals have continued to be developed for a new Health and Social Care Hub in the North East. A preferred site has been identified and an Outline Business Case is being prepared. A consultation and engagement plan was devised for the Hub to provide information on the project's development; gather ideas on the design and location; obtain feedback and comment on the planned services; and generate wider community interest in the proposal. The plan included:

- Four public engagement meetings to discuss proposals for the location site of the Hub.
- Option Appraisal on a series of proposed sites.
- Providing information and regular engagement - community councils, resident and community groups and other key stakeholder groups.
- Information for the wider community via newsletter distribution and articles/briefings provided on the HSCP, NHSGGC and New Gorbals Housing Association (NGHA) websites.
- Involvement of local people and communities in the North East Health and Care Hub Board and sub groups.
- Establishment of a North East Hub Design Group.

The public meetings and other regular presentations gathered information which was used to shape the design brief and initial agreement.

At the Option Appraisal session a detailed presentation highlighted the positive and negative aspects of a number of locations, taking into consideration issues such as transport links, environmental conditions and site development potential for each location. A total of 48 attendees took part in the scoring exercise, in which each individual was asked to score each Benefit Criteria for each site on a scale of 1 to 10. The Parkhead Hospital/Health Centre site scored the highest number of points in this process.

A North East Hub Design Group was then established and a 'Lessons Learned Engagement' Session hosted. This was attended by 45 people including staff, key stakeholders and public representatives. At this meeting, participants considered and gained knowledge from the presentations delivered by those involved in other recent Health and Social Care Centre developments in the city.

North West – North West Locality Plan

As mentioned above, each locality has a locality plan detailing how localities are taking forward the HSCP's Strategic Plan and responding to locally identified needs and priorities. In February 2019 an engagement session focusing on the North West Locality Plan was held involving over 40 representatives from the North West LEF, 3rd sector, HSCP and the wider community.

All the participants had an opportunity to discuss each of the service areas which resulted in a wide and varied number of comments, issues and points being recorded. The comments and points raised were sent to all participants, posted on the Glasgow City HSCP website and shared with the North West HSCP management teams.

The feedback has helped shape the priorities, proposals and actions detailed in the North West Locality Plan 2019-20. Follow up engagement sessions are planned to give an update on the progress of key priorities and provide patients, service users, and other key stakeholders a further opportunity to discuss service ambitions and challenges for the North West locality.

South Locality – Opening of New Gorbals Health and Care Centre

The new Gorbals Health and Care Centre which opened in January 2019 represents a significant investment in the regeneration of the Gorbals, providing a wide range of benefits for the community it serves. These include the transfer of four General Practices, one Dental Practice and other primary and community care services from the previous health centre; as well as the introduction of new services, including specialist children's services, alcohol and drug recovery services and children and families' social work services.

As part of the wider engagement plan for this project, a communication and engagement plan was created to provide information and opportunities for engagement to local stakeholders in the 3 month period prior to the opening of the centre in January 2019. During this time the following activities were carried out:

- Distribution of public facing newsletters.
- Distribution of A5 leaflet of new contact numbers.
- Social media – schedule of tweets from @gorbalscentre and retweets by @GCHSCP.
- Articles/briefings on GCHSCP, NHSGGC and NGHA websites.
- Series of public meetings with community stakeholder groups including community councils and residents committees, attended by approximately 75 people.
- Site visits/tours of the building for the local community.
- Post-opening survey for visitors, patients, users and carers.

Feedback from the above was overwhelmingly positive with the new facility viewed extremely positively locally. However, local stakeholders also raised concerns about additional car parking pressure in an already heavily congested area. As a result the HSCP consulted with local groups on the draft and final versions of the Travel Management Plan, with feedback from stakeholder's directly influencing decision making on various aspects of this Plan.

Pre-opening site visits/tours took place in early January with over 120 local people and other stakeholders attending. This proved to be an excellent opportunity to get initial feedback from people, many of whom had not been involved in the planning or design stages of the project but who would be using the services delivered there.

In addition, a survey of 60 patients, service users and visitors was carried out during the opening week in January. Feedback was 100% positive about the improvement from the previous facilities. Particularly positive comments were received about the reception and waiting areas, the courtyards and the art strategy installations. Around 30% of respondents said that both internal and external signage could be improved and the HSCP is making improvements in response to this feedback.

A schedule of follow up meetings for local stakeholder groups to discuss post-opening issues arising are planned and a formal post-occupancy survey will be undertaken in January 2020.


NEW GORBALS
HEALTH
& CARE
CENTRE

3.5. THRIVING PLACES

A key part of the **Community Empowerment (Scotland) Act 2015** is that local people have a right to be involved in local decisions. It also means that councils and other public sector organisations have a duty to improve outcomes in areas disadvantaged by inequalities.

HSCP staff, in particular Health Improvement staff, continue to take a focused neighbourhood approach in recognition of persistent inequalities within and between communities. This is aligned with the **Community Planning Thriving Places** approach, which aims to find a better way of working between organisations and with communities, making better use of existing resources and assets to achieve improved outcomes.

This work is being taken forward in **10 specific areas** across the city (3 North East, 3 North West and 4 South) and a wide range of initiatives have been taken forward in the last year. A key role for HSCP Health Improvement staff in Thriving Places is in supporting and facilitating local partnerships often at a community level which enables the development of co-produced localised programmes.

Additionally, Health Improvement staff provide guidance and support around data collection and analysis, monitoring and evaluation, and enabling access to funding streams. Examples - one citywide and then from each locality - which the Health Improvement Team have been involved in supporting are provided below:

City Wide - Community Budgeting

Community Budgeting initiatives funded via Health Improvement Teams have been introduced across the city. These involve small grants programmes aimed at supporting smaller 3rd sector and community groups in the delivery of locally identified priorities. Local residents are involved in both the development of eligibility criteria and the decision making processes with regard to how the money is spent.

CASE STUDY

The Gorbals Ideas Fund (GIF) was set up with a funding pot of nearly £17,000. A small grant of up to £500 was available for local people and non-constituted groups with a maximum award of £3,000 for constituted and formal groups. The fund was heavily promoted via social media, local networks and groups. Proposals received were assessed at a Voting Event in February 2019, with 229 people in attendance. This led to 18 awards being made covering a wide range of areas including:

- child and youth football teams.
- health and history walks.
- health programme for a men's group.
- an outdoor learning programme for nursery children.
- a girls group.
- a community café.
- a family fun programme.
- a musical production (health themed).
- a fitness programme and health and wellbeing sessions.

North East – Tea Dances

A joint initiative between the Health Improvement teams and Glasgow Life Communities deliver the **Glasgow Club Tea Dances** in Barlanark as well as in several other places throughout the city. The weekly tea dances are designed to give participants gentle, enjoyable exercise and the opportunity to socialise and relax. Instructors take participants through the dances so there is also a cognitive and learning dimension to these events.

CASE STUDY

Alan was in his 90's when he came along to the weekly tea dance in Barlanark. He was brought by his daughter who said her Dad had become isolated after the loss of his wife. Previously he and his wife would attend dances all over Glasgow but Alan could no longer (or did not wish to) dance for his own reasons. After attending for a few weeks his daughter remarked how he had changed. She felt this was a huge turnaround for him and he seemed to have a new lease of life.

She also said how this had helped her and the rest of the family, as they had found something they could do and enjoy together in her father's latter years. When the family and the grandchildren visited they also had something positive to talk about. Alan passed away after attending the dance for 18 months. After he died, his daughter read out a letter which he'd asked to be shared with the participants. In it he thanked everyone for the joy they had brought to the last year and a half of his life.

North West – Possilpark People's Trust

Possilpark People's Trust was formed by a committed group of residents and supporters who wish to see Possilpark thrive.

The Thriving Places group, chaired by the North West Health Improvement Team has supported local Trust members to engage with partner organisations and strengthen their skills and reputation with other local community partners and funders.

The Trust was provided with seedcorn funding which was used to support a feasibility study and subsequent development of a business plan.

The hard work and determination of the Trust, together with the support from the Thriving Places partners, culminated in a successful application to the Scottish Government's Capital and Regeneration Fund.

This has secured £1.5 million toward the development of a new state-of-the-art Community and Family Centre in Possilpark and the Thriving Places Group will continue to support the Trust to play a lead role in the regeneration of the local area.

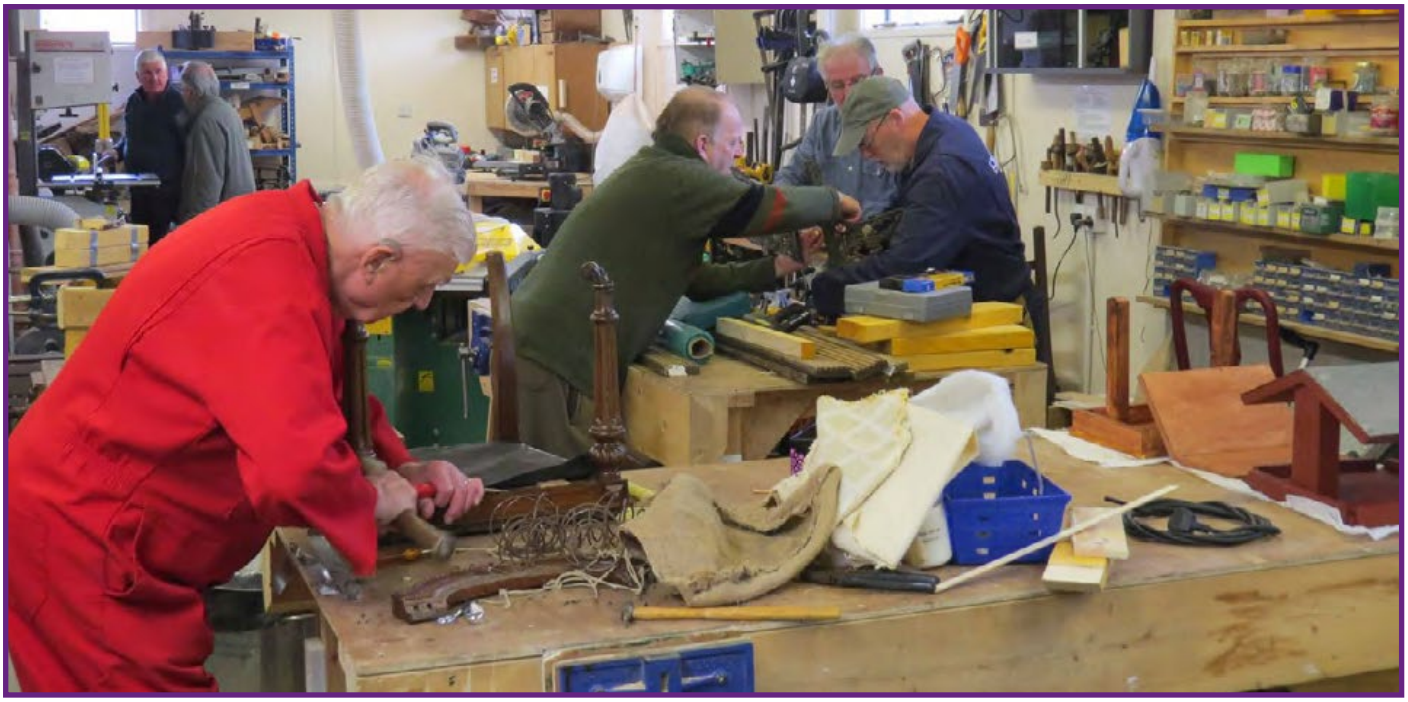
South – Men's Sheds

Scottish Men's Sheds are permanent meeting places which are run by volunteer groups and are for men over the age of eighteen who have 'time on their hands and want to socialise'.

They provide men with the chance to learn and/or mentor someone to enable them to learn a new skill within an alcohol free and welcoming environment.

Currently Health Improvement staff are supporting the development of a health programme for participants which will allow the men to participate in outdoor activities both locally and outwith their local community, as well as offering topic based information and awareness raising events.

Health Improvement staff also signpost the men to other services and organisations locally and highlight various funding sources that they can apply for.



CASE STUDY

A was a 58 year old man who at this point last year was in hospital due to ongoing mental health problems. He is now a regular participant and attends the Men's Shed 3 days a week. He reported that he feels less isolated and happier than he has been in years. He enjoys the camaraderie and informal support from other "Shedders" particularly having people to talk to on a regular basis.

He now feels confident enough to disclose some of his personal issues and to seek support for his dyslexia. He also really values the daily lunches provided and enjoys being able to help prepare and serve meals to the group. In addition, he really enjoys the additional activities which have included walks in the countryside, ten pin bowling and a visit to a golf driving range. He had never tried any of these activities before joining the group. He has recently been learning how to spot weld and is keen to join a gym. In addition, he now also engages in other groups and activities in the Gorbals area.

4. FINANCIAL PERFORMANCE

4.1 INTRODUCTION

National Health and Wellbeing Outcome 9 is set out below and within this chapter, we seek to demonstrate how we have achieved this. Firstly, we provide an overview of financial performance during 2018/19. We then describe the transformation programme we have been taking forward and the key capital investments progressed during the last year, before briefly considering the financial outlook for 2019/20.

OUTCOME 9
Resources are used effectively and efficiently in the provision of health and social care services.

4.2 2018/19 PARTNERSHIP BUDGET

The total financial resources available to the partnership for 2018-19 were around £1.1billion, as outlined below.

Client Group	Gross Expenditure Budget	Income Budget	Net Expenditure Budget
	£000's	£000's	£000's
Children and Families	152,440	3,382	149,058
Adult Services	327,615	49,585	278,030
Older People Services	318,213	40,939	277,274
Resources	63,073	3,401	59,672
Criminal Justice	17,797	18,637	-840
Prescribing	128,701	-	128,701
Family Health Services	195,083	9,264	185,819
Other Services	8,167	192	7,975
TOTAL	**1,211,089**	**125,400**	**1,085,689**

4.3 2018/19 SET ASIDE BUDGET

In addition to the above, there is a "Set Aside Budget" which is made available by the Health Board to the Integration Joint Board in respect of "those functions delegated by the Health Board which are carried out in a hospital within the Health Board area and provided for two or more Local Authority areas." The total set-aside budget for 2018/19 was £129.3m, which excludes the budget value for Adult Mental Health and Elderly Mental Health inpatient services.

4.4 2018/19 FINANCIAL PERFORMANCE

The financial position for public services continues to be challenging, and the IJB must operate within significant budget restraints and pressures. Financial pressures on health and social care services in the past 12 months have included:

- increasing costs of medications and care services.
- an ageing population, leading to an increase in the number of people who have more than one long-term condition (multi-morbidity) and the number of people with complex needs.
- increasing rates of dementia.
- the increasing minimum wage and move to a living wage, leading to increased employer costs and requests from health and social care contractors for more money to help meet these costs.

Budget Monitoring throughout 2018-19 had forecast an underspend of £2.046m. The final position secured was an underspend of £6.999m. The increase is mainly as a result of contingency budget for Prescribing not being required and an increase in the number of vacancies experienced within the service. The main broad elements are:-

- An underspend within Children Services, mainly as a result of early delivery of future year savings (£3.560m).
- Budgeted contingency in Prescribing not required to be utilised in 2018/19 mainly due to the delay to Brexit and the risk associated with global prices (£3.213m).
- An underspend across a range of services due to vacancies as a result of staff turnover and delays in recruitment, and maternity leave and equates to 2.1% of the annual budget. This was partially offset by overspends in overtime and agency costs (£8.667m). A number of factors have contributed to this underspend and include services experiencing an average wait of 7 months from starting recruitment to securing people in posts, skill shortages in some service areas and high turnover levels within existing employees. A number of actions are being progressed including streamlining the recruitment process, aligning recruitment timescales with the availability of newly qualified professionals and developing programmes of targeted recruitment.

- An underspend in traditional Supported Living and Older People Purchased Day Care Services (£2.045m), which is as a consequence of the introduction of personalisation and partially off-sets the overspend being experienced in this area.

This has been off-set by overspends, the main areas being unachieved savings from 2018/19 (£3.069m) and demand within Adult Services and Older People Services (£6.588m), both of which are linked to the demand being experienced for care homes and care packages. The Transformation Programme Board continues to monitor these savings to ensure these are secured moving forward.

A number of commitments made in 2018/19 in relation to local and national priorities will not complete until future years. These are:-

- Funding received for the delivery of national and local priorities including Primary Care and Mental Health Transformation which is required to meet future year commitments (£9.698m). The majority of this relates to ring- fenced funding which has been received to meet specific commitments and must be carried forward to meet the conditions attached to the receipt of this funding;
- Commitments which were made in 2018/19, where implementation has been delayed until 2019/20 (£3.215m).

The IJB elected to transfer £19,912,000 to both general reserves and for specific earmarked commitments in 2019/20. Details of this can be found **here.**

4.5 TRANSFORMING OUR SERVICES

Within the Partnership, we have been taking forward a Transformational Change Programme which has been approved by the IJB across the entirety of the HSCP's business over the course of the last year, as described in chapter 2 of this report. This Programme is being monitored via the Integration Transformation Board, chaired by the Chief Officer, which aims 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.

Delivery of the Transformation Programme is closely monitored by the Transformation Board and delivery of associated savings is reported regularly to the IJB and the IJB Finance, Audit and Scrutiny Committee through budget monitoring reporting. 82% of budget savings targets in respect of the IJB's Transformation Programme were achieved in 2018/19 and reflects the challenges which have been experienced in delivering savings in areas where the IJB continues to see high demand for services.

4.6 CAPITAL INVESTMENT AND PRIORITIES

Health and Care Centres
As described in chapter 3, the new £17m Gorbals Health and Care Centre opened in January 2019, representing a significant investment in health and social care in this area of the City.

During 18/19 work has also progressed on the development of the new £20m Woodside Health and Care Centre. This will accommodate a range of health and social care services including specialist children's services, community alcohol and drug services and an older people's day care unit. It is planned to be fully operational by August 2019.

Additionally, work continued on the plans for a new Health and Care Centre in the North East of the city. A preferred site has been identified and an Outline Business Case is being prepared, with a consultation and engagement plan ensuring local community involvement in this process. Details of the North East Hub consultation and engagement process are given in 3.4 of this report.

Older People's Residential and Day Care Centres
Tomorrow's Residential and Day Care programme is continuing and work has progressed on the new £14m residential care home in Blawarthill (Victoria Gardens); and the £24m residential care home at Leithland (Meadowburn), both of which are expected to be completed by July 2019. The development at Leithland will also include an integrated older people's day care centre, as will the new Woodside Health and Care Centre (see above).

In addition to the new builds, the HSCP has invested significantly in 4 existing day care units. The buildings have been completely refurbished inside and out to the same specification and quality of our new build units including the provision of dementia friendly gardens. The transformation has meant all of our day care services will be provided within sector leading environments specifically designed to meet the needs of Glasgow's most vulnerable older people.

Learning Disability Day Centres
During 2018/19, GCHSCP's two learning disability day centres at Riddrie and Calton both benefited from significant investment to upgrade their accommodation and facilities. This included new flooring, furnishings and finishes, as well as investment in new equipment.

Children's Residential Provision
Glasgow City HSCP has a statutory requirement to provide the highest standards of care to vulnerable young people and we have been pursuing a programme of new build developments within children's residential services. During 2018/19, there were 2 new build 8 bedroom houses completed and opened at Newlands Road (replacing 6 bed Newark) and Norse Road (replacing a 6 bed on the same site). These will help to support high standards of care for children and young people and help facilitate their successful integration into the wider community.

4.7 FINANCIAL OUTLOOK FOR 2019/20 AND BEYOND

The financial position for public services continues to be challenging and the IJB must operate within significant budget restraints and pressures. In March 2019, the IJB conditionally approved its budget for 2019/20, subject to approval of Health Board funding by NHS Greater Glasgow and Clyde and discussion with Glasgow City Council in relation to the joint development of a financially sustainable solution for both Homecare and Housing First.

This budget identified a funding gap of £23m which will be delivered through a wide range of service reforms, efficiencies and the use of reserves to address budget pressures in 2019/20 and support achievement of the National Health and Wellbeing Outcomes. Progress on achievement of this programme will be reported during the year to the IJB and the IJB Finance, Audit and Scrutiny Committee, as well as in the 2019/20 Annual Performance Report.

A **Medium Term Financial Outlook** was reported to the IJB on the 27 March. This looks orward to 2021-22 and identifies the need for a further £65m of savings to deliver a balanced budget over the next two years.

There has been significant progress already in transforming services. As well as delivering financial savings this has enabled services to increase their effectiveness and efficiency, enabling services to manage the increasing demand and complexity of the patients and service users supported. The IJB is committed to transforming services, and this programme of work will continue moving forward, however future gains will be smaller and this alone will be unable to bridge the funding gap which has been identified above.

A clear strategy is required to ensure the IJB remains financially sustainable over the medium term. This will require services to be re-imagined and a new social care contract to be discussed with the citizens of Glasgow. This will represent a significant change to the IJB, our partners and the citizens of Glasgow and will require us all to work together to focus our finite resources on offering services which are sustainable over the longer term and are targeted to those with the greatest need.

5. PERFORMANCE SUMMARY

5.1 INTRODUCTION

In chapters 2 and 3 of this report, we highlighted key areas of work carried out by the Partnership and localities during 2018/19. In this chapter, we draw on a number of different sources to give a more detailed picture of how the Partnership is performing.

Section 5.2 summarises the internal and external audit and inspection processes which have been undertaken during the last year. Section 5.3 then describes how we are performing in relation to our suite of Key Performance Indicators, with section 5.4 focusing on our performance in relation to the National Integration Indicators and Ministerial Strategic Group (MSG) Indicators.

Drawing on the above information, key achievements in relation to our performance over the last 12 months are highlighted in section 5.5. Finally, in section 5.6, several areas for improvement going forward are identified.

5.2 INSPECTION AND PRACTICE AUDIT

i. Care Inspectorate Grades for Glasgow City HSCP Registered Services

The Care Inspectorate undertook both scheduled and unscheduled inspections across 39 services provided by Glasgow City HSCP, including services provided previously by Cordia LLP (Housing Support and Care at Home Services), between April 2018 and March 2019. The overall quality of care was assessed as 'good' or better (Grade 4 and above in each Quality Theme) in 87% of the 39 services inspected during this period. The percentage of services inspected graded "good" or better across all 4 Quality Themes is presented by service area in the following table.

Service Area	No. of Units Inspected Apr 18 - March 19	% of Services graded 'good' or better* across All themes
Care Homes (Older People)	8	87.5%
Day Care Centres (Older People)	2	100%
Residential Children's Units	20	80%
Home Care and Other Support Services	9	100%

***Grade 4 and above in each Quality Theme**

New inspection processes, related to new **Health and Social Care Standards**, were introduced by the Care Inspectorate in 2018. The new processes have initially been used solely for the inspection of older people's residential care homes and will be extended to other care groups in future. Between April 2018 and March 2019, 6 residential care homes were inspected using these new processes. 33 services were inspected using the existing processes.

The tables below detail the individual services inspected during this period, the care grades achieved across each Quality Theme/Framework and the number of requirements made, for both sets of inspection processes. Full details of these inspections can be accessed on the **Care Inspectorate Website**.

The six-point evaluation scale noted below is used for both sets of inspection processes.

Key to Grading:

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

Existing Inspection Processes (33 Services Inspected)

Unit	Date Inspection Completed	Quality Theme Care Grades (out of 6)				No. of Requirements
		Care and Support	Environment	Staffing	Management & Leadership	
CARE HOMES (OLDER PEOPLE)						
Davislea Home For The Elderly	19/06/18	5	5	5	5	0
Forfar Avenue	19/07/18	5	5	5	5	0
OLDER PEOPLE'S DAY CARE CENTRES						
Riddrie Resource Centre	20/04/18	5	5	4	4	0
Hawthorn House	25/07/18	6	6	5	5	0
RESIDENTIAL CHILDREN'S UNITS (RCUs)						
Hamilton Park Av.	26/11/18	3	5	3	3	0
Monreith Road	04/05/18	4	4	5	4	0
Airth Drive	13/04/18	4	3	5	4	0
Crawford Street	12/07/18	3	5	5	3	2
Norse Road	27/08/18	4	3	3	4	1
Dalness RCU	17/08/18	4	4	4	5	1
Milncroft Road	02/10/18	5	5	5	5	0
Plenshin Court	17/08/18	5	5	5	5	0
Wallacewell RCU	24/10/18	5	5	5	4	0
Kempsthorn RCU	30/08/18	5	4	5	5	0
Hinshaw Street	11/12/18	4	5	4	4	1
Wellhouse RCU	01/06/18	5	5	5	4	0
Crossbank Crescent	06/11/18	5	4	5	4	0
Netherton RCU	07/11/18	5	5	5	6	0

Unit	Date Inspection Completed	Quality Theme Care Grades (out of 6)				No. of Requirements
		Care and Support	Environment	Staffing	Management & Leadership	
Main Street RCU	14/12/18	5	5	5	4	0
Chaplet Avenue	14/12/18	5	5	4	4	0
Broomfield Crescent	08/01/19	5	5	6	5	0
Seamill Street	20/11/18	5	4	5	4	0
Balmore RCU	06/03/19	5	5	5	5	0
Newlands Road	13/03/19	5	4	4	4	0
HOME CARE AND OTHER SUPPORT SERVICES						
Elder Street Project Housing Support Service	18/04/18	6	Not applicable	6	6	0
Petershill Road Community Support Project	13/08/18	5	Not applicable	5	5	0
Supported Carers – Adult Placement Service	07/02/19	5	Not applicable	4	4	0
Housing Support Service – North East	29/03/19	4	Not applicable	4	4	0
Care at Home – North East	29/03/19	4	Not applicable	4	4	0
Housing Support Service – North West	29/03/19	4	Not applicable	4	4	0
Care at Home - North West	29/03/19	4	Not applicable	4	4	0
Housing Support Service – South	26/03/19	4	Not applicable	4	4	0
Care at Home - South	29/03/19	4	Not applicable	4	4	0

New Inspection Processes (6 Services Inspected)

UNIT	DATE INSPECTION COMPLETED	How well do we support people's wellbeing?	How well is our care and support planned?	How good is our setting?	How good is our Staffing?	How good is our leadership?	No. of Requirements
CARE HOMES (OLDER PEOPLE)							
Crossmyloof Care Home	26/04/18	5	5	4	5	4	0
Hawthorn House	05/11/18	4	4	Not assessed	Not assessed	Not assessed	0
Drumry House	03/08/18	5	4	Not assessed	Not assessed	Not assessed	0
Rannoch House	31/10/18	4	4	Not assessed	Not assessed	Not assessed	0
Orchard Grove House	08/08/18	5	4	Not assessed	Not assessed	Not assessed	0
Riverside House	15/11/18	4	4	5	3	4	0

ii. Practice Audit

In addition to external inspections, the Partnership has an ongoing planned programme of audit and self-evaluation to give quality assurance across all service areas. A list of Practice Audit and Evaluation activity carried out by Social Work between April 2018 and March 2019 is listed in the following table.

Audit/ Self-Evaluation	Service Area
Audit	Contract Management
Audit	Intermediate Care & Outcomes for Older People leaving hospital
Audit	Use of 13za Legislation
Evaluation	Interim evaluation of the Signs of Safety pilot
Self-Evaluation	Adult Support and Protection (ASP) Thematic Self-Evaluation
Evaluation	Hamish Allan Centre – Out Of Hours pilot evaluation
Evaluation	Winter Night Shelter – Lodging House Mission evaluation
Evaluation	Mental Health Officers Review
Evaluation	Supported Living (Cordia) Home Care Evaluation
Audit	Norm referrals and outcome
Self-Evaluation	Update to 2015 staff supervision self-evaluation
Audit	Temporary Accommodation Development Service
Audit	Admissions to 24-Hour Services 2018
Evaluation	Supervision in Children's Residential Services

5.3 LOCAL PERFORMANCE INDICATORS

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

A full list of the key performance indicators reported to the IJB, comparing current and baseline performance, is provided in the following tables, along with a description of the system used to rate our performance.

A more detailed set of operational indicators are reported quarterly to the IJB Finance, Audit and Scrutiny Committee and management teams.

Quarterly reports to the IJB Finance, Audit and Scrutiny Committee are available **here**.

Where status against target is available, performance measures have been rated on a traffic light basis using Red, Amber or Green (RAG) categories to reflect this. Outlined below is a key to the classifications used in this report. The **Status** is provided for the end of 2018/19 and the 3 previous years. **Direction of Travel** compares the year-end figure for 2018/19 with the corresponding figure for the end of 2015/16 (Baseline) and 2017/18.

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

DIRECTION OF TRAVEL	
▲	Improving
▶	Maintaining
▼	Worsening

INDICATOR	OUTCOME NUMBER	TARGET	2015/16 BASELINE	2016/17 YEAR END	2017/18 YEAR END	2018/19 YEAR END	Direction of Travel since 2015/16	Direction of Travel since 2017/18
OLDER PEOPLE								
1. Number of community service led Anticipatory Care Plans in place.	2	360 (15 to 17) 720 (17/18) 900 (18/19)	61	484	824	989	▲	▲
2. Number of people in supported living services.	2	650 by year end 2017/18 830 by year end 2018/19	231	231	734	842	▲	▲
3. Percentage of service users who receive a reablement service following referral for a home care service.	2	Hospital discharges 75%	83%	73%	72.8%	75.8%	▼	▲
		Community referrals 75%	79%	76.5%	78.2%	74.8%	▼	▼
4. Total number of Older People Mental Health patients delayed (Excluding AWI)	9	0	11	11	16	9	▲	▲
5. Intermediate Care: Percentage of users transferred home.	2	>30%	25%	29%	21%	24%	▼	▲

INDICATOR	OUTCOME NUMBER	TARGET	2015/16 BASELINE	2016/17 YEAR END	2017/18 YEAR END	2018/19 YEAR END	Direction of Travel since 2015/16	Direction of Travel since 2017/18
PRIMARY CARE								
1. Prescribing Costs: Compliance with Formulary Preferred List.	9	78%	City wide data not available	City wide data not available	79.45%	78.0%	**N/A**	▼
UNSCHEDULED CARE								
1. New Accident and Emergency (A&E) attendances (All ages)	9	197,542 for 18/19	201,573	201,768	205,642	212,516	▼	▼
2. Total number of Acute Delays	9	20	N/A	41	60	59	**N/A**	▲
3. Total Number of Acute Bed Days Lost to Delayed Discharge (Older People 65+).	9	10,000 for 18/19	21,288	15,557	10,982	15,288	▲	▼
4. Total number of Acute Bed Days lost to delayed discharge for Adults with Incapacity (AWI) (Older People 65+).	9	1,910 for 18/19	10,715	6,050	2098	3781	▲	▼
CARERS								
1. Number of New Carers identified during the year that have gone on to receive a Carers Support Plan or Young Carer Statement	6	1,650 per annum	N/A	N/A	1,942	1,984	New indicator from 2017/18	▲

INDICATOR	OUTCOME NUMBER	TARGET	2015/16 BASELINE	2016/17 YEAR END	2017/18 YEAR END	2018/19 YEAR END	Direction of Travel since 2015/16	Direction of Travel since 2017/18
CHILDREN'S SERVICES								
1. Percentage of HPIs (Health Plan Indicators) allocated by Health Visitors by 24 weeks.	4	95%	95% NE 93% NW 96% South	99% NE 98% NW 98% South	93% NE 96% NW 96% South	98% NE 99% NW 99% South	NE ▲ NW ▲ S ▲	NE ▲ NW ▲ S ▲
2. Access to specialist Child and Adolescent Mental Health Services (CAMHS): % seen within 18 weeks	9	100%	100%	100%	93.6%	86.4%	▼	▼
3. Percentage of young people currently receiving an aftercare service who are known to be in employment, education or training.	4	75%	67%	61%	67%	74%	▲	▲
4. Number of high cost placements. New indicator introduced for 2017/18.	4	Reduce to 67 by year end 17/18 Reduce to 47 by end of 2018/19	126	111	67	51	▲	▲
5i. Mumps, Measles and Rubella (MMR) Vaccinations: % uptake in Children aged 24 months	1	95%	94.6%	93.8%	93.9%	92.3%	▼	▼

INDICATOR	OUTCOME NUMBER	TARGET	2015/16 BASELINE	2016/17 YEAR END	2017/18 YEAR END	2018/19 YEAR END	Direction of Travel since 2015/16	Direction of Travel since 2017/18
5ii. Mumps, Measles and Rubella (MMR) Vaccinations: % Uptake in Children aged 5 years.	1	95%	95.9%	96.4%	96.0%	96.0%	▲	▶
ADULT MENTAL HEALTH								
1. Psychological Therapies: % of people who started treatment within 18 weeks of referral.	9	90%	N/A	87.1% NE 81.7% NW 96.5% S	88.3% NE 87.1% NW 96.5% S	78.2% NE 89.4% NW 97.6% S	N/A	NE ▼ NW ▲ S ▲
2. Total number of Adult Mental Health delays	9	0	17	12	21	13	▲	▲
ALCOHOL AND DRUGS								
1. Percentage of clients commencing alcohol or drug treatment within 3 weeks of referral.	7	90%	97%	97%	92%	98%	▲	▲
HOMELESSNESS								
1. Number of households reassessed as homeless or potentially homeless within 12 months.	4	<300 per annum (15/16 & 16/17) <480 per annum (17/18 & 18/19)	395	493	444	400	▼	▲

INDICATOR	OUTCOME NUMBER	TARGET	2015/16 BASELINE	2016/17 YEAR END	2017/18 YEAR END	2018/19 YEAR END	Direction of Travel since 2015/16	Direction of Travel since 2017/18
CRIMINAL JUSTICE								
1. Percentage of Community Payback Order (CPO) unpaid work placements commenced within 7 days of sentence.	9	80%	64%	65%	67%	66%	▲	▼
2. Percentage of Community Payback Orders (CPO) with a Case Management Plan within 20 days.	9	85%	94%	97%	80%	76%	▼	▼
HEALTH IMPROVEMENT								
1. Alcohol Brief Intervention delivery (ABI).	4	5,066 per annum	5,643	7,400	6,470	5,055	▼	▼
2. Smoking Quit Rates at 3 months from the 40% most deprived areas.	5	1,388 (16/17- 17/18) 1,128 (18/19)	1,229	1,250	1,398	1,412	▲	▲
3. Women smoking in pregnancy (general population)	1	<13%	N/A	N/A	10.6%	10.4%	N/A	▲
4. Women smoking in pregnancy (most deprived quintile)	5	<19%	N/A	N/A	18.7%	18.9%	N/A	▼
5. Exclusive Breastfeeding at 6-8 weeks (general population)	1	24%	N/A	25.7% (2016)	26.9% (2017)	30.4% (2018)	N/A	▲
6. Exclusive Breastfeeding at 6-8 weeks (15% most deprived data zones).	5	21.6%	N/A	18.2% (2016)	20.3% (2017)	21.2% (2018)	N/A	▲

INDICATOR	OUTCOME NUMBER	TARGET	2015/16 BASELINE	2016/17 YEAR END	2017/18 YEAR END	2018/19 YEAR END	Direction of Travel since 2015/16	Direction of Travel since 2017/18
HUMAN RESOURCES								
1. NHS Sickness absence rate (%)	1	<4%	6.3%	6.19%	5.42%	6.23%	▲	▼
2. Social Work Sickness Absence Rate (Average Days Lost)	1	<2.53 ADL at Q4 (ave. days lost per employee)	2.6 ADL	2.7 ADL	3.3 ADL	3.9 ADL	▼	▼
BUSINESS PROCESSES								
1. Percentage of NHS Stage 1 complaints responded to within timescale*	3	70%	n/a	n/a	96.6%	96.2%	n/a	▼
2. Percentage of NHS Stage 2 complaints responded to within timescale*	3	70%	n/a	n/a	60%	70%	n/a	▲
3. Percentage of Social Work Stage 1 Complaints responded to within timescale*	3	70%	n/a	n/a	61%	67%	n/a	▲
4. Percentage of Social Work Stage 2 Complaints responded to within timescale*	3	70%	n/a	n/a	29%	46%	n/a	▲
5. Percentage of elected member enquiries handled within 10 working days.	3	80%	93%	92%	94%	88%	▼	▼

Notes* The Scottish Public Services Ombudsman developed and published model complaints handling procedures for both the NHS in Scotland and Social Care Providers. These were implemented on 1st April 2017 and the resulting change of processes led to the introduction of new performance indicators.

5.4 NATIONAL INTEGRATION INDICATORS

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

The Integration Indicators are grouped into two types of measures: 9 are based on feedback from the biennial Scottish Health and Care Experience survey (HACE) and 10 are derived from Partnership operational performance data.

A further 4 indicators are currently under development by NHS Scotland Information Services Division (ISD).

The following tables provide the most recent data for the 19 indicators currently reportable, along with the comparative figure for Scotland, and provides trends over time where available.

i. Scottish Health and Care Experience Survey (2017/18)

Information on 9 of the National Integration Indicators is derived from the biennial Scottish Health and Care Experience survey (HACE) which provides feedback in relation to people's experiences of their health and care services. The most recent survey report can be accessed at **Scottish Health and Care Experience Survey (2017-18)** and the results are summarised below.

NATIONAL INTEGRATION INDICATOR	OUTCOME	GLASGOW	SCOTLAND
1. Percentage of adults able to look after their health very well or quite well	1	90%	93%
2. Percentage of adults supported at home who agreed that they are supported to live as independently as possible	2	82%	81%
3. Percentage of adults supported at home who agreed that they had a say in how their help, care or support was provided	3	80%	76%
4. Percentage of adults supported at home who agree that their health and social care services seemed to be well co-ordinated	3	77%	74%
5. Percentage of adults receiving any care or support who rate it as 'excellent' or 'good'	3	79%	80%
6. Percentage of people with positive experience of the care provided by their GP practice	3	86%	83%
7. Percentage of adults supported at home who agree that their services/support had an impact on improving or maintaining their quality of life	4	80%	80%
8. Percentage of carers who feel supported to continue in their caring role	6	38%	37%
9. Percentage of adults supported at home who agreed they felt safe	7	85%	83%

ii. Operational Performance Indicators

Indicator No. / Outcome	11. Premature mortality rate per 100,000 persons: by calendar year			
Outcome 1	2015	2016	2017	Direction of Travel 2016 to 2017
Glasgow City	634	617	614	▲
Scotland	**441**	**440**	**425**	▲

Indicator No. / Outcome	12. Rate of emergency admissions per 100,000 population for adults.					
Outcome 9	2015/16	2016/17	2017/18	2018/19 (To Q3)	Direction of Travel	
					15/16 to 18/19	17/18 to 18/19
Glasgow City	14,773	14,318	12,864	9778	▲	▼
Monthly Average	1231	1193	1072	1086	▲	▼
Scotland	**12,281**	**12,255**	**12,192**	**N/A**	**-**	**-**

Indicator No. / Outcome	13. Rate of emergency bed days per 100,000 population for adults.					
Outcome 9	2015/16	2016/17	2017/18	2018/19 (To Q3)	Direction of Travel	
					15/16 to 18/19	17/18 to 18/19
Glasgow City	144,636	146,117	139,490	116,842	▲	▲
Monthly Average	12,220	12,218	11,624	11,107	▲	▲
Scotland	**128,630**	**126,945**	**123,160**	**107,921**	**-**	**-**

Indicator No. / Outcome	14. Rate of readmissions to hospital within 28 days of discharge per 1,000 admissions.					
Outcome 4	2015/16	2016/17	2017/18	2018/19 (To Q3)	Direction of Travel	
					15/16 to 18/19	17/18 to 18/19
Glasgow City	98	102	96	98	▶	▲
Scotland	**98**	**101**	**103**	**N/A**	**-**	**-**

Indicator No. / Outcome	15. Proportion of last 6 months of life spent at home or in a community setting					
Outcome 9	2015/16	2016/17	2017/18	2018/19 (To Q3)	Direction of Travel	
					15/16 to 18/19	17/18 to 18/19
Glasgow City	85%	86%	87%	89%	▲	▲
Scotland	**87%**	**87%**	**88%**	**89%**	▲	▲

Indicator No. / Outcome	16. Falls rate per 1,000 population aged 65+					
Outcome 9	2015/16	2016/17	2017/18	2018/19 (To Q3)	Direction of Travel	
					15/16 to 18/19	17/18 to 18/19
Glasgow City	28.9	31.1	30.7	22.5	▼	▲
Quarterly average	7.2	7.8	7.7	7.5	▼	▲
Scotland	**21.6**	**21.8**	**22.7**	**N/A**	**-**	**-**

Indicator No. / Outcome	17. Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections*					
Outcome 9	2015/16	2016/17	2017/18	2018/19 (To Q3)	Direction of Travel	
					15/16 to 18/19	17/18 to 18/19
Glasgow City	81%	86%	90%	86%	▲	▼
Scotland	**83%**	**84%**	**85%**	**82%**	▼	▼

*This indicator looks at the Care Inspectorate grades for all provided care services. The indicator is updated annually and shows the latest grades for each care service at the end of March. Where a service has not been inspected during the reporting year the grades for earlier years are carried forward.

Indicator No. / Outcome	18. Percentage of adults with intensive care needs receiving care at home			
Outcome 9	2015	2016	2017	Direction of Travel 2015 to 2017
Glasgow City	56%	55%	55%	▼
Scotland	**61%**	**62%**	**61%**	▶

Indicator No. / Outcome	19. Number of days people aged 75+ spend in hospital when they are ready to be discharged, per 1,000 population					
Outcome 9	2015/16	2016/17	2017/18	2018/19	Direction of Travel	
					15/16 to 18/19	17/18 to 18/19
Glasgow City	627	464	324	456	▲	▼
Scotland	**915**	**842**	**762**	**805**	▲	▼

Indicator No. / Outcome	20. Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency					
Outcome 9	2015/16	2016/17	2017/18	2018/19	Direction of Travel	
					15/16 to 18/19	17/18 to 18/19
Glasgow City	25%	27%	26%	22%	▲	▲
Scotland	**24%**	**24%**	**25%**	**22%**	▲	▲

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

INDICATOR NUMBER	OUTCOME
10 Percentage of staff who say they would recommend their workplace as a good place to work	**8**
21 Percentage of people admitted to hospital from home during the year, who are discharged to a care home	**2**
22 Percentage of people who are discharged from hospital within 72 hours of being ready	**9**
23 Expenditure on end of life care, cost in last 6 months of life	**9**

Ministerial Steering Group Indicators

A number of indicators have been specified by the Ministerial Steering Group (MSG) for Health and Community Care which cover similar areas to the above National Integration Indicators. Health and Social Care Partnerships have been asked to develop plans and identify targets in relation to these which are shown below for 2018/19, along with performance over the last three years.

INDICATOR	2015/16	2016/17	2017/18	18/19 Target	2018/19
1. Number of Emergency Admissions (all ages) - Total and monthly average	77,296 (6,441)	75,646 (6,304)	69,729 (5,811)	75,750 (6,312)	64,932 (5,902) (To Feb 19)
2. Number of Unscheduled Hospital Bed Days (acute specialities & all ages) - Total and monthly average	504,761 (42,063)	527,097 (43,763)	520,368 (42,097)	454,285 (37,857)	411,729 (41,173) (To Feb 19)
3. New Accident & Emergency attendances (all ages)	201,573	201,768	205,642	197,542	212,516
4. Number of Acute Bed Days Lost to Delayed Discharge (Older People 65 +)	21,288	15,557	10,982	10,000	15,288
5. Percentage of last six months of life spent in Community setting	84.8%	85.5%	86.8%	86.8%	TBC
6. Percentage of population unsupported at home (aged 65+)	87.9%	88.1%	88.2%	89.9%	TBC

5.5 KEY ACHIEVEMENTS

In this section we highlight where performance has shown the greatest improvement over the past 12 months (April 2018 – March 2019).

INDICATOR	BASELINE (17/18 YEAR END)	YEAR END (18/19)
Older People		
Number of community service led Anticipatory Care Plans in place.	**824**	**989**
Number of people in supported living services	**734**	**842**
Carers		
Number of New Carers identified during the year that have gone on to receive a Carers Support Plan or Young Carer Statement	**1942**	**1984**
Children's Services		
Percentage of young people currently receiving an aftercare service who are known to be in employment, education or training.	**67%**	**74%**
Number of children in high cost placements	**67**	**51**
Alcohol and Drugs		
Percentage of clients commencing alcohol or drug treatment within 3 weeks of referral	**92%**	**98%**
Homelessness		
Number of households reassessed as homeless or potentially homeless within 12 months.	**444**	**400**
Health Improvement		
Breastfeeding at 6-8 weeks	**26.9% (General) 20.3% (Deprived)**	**30.4% (General) 21.2% (Deprived)**
Business Processes		
Percentage of NHS Stage 2 Complaints responded to within timescale.	**60%**	**70%**

5.6 AREAS FOR IMPROVEMENT

Ongoing improvement is sought across all services within the HSCP and a range of mechanisms are in place to scrutinise performance at city wide and locality levels, as described in chapter 1. Specific areas we would like to improve and key actions we will progress to achieve these improvements are summarised below.

Area for Improvement	Actions
Older People	
Total number of Older People Mental Health (OPMH) patients delayed (Excluding AWI)	Actions we will take to achieve improvement include: • Develop and implement an improvement plan. • Ensure there is a regular and robust scrutiny process in place for all cases involving clinicians, hospital managers, and health and social work service managers. • Test a newly developed discharge pathway that supports 72 hour discharge within the South Glasgow OPMH wards.
Intermediate Care: Percentage of users transferred home.	Actions we will take to achieve improvement include: • Take forward actions agreed at a recent development day which focus on risk enablement and resources to support and optimise the numbers returning home. • Implement cluster based supported living models which provide an alternative to residential care admission and support discharge home where possible. • Take forward conclusions from a recent practice audit which identified areas for practice development and improvement.
Unscheduled Care	
New Accident and Emergency (A&E) attendances (All ages)	Actions we will take to achieve improvement include: • Support implementation of the Health Board wide unscheduled care improvement programme. • Continue work to understand the reasons for the rising trends and seek to differentiate between emergency and urgent care so patients get the right treatment at the right time. • Work closely with acute colleagues to try and reduce new and repeat attendances, including supporting acute clinicians to develop a policy of re-direction.

Area for Improvement	Actions
Total number of Acute Delays and Bed Days Lost to Delayed Discharge (Older People 65+).	Actions we will take to achieve improvement include: • Continue to monitor delays closely and seek reductions through weekly joint operational meetings, which seek to resolve complex discharge issues. • Continue to develop and strengthen the role of the Home is Best Team which seeks to ensure consistency of practice and effective partnership working across all hospital sites in respect to facilitating hospital discharges. • Continue to implement improvements in discharge pathways to intermediate care (see above).
Children's Services	
Access to specialist Child and Adolescent Mental Health Services (CAMHS)	Actions we will take to achieve improvement include: • Temporarily extend our core hours of business to include early evenings and weekend work. • Introduce a Quality Improvement Programme which aims to achieve more rapid access while also reducing the number of rejected referrals. • Continue work to reduce the number of missed appointments (Did Not Attends).
Adult Mental Health	
Total number of Adult Mental Health delays	Actions we will take to achieve improvement include: • Continue to closely monitor and respond to trends. • Explore the potential for additional funding to support improvements in acute inpatient and discharge pathways. • Support delivery of the Health Board wide 'Mental Health' and 'Moving Forward Together' Strategies.
Criminal Justice	
Percentage of Community Payback Order (CPO) unpaid work placements commenced within 7 days of sentence.	Actions we will take to achieve improvement include: • The Fast Track team will liaise with court clerks and increase their court presence to seek to ensure that those being sentenced to a CPO report to the court Social Work Department. • Develop new processes with providers enabling them to refer clients directly to local placements. • Establish regular performance meetings within each locality.
Percentage of Community Payback Orders (CPO) with a Case Management Plan within 20 days.	Actions we will take to achieve improvement include: • Establish regular performance meetings within each locality. • Support team leaders to use caseload and performance reports to address recording issues.

Area for Improvement	Actions
Human Resources	
Sickness absence rates	Actions we will take to achieve improvement include: • Ensure individual action plans are in place for long term absences. • Implement early intervention processes for psychological and musculoskeletal absences. • Provide training on absence and stress awareness. • Shift the focus onto 'promotion of attendance' and target areas where absence rates are highest.

APPENDIX A

Glasgow City Profile – Additional Information

Development and Regeneration Population page	Information on the city's population and needs
Understanding Glasgow	Health and wellbeing profiles for adults and children
NHS Greater Glasgow and Clyde Health and Well-being Survey - Glasgow City Main Report **NHSGG&C Health and Well-being Survey Glasgow City Summary Report 2017/18**	Survey information on adult health and behaviours in the city. A suite of full and summary reports for the 2017/18 survey for Glasgow City and each of the 3 localities within the city are available in addition to reports for other local authority and HSCP areas.
Glasgow City Schools Health and Wellbeing Survey	Survey Information on secondary school children's health and behaviours in the city. The latest published survey was for 2014/15. The most recent survey was undertaken at the start of the 2018/19 school year, and will be reported during 2019.
Glasgow Health and Care Experience Survey	This is used for measuring perceptions in relation to GP, care and carers services. It also measures progress against the National Integration Indicators. The latest survey is for 2017/18.
Scottish Health Survey	Information in relation to health and health related behaviours. Annual survey with latest results from the 2017 survey.
Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS)	Conducted on a biennial basis, targeting secondary school pupils in local authority and independent schools. The SALSUS 2015 survey provides national level data on smoking, drinking, drug use and lifestyle issues amongst Scotland's secondary school children.
2016 SIMD	Uses multiple indicators to provide comparative information on population deprivation at a small area level (data zones) within Scotland.
Scottish Public Health Observatory profiles (ScotPHO)	Presents a range of information from routine health statistics to survey data.
Scotland's Census	Takes place every 10 years with the last one in 2011.
statistics.gov.scot	Scottish Government statistics website offering a wide range of official statistics from multiple sources including population, government statistics and survey data.
Scottish Government Statistics	Scottish Government statistics website pre-dating the website above that still contains some national statistics publications or data not offered via other platforms eg. homelessness data.

APPENDIX B

National Health and Wellbeing Outcomes

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