Item No: 12

Meeting Date: **Wednesday 18th September 2019**

Glasgow City Integration Joint Board

Report By: **Susanne Millar, Interim Chief Officer**

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HEALTH AND SOCIAL CARE PARTNERSHIP LOCALITY PLANS 2019-22

Purpose of Report:	To present the 2019-22 draft locality plans of North East, North West and South Localities for approval. In doing so, to highlight the key areas of work, timescales and outcomes sought that will contribute to the delivery of the IJB Strategic Plan and local priorities.

Background/Engagement:	The priorities and actions set out within them are the product of a broad range of engagement activity. This has ranged from community engagement on previous locality plans, service specific engagement events, the IJB Strategic Plan consultation and the regular locality forums and networks. It is intended that further locality engagement events take place in October and November 2019 before the final version of each plan is produced. Accordingly, it is proposed the locality plans retain their draft status during that engagement in order to accommodate any further stakeholder feedback. The final version of the locality plans will then be brought back to the IJB for approval in January 2020.

Recommendations:	The Integration Joint Board is asked to: a) approve the draft locality plans, attached, for locality engagement and to note the intention to bring back final versions to the IJB in January 2020 for approval, along with feedback from engagement events; b) note the intention to produce a summary version of the locality plans as part of the locality engagement activity and for the final, approved versions of the plans to be accessible on the GCHSCP website and in other formats as necessary; and c) note the intention to present an annual performance report to the IJB summarising progress made against the actions set out within the locality plans, commencing September 2020.

Relevance to Integration Joint Board Strategic Plan:

The IJB Strategic Plan commits the Partnership to the development of locality plans to show how the Strategic Plan is to be implemented in each locality, and how localities intend to respond to local needs and issues. The priorities and actions set out within the locality plans will contribute to the delivery of the key priorities set out within the Strategic Plan.

Implications for Health and Social Care Partnership:

Reference to National Health & Wellbeing Outcome:	The locality plans will support the delivery of all nine national integration outcomes including outcomes for children and criminal justice services.

Personnel:	Awareness of the content of locality plans will support staff to better understand key priorities and actions for their locality and across services

Carers:	Locality plans include specific actions to support carers in their caring role.

Provider Organisations:	None

Equalities:	Locality plans outline how localities will progress the Vision and priorities outlined in the Strategic Plan, which was subject to EQIA and agreed in March 2019. Significant areas of service change referred to within the draft locality plans will already have been subject to an EQIA and made available on the GCHSCP website, accessible at the link below: https://glasgowcity.hscp.scot/equalities-impact-assessments

Fairer Scotland Compliance:	The draft locality plans include a number of actions aimed at promoting equality and reducing health inequalities. The plans also set out headline findings from health and wellbeing survey results, including those linked to social health and deprivation.

Financial:	Locality plans will be taken forward within the resources available within each locality.

Legal:	The draft locality plans comply with the Scottish Government's guidance on localities issued in 2015.

Economic Impact:	None

Sustainability:	None

Sustainable Procurement and Article 19:	None

Risk Implications:	None

Implications for Glasgow City Council:	None

Implications for NHS Greater Glasgow & Clyde:	None

Direction Required to Council, Health Board or Both	Direction to:	
	1. No Direction Required	✓
	2. Glasgow City Council	
	3. NHS Greater Glasgow & Clyde	
	4. Glasgow City Council and NHS Greater Glasgow & Clyde	

1. Purpose

1.1 To present the 2019-22 draft locality plans of North East, North West and South Localities for approval. In doing so, to highlight the key areas of work, timescales and outcomes sought that will contribute to the delivery of the IJB Strategic Plan and local priorities.

2. Background

2.1. The Integration Joint Board's Strategic Plan 2019-22 describes the three localities that make up Glasgow City Health and Social Care Partnership, along with the commitment to develop locality plans in line with Scottish Government guidance on the production of locality plans.

2.2. The purpose of locality plans is to:

a) set out what we know about the demographics and health and social care needs of the local population;
b) reflect the priorities and actions that are relevant to the locality;
c) demonstrate how each locality will contribute to the implementation of the IJB Strategic Plan;
d) communicate our performance against key targets;
e) set out the services within each locality and associated resources, including headline information on staffing, finance and accommodation; and
f) to be a vehicle for stakeholder engagement to ensure there is effective local engagement in service planning activities.

2.3 While locality plans have been produced on an annual basis to date, the majority of priorities and actions set out within them do not change significantly from year to year. This is mainly due to the strategic nature of those priorities and the medium-to-longer-term timescale often required to deliver substantial change and improvement.

2.4 Given that the priorities within locality plans derive, in the main, from the broader strategic priorities set out in the IJB Strategic Plan, it is considered the planning and production cycles for locality plans and the IJB Strategic Plan should be aligned. Accordingly, locality plans have been produced for the period 2019-22 in line with the IJB Strategic Plan. In addition, the various priorities and actions in the draft locality plans have been grouped by the five overarching strategic priorities / themes set out in the IJB Strategic Plan.

2.5 The priorities and actions set out in the draft locality plans have been identified as either ‘city-wide’ or ‘locality specific’. City-wide’ activities are those that are applicable across all three localities. Locality-specific activities are those that are only applicable or more tailored towards a particular locality. Not surprisingly, the vast majority of the actions within each locality plan are identified as ‘city-wide’, supplemented with a smaller number of actions more relevant to a particular locality. This reflects both the consistency of the service issues across localities and the co-ordinated processes in place to progress them.

3. Locality Engagement

3.1 The priorities and actions set out within the draft locality plans are the product of a broad range of engagement activity. This has ranged from community engagement on previous locality plans, service specific engagement events, the IJB Strategic Plan consultation and the regular locality forums and networks. It is intended that further locality engagement events take place in October and November 2019 before the final version of each plan is produced.

3.2 Accordingly, it is proposed the locality plans retain their draft status during that engagement in order to accommodate any further stakeholder feedback. The engagement period will also allow services to give further consideration to the potential to set more precise timescales to the delivery of actions. The final version of the locality plans will be brought back to the IJB for approval in January 2020.

4. Annual Performance Reporting

4.1 Scottish Government Localities Guidance (2015) requests that each integration authority's annual performance report include an assessment of localities' performance. As is currently the case, GCHSCP's annual performance report will report on each locality's performance. In addition, it is proposed to present an annual performance report to the IJB summarising progress made against the actions set out within the locality plans, commencing September 2020.

5. Recommendations

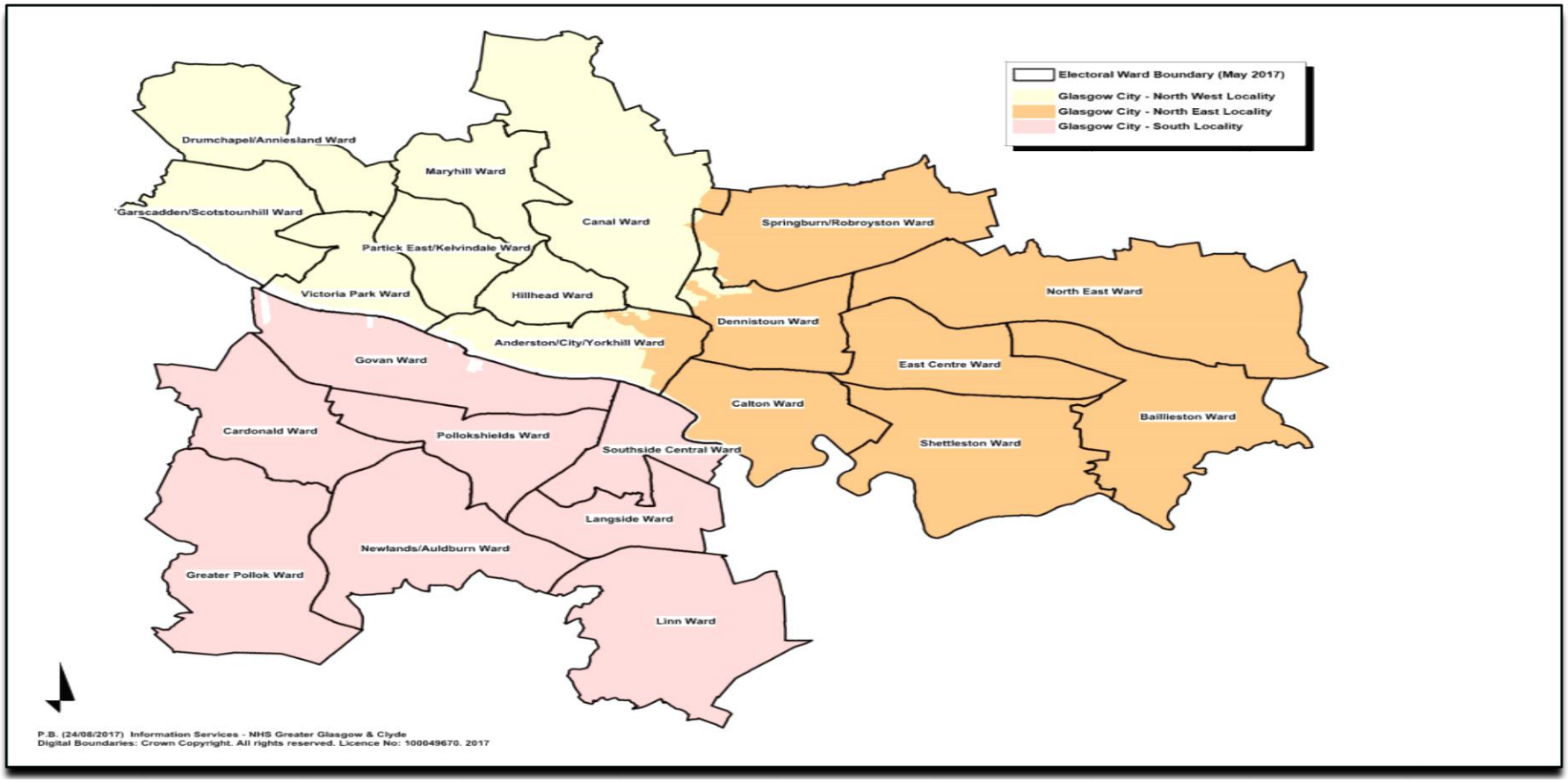
5.1 The Integration Joint Board is asked to:

a) approve the draft locality plans, attached, for locality engagement and to note the intention to bring back final versions to the IJB in January 2020 for approval, along with feedback from engagement events;
b) note the intention to produce a summary version of the locality plans as part of the locality engagement activity and for the final, approved versions of the plans to be accessible on the GCHSCP website and in other formats as necessary; and
c) note the intention to present an annual performance report to the IJB summarising progress made against the actions set out within the locality plans, commencing September 2020.

Glasgow City HSCP
Health and Social Care Partnership

North East

Draft Locality Plan 2019-22



FOREWORD NORTH EAST LOCALITY PLAN 2019-2022

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

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

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

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

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

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

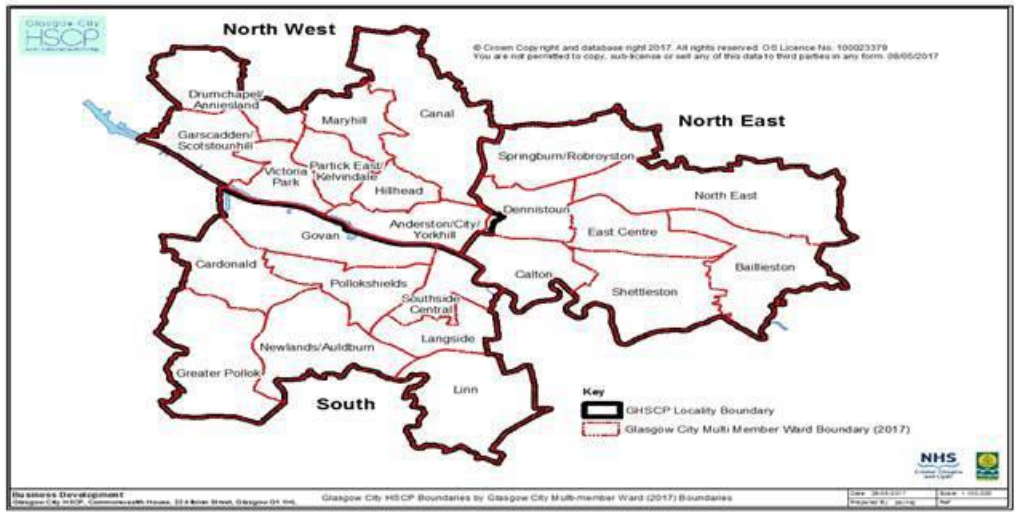
North East Locality is committed to planning and designing services in partnership with local people, working in partnership with staff, independent contractors and also our key partners across acute services, housing, community planning, care homes and the Third Sector.

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

Assistant Chief Officer
Children's Services and North East Operations

1. LOCALITY PROFILE *NORTH EAST*

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



North East Locality

North East Locality covers the following wards:

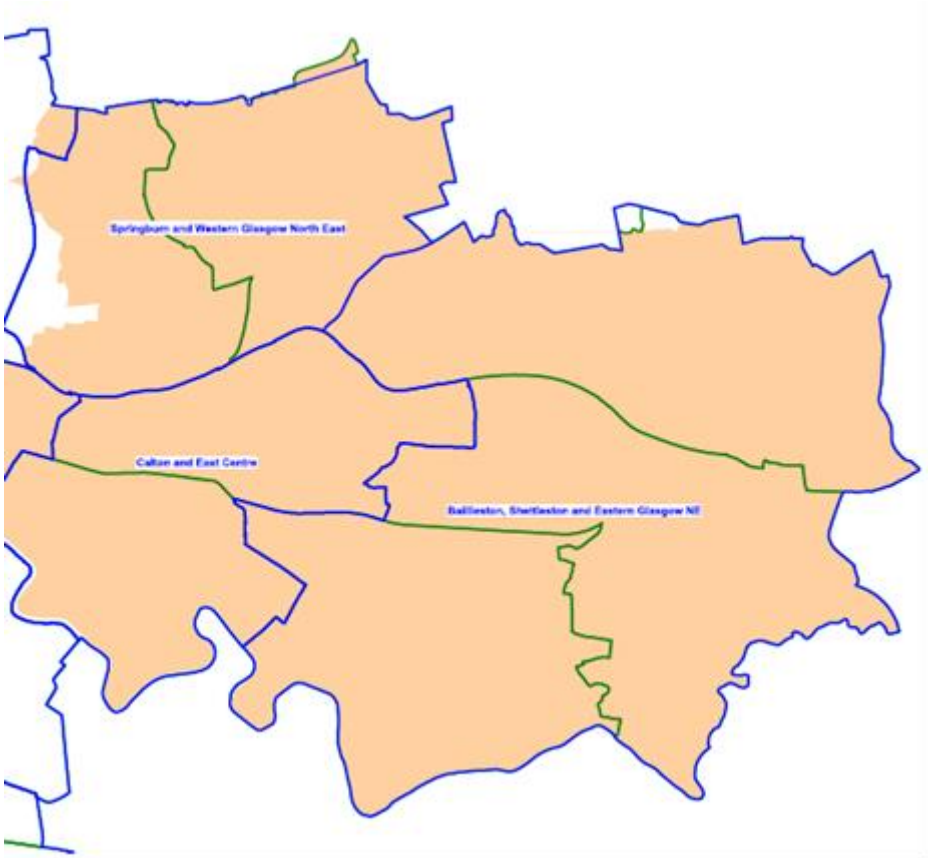
- Calton
- Dennistoun
- Springburn/Robroyston
- East Centre
- North East
- Shettleston
- Baillieston

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

Age Band	**Number of People**	**% of population**	**%of this age band n Glasgow City**
0-15years	**27,971**	**17**	**16.1**
15-64	**116,630**	**68.3**	**70.1**
65years and over	**25,012**	**14.7**	**13.8**

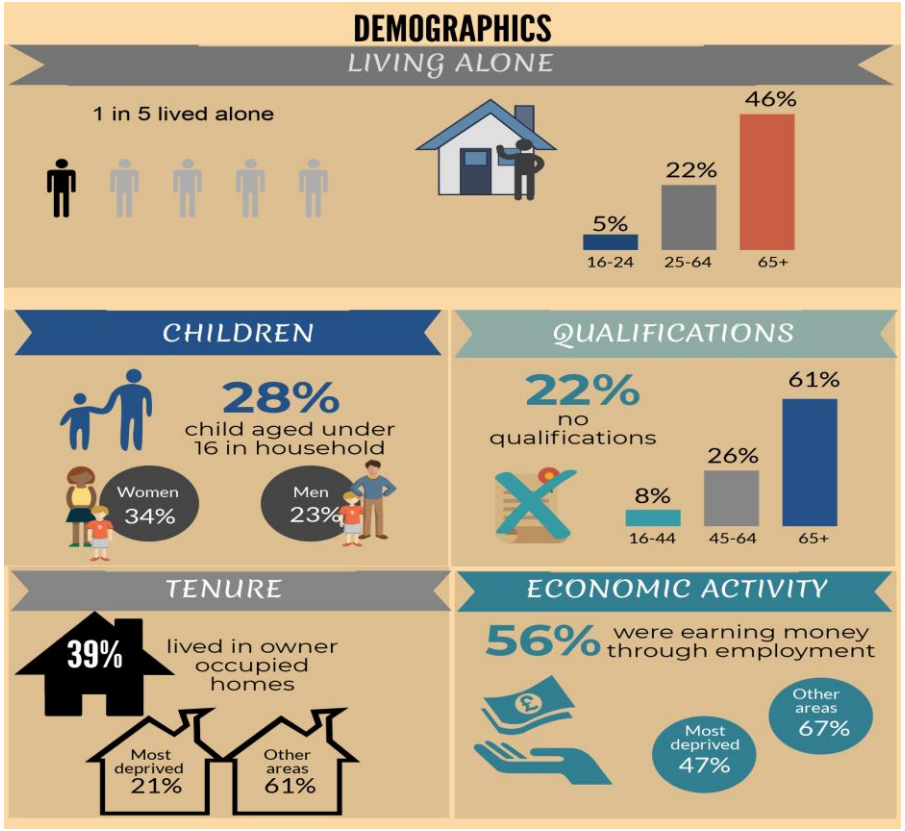
We are keen to ensure that there is a strong and effective connection between our services and the local communities we serve. To further assist this, we have structured our community services for older people into Neighbourhood Teams within North East. This will also help to improve joint working with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

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



NE Locality Health & Wellbeing Survey

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



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

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

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

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

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

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

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

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

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

2. HSCP KEY PRIORITIES

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

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

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

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

The purpose of this locality plan is to:

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

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

The locality plan is based on:

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

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

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

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

3. COMMUNITY ENGAGEMENT – NORTH EAST LOCALITY ENGAGEMENT FORUM

COMMUNITY ENGAGEMENT – LOCALITY ENGAGEMENT FORUM

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

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

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

N.E. LEF members have met with Mental Health service recovery groups to discuss their ideas on service provision at the proposed North East Health and Social Care Hub. Examples from service users that are now actively being considered are a café to help combat social isolation with community garden maintained by volunteers to develop skills and build the confidence of local people who are in recovery. N.E. LEF members have taken part in four separate engagement sessions with the appointed **architects Hoskins** and completed visits to Gorbals, Eastwood, and Maryhill Health and Social Care centres.

This level of public engagement will continue through to the completion of the Hub project.

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

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

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

4. PERFORMANCE INFORMATION NE LOCALITY

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

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

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

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

5. STRATEGIC PRIORITIES & SERVICE ACTIONS

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

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

The following section highlights activities underway for 2019/20 using the key care group / service delivery headings. Each section shows how the care group will deliver the five strategic priorities for the Partnership. The main activities will be delivered consistently across each Locality area and are identified as “City-wide”, but these will be delivered and monitored by the Locality teams. Some specific actions will be delivered in a single Locality, but may be subject to wider roll out in future years across the Partnership if appropriate

5.1 Children's Services

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

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

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

	group programmes providing accessible, appropriate, culturally sensitive parenting support in Glasgow Expand the development and implementation of a culturally sensitive community based approach to service delivery to identify and respond effectively, efficiently and sensitively to parenting needs within local community groups and settings Develop and implement parenting support pathways for targeted Triple P Teen Discussion Group support within Glasgow Secondary Schools in partnership with Police Scotland Campus Officers and Education Continue the provision of the Glasgow Solihull Approach Workforce training programme expanding the programme development to include the Solihull Plus Trauma Awareness training to support trauma informed practice across Children and Families		groups and services Increased support to families through the provision of accessible Targeted Teen Parenting programmes and workshops available in Glasgow Secondary Schools Children & Families staff across services will understand the impact of trauma on children, young people, families and adults. Use the Solihull Approach model to help and support families
School nursing services are to be reviewed across the city.	Interim plan to pool 3 locality School Nursing team to one Glasgow city school team complete. Glasgow will focus on 2 priority pathways: Emotional health & wellbeing and CP. Information being shared with key agencies.	**July 2019**	Glasgow City School Team in place
Locality Specific Action North East	**Priority Actions**	**Timescale**	**Outcomes Sought**
Review of vulnerable pregnancy liaison group	Once agreed to progress test of change which will mirror the pre-school JST model. This will be done in partnership with SWS, Midwives and Third Sector	**When agreed**	Improved access and planning for women who do not fit child protection

			criteria but do need additional support in the antenatal period

Children's Services			
Providing greater self determination and Choice			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Listening to children and young people	Provide the best tools for children and young people looked after by Glasgow City HSCP to enable them to give their views and for these to be listened to and taken into account in decision making	**2019/20**	Promotion of the participation and engagement of young people in Glasgow which truly informs service provision 93% of looked after children agreed their views were listened to. Annual Performance figs 2017/18/19
Glasgow Young people's Champion's Board	This board seeks to maximise opportunities for children and young people to get involved and have their voices heard by services and leadership groups. In addition it will seek to identify barriers to participation and work jointly on ways of addressing these, identify issues and concerns and work with children's service decision makers to find solutions, improve young people's leadership skills and help		Increased numbers of young people being involved in decision making and informing service development

	get them ready for employment		
Continue to consult with young people and develop contemporary strategies which reflect how young people currently communicate through social media and determine how this can influence child protection and looked after children and processes	Children's Rights Group is exploring innovative ways of consulting with young people including looked after and accommodated children. Review of Viewpoint/Have your Say is ongoing	**Ongoing**	Involve children in decisions that affect them, have their voices heard

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

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

Children's Services			
Shifting the Balance of Care			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
High-cost placements for children and young people	Reduce reliance on high-cost residential care placements Re-focus investment on family and community based supports located in Glasgow for young people who are currently 'looked after' by the Council	**2021/22**	Reduce reliance on high-cost residential care placements Number of children in high cost placements decreased by two-fifths, from 111 the previous year to 67. 2018-19 (to Quarter 3)
Shift the emphasis from placements out with Glasgow	Children and young people who require to be looked after and accommodated by the local authority can expect to remain living in the city and maintain connections important	**2019/20**	Further reduce the number of children living out with the city by 10%.

	to them.		
Work with families to improve the life chances for children, with a specific focus on family resilience, health improvement, educational attainment and reducing the number of children looked after away from home	Continue to Develop the Intensive Outreach Family Support Service (IOFSS**)** .The aim of the service is to provide intensive community supports to prevent young people being taken in local authority care:	**2019/20**	Continued reduction in the number of children placed on the CPR and length of time on the Register, including referrals to high cost placements

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

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

5.2 Adult Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Locality Specific Areas of Activity North East	Priority Actions	Timescale	Outcomes Sought
Mental Health			
Improve mental health inpatient accommodation	Deliver new, purpose built accommodation for mental health acute inpatient accommodation at Stobhill Hospital	2020	Improve the physical and therapeutic environment to the benefit of patients and staff
Drug and Alcohol Services			
	Deliver training to an increased number of Children's residential units		**Children and Young People affected by their own, or their carers', alcohol or drug use are supported**

ADULT SERVICES			
Enable Independent Living			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Implementation of Assisted Technology (TECS) and where appropriate alternative models of support	• Progress transformational change programme to embed consideration of TECS within assessment processes and explore alternative arrangements to sleepovers. • Pending evaluation of Connecting Neighbourhoods test for change work in Castlemilk and Shettleston, roll out new responder service for overnight care elsewhere in the City	2019/20 2021/22	People are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community Reduction in the volume and cost of sleepover provision

Modernising Learning Disability Day Services	• Extend the range of health clinics offered at day centres • Improve access to health checks • Consider alternative and quicker responses to service users or carers in times of 'social or care crisis' • "Respite" or increased support for short periods within a structured environment. • Undertake an option appraisal to consider the replacement of 2 LD day care centres	2020/21	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
Integration of Learning Disability services	Informed by test for change work in North East, implement and evaluate new processes, protocols and systems that support the delivery of more integrated Learning Disability services throughout the City, including improved access to and experience of 'mainstream' services	2019-21	People who use health and social care services have positive experiences of those services, and have their dignity respected Reduction in waiting times to access services
Improve links between Alcohol & Drug Recovery services and with housing support services.	• Continue to work closely with housing providers and housing support services to identify individuals who require alcohol and/or drug interventions to assist in tenancy sustainment.	Ongoing	Early access to care and treatment. Tenancy sustainment
Review frequent Emergency Department presentations and aim to support to reduce attendances	Continue to review and audit frequent Emergency Department attenders.	2019/20	Reduction in A&E attendances
Locality Specific Areas of Activity North East	**Priority Actions**	**Timescale**	**Outcomes Sought**

Mental Health Services			
Complete personalisation assessments for all people who have a mental health difficulty and are eligible for services	Improve performance in relation to the completion of Support Needs Assessments and Outcome Based Support Plans which will improve access to social care services. Additional performance targets to be set with all plans to be routinely completed within two month period	**Ongoing**	Outcome based support plans(OBSPs) are developed in collaboration with service users, families and other partners ensuring that people are safe, protected and supported to live as independent lives as possible and exercise choice and self determination in their lives
Supported Living	Review all models of support to take forward the reshaping of supported accommodation and supported living to meet current needs, ensuring that people in most need can be prioritised for high levels of support		More people are able to live independently with support
Drug and Alcohol Services			
Recovery	Continue to support recovery volunteers though formal supervision; Further develop in-reaching to treatment clinics by recovery volunteers; Develop a weekly reception area presence of recovery volunteers in ADRS	**2019/2020**	recovery is an integral part of treatment, from the first point of contact through to exit
Homelessness	Continue to input into Local Letting Communities and improve interface with Housing providers to increase access to settled accommodation	**2019/2020**	Increase in numbers of households securing permanent accommodation

ADULT SERVICES			
Public Protection			
City Wide areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Adult Support and Protection Act	• Ensure staff continue to be supported to meet ASP standards and requirements • Contribute to maintaining and where necessary, improving practice arising from the annual joint self evaluations	Ongoing	Continue to ensure people, particularly the most vulnerable, are kept safe from harm and that risks to individuals or groups are identified and managed appropriately.
Develop more integrated working practices between Criminal Justice and other Adult Services to better manage vulnerability	• Develop more integrated risk assessment and risk management processes with Alcohol and Drug Recovery Services (and ensure all MAPPA clients with alcohol and /or addiction issues are able to access local services). • Ensure criminal justice staff have a full understanding of processes and supports aimed at preventing homelessness	2019-21	Clients have timely access to appropriate services, including better access to Addiction and Homelessness services Criminal Justice staff to be aware of the housing first model and be able to support service users to access / utilise this service when appropriate Criminal Justice staff have a better understanding of complex mental health issues (eg personality disorder) and the best approach to manage / address these needs

	• Review referral pathways with Mental Health and promote best practice with service users with complex mental health needs • Ensure follow-up for non-engagement, with particular consideration to vulnerability and risk • Develop more robust links and working practices with Scottish Prison services		Early identification of vulnerability.
The efficient processing of community payback orders (CPOs) and criminal justice social work reports	• Ensure all CPOs are reviewed by a Team Leader at the 3 month stage and throughout the order. • Ensure service users have a comprehensive risk assessment and supervised action plan in place within 20 days of a CPO.	Ongoing	75% of CPOs 3 month Reviews held within timescale Compliance target of 85%
Increase BBV testing and support access to Hepatitis C and HIV treatment	• Continue to increase testing and access to BBV (blood-borne virus) treatment. • Increase staff trained in Dry Blood Spot testing (DBST)	2019-22	Reduction in the number of people infected with Hep C and HIV

Establish the Enhanced Drug Treatment Service (EDTS)	• The Enhanced Drug Treatment Service will commence in September 2019 with a focus on prescribed diamorphine treatment for a small group of people who inject drugs within the city centre.	2019/20	Reduction in drug deaths and supporting people to access other care and treatment pathways as necessary
Develop a service improvement programme for Prison Healthcare	• The development of Advanced Nurse Practitioner posts across the service to address the challenge of providing accessible medical cover. • The review of recruitment practice around nursing and medical staff to support retention and vacancy management. • A review of the workforce to enable improved service delivery, including enhanced mental health /psychology provision funded through 'Action 15' monies. • A robust Health Improvement approach is in place • The development of enhanced IT provision	2019-22	Performance framework to be developed Within available parameters, people in prisons have equity of access to safe, effective and responsive healthcare

	to assist service improvement opportunities		
Continue to provide a combined high quality Police Custody healthcare service, including delivery of Forensic Medical Service provision	• Be responsive to the health care needs of people in custody and to ensure appropriate links are made to other services (e.g. Addiction, Mental Health Services) to meet individuals' on-going health needs. • Enhance mental health service provision through 'Action 15' monies. • The development of enhanced IT provision to assist service improvement opportunities • The development and implementation of a robust Health Improvement approach	2019-22	Performance framework to be developed Within available parameters, people in police custody have equity of access to safe, effective and responsive healthcare
Development of Archway Sexual Assault and Referral Centre (ASARC)	• Work with partners to maintain the high standard of forensic care and increased opening hours in the Archway sexual assault and referral centre. Progress development of a new West of Scotland regional		Improved access to specialist care and support

	service, including transfer of ASARC from Sandyford to upgraded accommodation at William Street Clinic		
Development of Community Custody Unit for women	Work in partnership with Scottish Prison Service to develop the HSCP service and staffing model required to provide effective care and support to women in the new facility to be developed in Maryhill	2020	Provide safe accommodation and support the needs of women who are suitable for, and would benefit from, closer community contact and access to local services, to create and sustain independence in preparation for successful reintegration into the community
Ensure North East Women's Team continue to be effective in terms of impact on service user's wellbeing indicators	The North east Women's Team (NEWT) will contribute to a citywide evaluation of services for Women within the Criminal Justice system The outcomes of the most recent evaluation of the NEWT to be shared with criminal justice colleagues / senior management	**2019/2020**	Overall services / supports for women within the CJ system to be improved with any gaps in provision addressed. Learning from the positive review of the NEWT to be shared with colleagues both within NE and across the city in terms of best practice approach to working with women

5.3 Older People and Physical Disability

OLDER PEOPLE'S & PHYSICAL DISABILITY SERVICES			
Prevention Early intervention and Harm Reduction			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Anticipatory care plans	1089 were completed last year which is more than doubled since 2017. A new model National model called my ACP is being introduced in 2019/20. • Complete staff awareness sessions • Implement Clinical Portal Version of ACP summary • Raise public awareness • Provision of additional support to Partnership staff from MacMillan ACP Facilitator • Develop and agree new HSCP ACP Booklet • Work with HIS to form and develop a Living and Dying Well Frailty Collaborative	Introduced this financial year.	Targeted use of ACP within District Nursing Services, Long Term Conditions and Care Homes Share ACP summaries with GPs and other relevant professionals involved in the persons care. Empower people through greater awareness, control, choice and self management of their LTC. Test new approaches to the identification and management of Frailty
The use of falls prevention and projects to support frail older people.	Glasgow's target rate is 6.75 per 1,000 but the current rate is 7.5: a number of actions are identified including; • Develop a referral pathway with Scottish Fire	Actions to be progressed in 2019/20	Increased referrals to rehab services and community falls team. and established

	and Rescue to carry out level one conversations and refer into NHS falls and rehab services Introduce a frailty tool with specific focus on evidence based interventions. • Promote the use of the “Up and About” resources on prevention of falls • Agree ways of improving data collection for falls including determining a realistic and meaningful baseline. • Continue to support Scottish Ambulance to reduce the number of non injured fallers conveyed to hospital • Contribute to the response to the Falls and Fracture Prevention Strategy for Scotland 2019 -2024 consultation document • Contribute to the development of the NHSGGC Falls Strategy • Promote the use of Technology Enabled Care for those who are at risk of falling • Connect various sources of information on people who fall to services i.e. homecare and rehab		use of frailty tool
Maximise use of Link worker capacity within Primary care, Dementia Services and Community Connectors	• Raise awareness of roles of links workers • Promote networking of Links Workers to make efficient use of capacity		

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

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

Link with the five year strategy for older people's mental health	The OPMH 5 year strategy is currently in development and will have a focus on shifting the balance of care including looking at alternatives to admission to inpatient care. Dementia is one strand of the above. **Technology** Ensure all staff have the knowledge, skills & competencies around the availability of technology to support individuals at the different stages of dementia. **Promoting Excellence** All HSCP employees in contact with people with dementia will have a level of training appropriate to the promoting excellence framework. **Advanced Dementia/sharing good practice** Sustainability around good practice in the area of dementia service delivery, shared learning across the HSCP and third sector. **Dementia Public Awareness** Through public awareness and involvement of third sector organisations . People will have a better understanding of basic rights and entitlements, ensuring more resilience and less likelihood of delays in hospital. People have a better understanding of lifestyle choices which could impact of the onset of dementia People will feel they can live well with dementia People experience a positive approach to dementia where they live. **Post Diagnostic Support (PDS).** Patients and service users receive timely post diagnosis support	To reduce waiting time and gather accurate data in relation completed PDS, referrals and waiting times -Revise IJB Performance measures. -Explore opportunities to develop PDS pathways for people with more advanced dementia -Manage Alzheimer's Scotland PDS contract and consider options for how 5 Pillar PDS is delivered in 2020 -Benchmark against the PDS framework for quality	Improved co-ordination across acute and mental health systems Continue to Increase the number of service users with a diagnosis of dementia on the GP Dementia register and ensure effective delivery of pos

	Specialist dementia Unit improvement programme. A national improvement programme will continue to ensure continuing improvements in the provision of specialist dementia units using and Experience based on a co-design model. **Effective and Efficient Community Mental Health Teams** Ensure that Community Mental Health Teams are operating effectively and efficiently to meet the needs of the current population and improve outcomes for people living with dementia and or functional mental health illness	improvement -Gather qualitative information from patients/service users	
Integration of Occupational Therapy within Older People's services	The review of OT has focused on creating integrated OT Services within Older People and Primary Care Group. A piece of work to identify competencies has been undertaken and will be rolled out following a successful test of change. This aim of this is to ensure that we can make best and full use of all the skills of OT's, and reduce onward referral to OT colleagues to a minimum There is also a data and performance work stream that has tested out a number of measures to assess the impact of OT on services user health and well - being and assess the impact of individual OT's. In addition plans are underway to measure waiting times across all services in a consistent way.	2019/20	**Consistent and effective use of services and Occupational Therapy skills**

Older People and Physical Disability Services			
Enabling Independent living for longer			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Increases in the amount of homecare reviews undertaken and offered.	During 18/19 83% of those aged over 65 receiving home care were reviewed. This above the target figure of 81%. However South area averaged 78% due to staff shortages and this is an area for improvement.	During 2019/20	Regular review of homecare and maintenance or improvement of target figures
Increases in the amount of supported living placements including the living well project.	The number of people in supported living services increased during 18/19 to 878 which is above the target rate of 830 per annum. The increase in the number of OP personalisation packages is a driver for this. Further increases during 2019/20 are sought.	2019/20	**Delivery of supported living placements**
Development of bespoke OP residential housing with care.	202 service users are currently supported with care and support packages via housing providers. 75 more properties are coming on stream during this financial year.	Track occupancy progress during 19/20.	**Delivery of supported living placements in partnership with Housing providers**
Increase take up and support for palliative care.	Palliative Care services have been a factor in increasing the percentage of people who spend the last 6 months of their life in the community. Target for 2019/20 is to increase those spending the last 6 months of their life in the community by 2%.	Further work during 2019/20 to improve RAG classifications and data collection.	**Increased use of palliative care provision and choice for people to spend last 6 months of life in home or community setting**
Creating a safer home environment through Improving identification of vulnerable Older People through Housing and relationship with Registered Social Landlords and Housing Options	Maximise the use of RSLs and HOs to support HSCP in identifying vulnerable older people and assist them in identifying where housing options, Telecare, ACP, adaptations etc.	Measures to be developed around Use of Clustered Supported Living	Review through Essential connection forum with partner organisations and develop measures for uptake of Telecare and use of Anticipatory Care Plans

		Placements and uptake of appropriate support	with appropriate people

5.4 Primary Care and Community Services

PRIMARY CARE SERVICES			
Prevention early intervention and harm reduction			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Primary Care Improvement Programme (PCIP) – General Practice Multi-Disciplinary Team Workflow	• Agree process for application to Health Improvement Scotland Practice Administrative Staff Collaborative (PASC) collaborative for general Practice in Glasgow • Support applications under PASC – signposting training • Support roll successful practices in the roll out and implementation of the PASC Collaborative	Aug 2019 Autumn 2019 and ongoing for successful applications	Glasgow City practices successfully in a national collaborative to promote signposting as a way of working and increasing the number of people seeking consultations who are seen first by the person / service most able to help
PCIP - Improve communication and working relationships between the HSCP and General Practices.	• Increasing contact between HSCP and GPs using the cluster guidance, Cluster Quality Leads to be offered by PCIP Team • Agree implementation of cluster guidance for up to 4 sessions per month for clusters • Increase frequency of meetings between HSCP & GPs to boost tripartite arrangements.	12 months	Increased and improved collaboration between HSCP and GPs.
PCIP - Pharmacotherapy	• Continue close working with pharmacy colleagues to ensure that all practices have	April 2020	All practices aware by end 2019 of the level of input

	some pharmacotherapy input by Spring 2020		they can expect
PCIP – Musculo-Skeletal (MSK) Physiotherapy	• To co-ordinate use of Advanced Practice Physiotherapists (APPs) to improve patient care and reduce GP workload. • To embed the learning gained from experience in north east practices.	March 2020	To offer APP to appropriate practices in north east and across the city.
PCIP - Vaccination Transformation Programme (VTP)	• To link Glasgow City VTP to Greater Glasgow & Clyde priorities and programme board. • To effectively and safely transfer current vaccination programme to new service models under PCIP to improve vaccination uptake.	Ongoing April 2021	To maintain / improve vaccination levels under new arrangements.
PCIP Urgent Care	Know Who To Turn To banners in GP practices	Autumn 2019	Raise patient awareness of alternatives to GP visit

Primary Care Services			
Providing Greater determination and choice			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
PCIP – Community Care & Treatment; Phlebotomy	Continued roll out of phlebotomy service to areas of the City/ Locality not served by Health Centres providing patients with more choice about where they attend to have their bloods taken	Autumn 2019 and ongoing	Provision of service to increased number of practices with an initial emphasis on those practices who do not have access to existing Treatment Rooms
PCIP Community Care and Treatment/Phlebotomy/Premises Work stream	Support sourcing of suitable accommodation for Phlebotomy service	Autumn 2019	Provision of service to increased number of practices with an initial

			emphasis on those practices who do not have access to existing Treatment Rooms
Locality Specific Areas of Activity North East	**Priority Actions**	**Timescale**	**Outcomes Sought**
To improve communication and good working relationships between the HSCP and General Practices.	This will involve increasing contact between HSCP and GPs using the cluster guidance, CQLs to be offered 4 sessions per month for cluster working. We will increase frequency of meetings between HSCP & GPs to boost tripartite arrangements.	12 months	Increased interaction between HSCP and GPs.

Primary Care Services			
Shifting the Balance of care			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
PCIP - Primary Care Sustainability	• Test more systematic and proactive approach to the identification of sustainability challenges e.g. combining our current intelligence with the offer of a proactive survey of all practices in one Locality. • Strengthening support to practices could primarily take the form of ensuring that the wider supports are available to the practices in greatest need, examples of these include; MDT, workflow, administration support, training and other ways of meeting practice specific needs. • Quantify GP time freed up and time spent with those with more complex needs	April 2020	Ensuring continuity of care as implementation of PCIP

PCIP – Urgent Care	• Support the roll out of the ANP model into HSCP care homes. • Develop and provide ANP to new residential units opening in the NW in late summer 2019	Autumn 2019 and ongoing	Enhanced support for care home residents and reduced workload including housecalls for GPs
Locality Specific Areas of Activity North East	**Priority Actions**	**Timescale**	**Outcomes Sought**
Hospital attendance	To liaise with Secondary Care via the local interface groups, by this means to attempt to reduce hospital attendance both at A & E and GP admissions.	12 months	To have closer working relationships and concrete plans to reduce hospital attendance.

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

5.5 Health Improvement

HEALTH IMPROVEMENT SERVICES			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Youth Health Services	Establish two new sites for a holistic youth health service (one in North East, one in South) Develop implementation plans to include youth engagement processes Commence service model delivery	By March 2020	• Improved access to holistic, bespoke youth health services • Vulnerable young people receive holistic support services before adulthood • Young people access enhanced tier 0-2 mental health and well being support
Community Link Worker programme (Primary Care Improvement Plan)	Support the phased rollout of the community link worker programme; working closely with primary care Refine current operational model and data collection Delivery of the procurement processes to determine allocation of additional link workers	Phased 2019-20	Improved collaboration with GP practices and the Alliance Increased uptake of social prescribing in areas of deprivation Improved connectivity into relevant services and local community supports

Community based mental health and well being services (adult and children)	Deliver preparatory work and commissioning process to determine a service provider for community based adult mental health and well being support Undertake scoping to inform the development of service model options to address mental health and well being in children aged 5 – 12	By March 2020	Adults experiencing poor mental health and well being can access community based support service Development of a service model to support mental well being of children aged 5-12
Locality Specific Areas of Activity North East	Priority Actions	Timescale	Outcomes Sought
Placed based work	Contribute to the development of Thriving Places action plans in Easterhouse/Springboig/Barlanark and Parkhead/Dalmarnock/Camlachie with community planning partners	September 2019	Neighbourhoods inform priorities for local development
Financial inclusion	Deliver financial inclusion embedded into GP practices in Bridgeton and Parkhead	April 2019-March 2020	Maximise income and address debt to support health and well being
5.6 Carers			
CARERS SERVICES			
City-wide Areas of Activity	Priority Actions	Timescale	Outcomes Sought
Implement the Carers (Scotland) Act 2016	Workforce learning and Development Plan to be made available to all Health and Social Care Partnership	Initially role out for Older People	Carer's (Scotland) Act 2016 training to be available

	staff to ensure Carers are support is embedded within practice. Monitor and evaluate training attendance and effectiveness via North West locality quarterly performance monitoring and annual carers report via the Integrated Joint Board (IJB).	and Primary Care Services. Followed by Adult Services and then Children's Services. All operational staff would be expected to attend awareness raising sessions or complete Carer (Scotland) Act 2016 e-learning module.	August 2019 onwards.
Carers are identified early in their caring role	Continue to promote and distribute carer Information Booklets to enable carers to self-refer. Continue to promote SCI-gateway as primary care / GP referral pathway for carers. Continue to offer carer awareness information sessions to raise awareness of carers. Continue to promote the Carers Information Line. Improve Carefirst recording where the carer is supported jointly with the service user.	The 2019/20 target for total number of new carers that have gone on to receive an adult carer support plan or young carer statement in Glasgow HSCP is 1650 per annum.	In 2018-19 the total carer information booklets distributed were 8724: • North West (NW) distributed 3172 • South distributed 2931 • North East (NE) distributed 2621 In 2018-19 the total calls to the Carers Information line were 482:

		The 2019/20 target for carers being offered preventative support early in their caring role is 70%. Monitor and report the effectiveness of the carer Strategy including protected Characteristics data.	• NW enquiries totalled 84 • South enquiries totalled 250 • NE enquiries totalled 138 The total New carers offered a support plan or Young Carer Statement in 2018-19 was 2007 64% of new referrals were preventative Equalities Impact Assessment (EQIA) will be included in performance Monitoring from 2019 onwards. Carefirst e-forms and changes required for Carers (Scotland) Act 2016 expected to be completed August 2019

6. PROMOTING EQUALITY

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

- Maintaining accessibility audits of new buildings
- Participation in Equality Impact Assessments of cost savings, service redesigns, service developments and policies
- Hate crime awareness and reporting

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

7. RESOURCES

7.1 Accommodation

New Health and Care Centre

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

Reviewing Accommodation Requirements and Promoting Co-location

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

7.2 Human Resources

North East Locality directly manages a staffing compliment of :

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

7.3 Finance

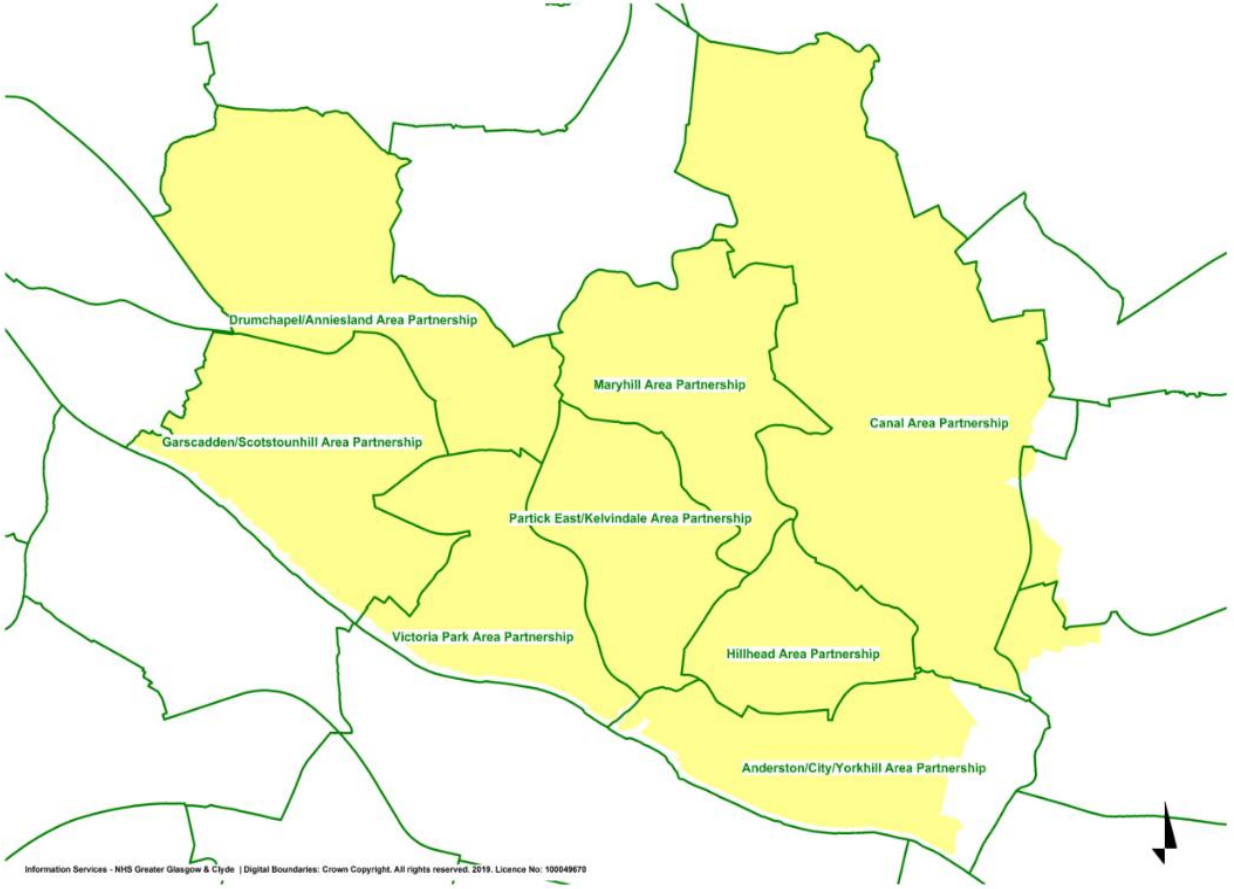
North East Locality has a total net recurring budget for service provision of approximately £230m and directly manages a staffing compliment of approximately 3109 people. The budget for North East Locality in 2019/20 is set out below.

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

Glasgow City HSCP
Health and Social Care Partnership

North West

Draft Locality Plan 2019-22



FOREWORD

I am very pleased to introduce the North West Locality Plan for the period 2019-22.

Our plan highlights the priorities and actions that will be progressed in North West to address local needs and contribute to the wider strategic agenda set out within the Glasgow City IJB Strategic Plan 2019-22. Our work will be progressed in partnership with our stakeholders, including service users, patients, carers, third sector organisations and community planning partners.

We are keen to build on the successes made over the last year, which included opening a new £20m Woodside Health and Care Centre, the further development of General Practice 'clusters', supporting the implementation of City-wide transformational change programmes for Children's, Adults and Older People's services, as well as continuing to make good progress on a range of performance targets and standards aimed at improving service quality and access.

The period ahead will undoubtedly continue to bring its challenges as we strive to meet increasing demand within a constrained financial envelope. To meet those challenges we will need to ensure our services are working as efficiently and effectively as possible and targeted appropriately to meet need. The integration of health and social care has provided an excellent platform to do just that and more importantly, to deliver better outcomes for our service users, patients and carers.

Finally, while the actions set out in this plan are numerous, they are by no means exhaustive and cannot capture all the day to day activities undertaken by our services and I would like to take this opportunity to thank all of the staff in North West locality for their continuing hard work and dedication.

Jacqueline Kerr
Assistant Chief Officer,
Adult Services and North West Locality
Glasgow City Health and Social Care Partnership

1. LOCALITY PROFILE

Glasgow City is the largest HSCP in Scotland by population and budget and is responsible for health and social care provision across 3 localities in the City; North West, North East and South Glasgow. North West locality covers a population of 206,483. Its boundary is coterminous with the community planning boundary for North West Sector, inclusive of 8 Area Partnerships, below:

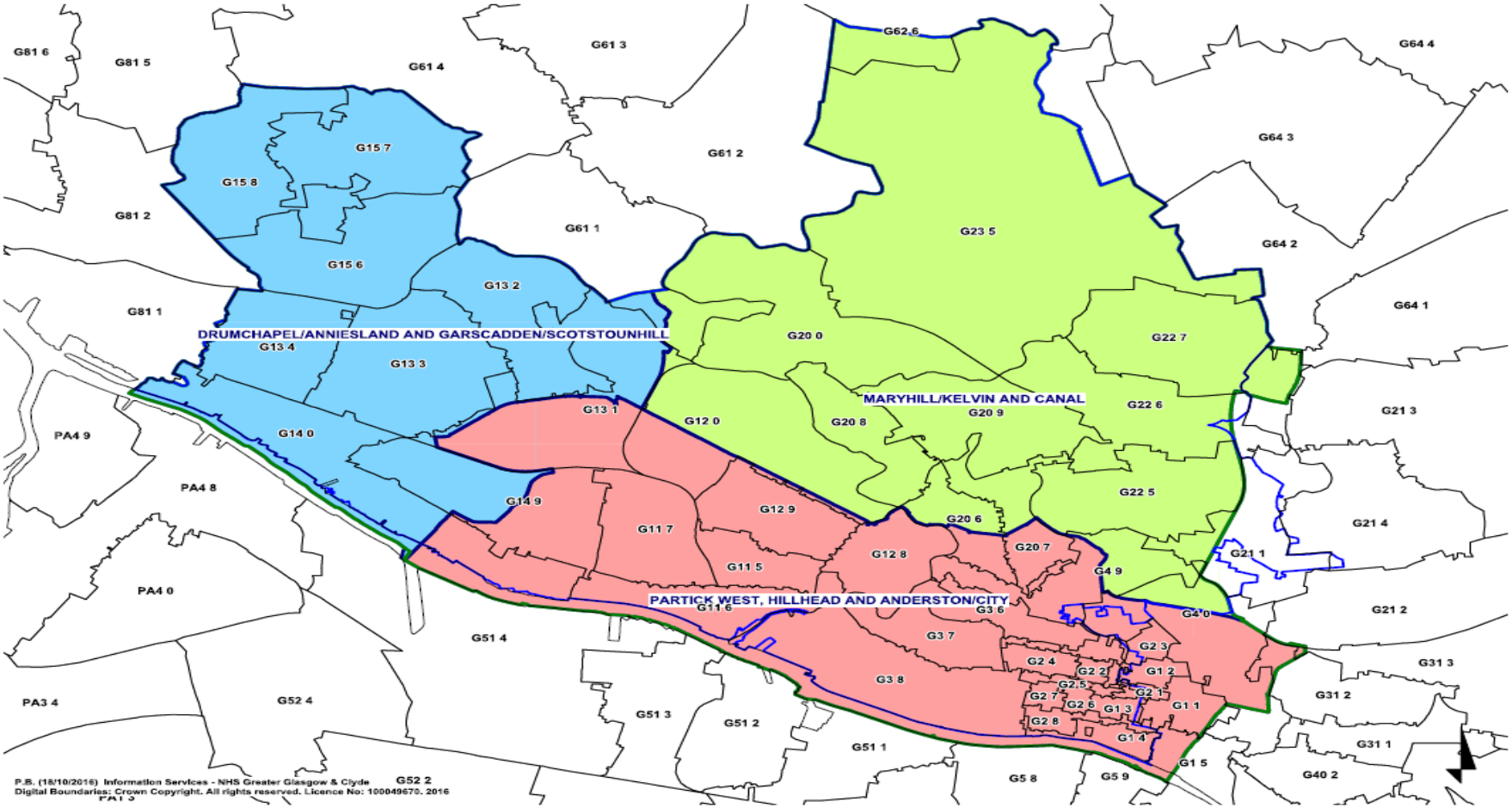
- Anderston/City/Yorkhill Area Partnership
- Hillhead Area Partnership
- Partick East/Kelvindale Area Partnership
- Garscadden/Scotstounhill Area Partnership
- Drumchapel/Anniesland Area Partnership
- Maryhill Area Partnership
- Canal Area Partnership
- Victoria Park Partnership

A significant feature of North West locality is the very marked difference in the social and economic circumstances of people living in different areas in the locality, ranging from some of the most affluent areas in Scotland to some of the most deprived. A key responsibility of localities is to produce a locality plan for the area they serve. This document is the locality plan for North West Glasgow and is guided by the overarching priorities set out in the HSCP's Strategic Plan.

As well as having responsibility for supporting the delivery of the range of services set out within this plan to our local population, the Assistant Chief Officer for North West locality also has a lead responsibility within Glasgow City HSCP for managing all Adult Services. This includes Sexual Health Services, and healthcare for prisons and police custody which are all hosted by Glasgow City HSCP on behalf of other HSCPs in Greater Glasgow and Clyde.

We are keen to ensure that there is a strong and effective connection between our services and the local communities we serve. To further assist this, we have structured our community services for older people into 3 Neighbourhood Teams within North West. This will also help to improve joint working with GP Clusters and other partner organisations, such as Housing providers. These Neighbourhood Teams will broadly work within the 3 boundary areas shown in map overleaf.

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



Health and Wellbeing

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

People in NW more likely to binge drink 67% in NW (Glasgow city 62%).

34% of NW say they do not drink alcohol .

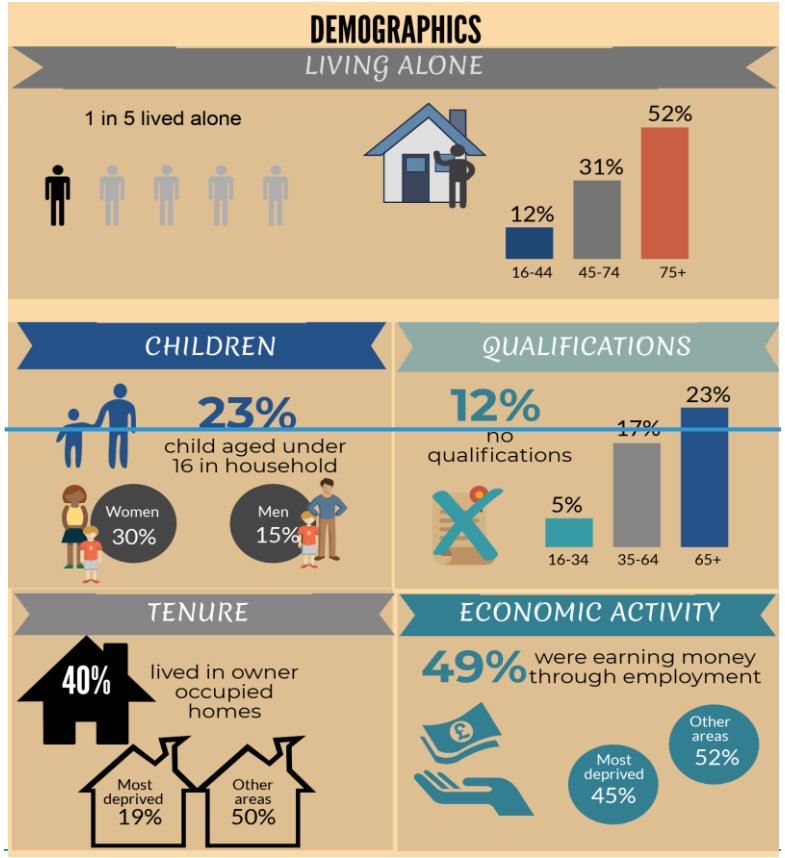
Positive trends in tobacco prevalence and exposure to second hand smoke: NW prevalence down by 10% to 24% and exposure down from 39.1% to 31.5% in NE

32% of people have difficulty meeting necessary expenses - rising to 42% in the most deprived areas(more common in those aged 16-24 at 46%)

More people definitely feel in control of decisions affecting their daily life, up 10% to 69%

19% of people in NW felt lonely or isolated (Glasgow 15%) - a 10% increase from 2008

15% of NW respondents aged 35-64 experienced food insecurity in the last year



Full report: North West Glasgow - https://www.stor.scot.nhs.uk/handle/11289/579886
Summary report: North West Glasgow - https://www.stor.scot.nhs.uk/handle/11289/580029
Ruchill/Possilpark Report - https://www.stor.scot.nhs.uk/handle/11289/579895

2. HSCP KEY PRIORITIES

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

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

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

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

The purpose of this locality plan is to:

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

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

The locality plan is based on:

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

3. COMMUNITY ENGAGEMENT – LOCALITY ENGAGEMENT FORUM

The priorities and actions set out within this locality plan have been informed by a broad range of community and service user engagement activity. This has included engagement on the 2018-19 locality plan, consultation on Glasgow City IJB's Strategic Plan 2019-22 and involving service users, carers, community groups and partner agencies in the development of a variety of service strategies and action plans.

In particular, the North West Locality Engagement Forum (LEF) has been a catalyst for communication, engagement and participation. Local people, community groups and organisations have had the opportunity to discuss and give their opinions on a range of Locality topics including:

- North West Locality Plan 2018-19 and future priorities
- Health Improvement service priorities including the development of the Volunteer Charter
- Older Peoples' services including on Residential and Day Care developments
- Adult services priorities focusing on the work of the Distress Collaborative and Suicide Prevention
- HSCP Criminal Justice services and priorities
- HSCP Homelessness and Housing services
- Monitoring progress of the Woodside Health and Care Centre development
- Weight Management Service
- Presentations from 3rd Sector partners such as Marie Curie

In September 2018 the NW LEF and North West Voluntary Sector Network organised a joint event around disability and equalities. Forum members, 3rd sector partners and the wider community have also participated in events and had the opportunity to contribute to HSCP and Board wide service priorities, reviews and consultations. These included:

- Review of Out of Hours Services
- Moving Forward Together
- Primary Care Improvement Plan
- Review of Overnight Support
- Carers Strategy consultation, and the
- HSCP Strategic Plan 2019- 22

The North West LEF priorities for the next three years will be to:

- continue to have regular meetings to discuss and contribute to locality care group priorities, as well as topic focused discussions to encourage participation and involvement from the wider community;
- continue to promote greater representation of vulnerable people and groups;
- continue to work in partnership with North West Voluntary Sector Network, North West Youth Network and North West Mental Health, Wellbeing and Suicide Safer Communities Forum, as well as develop closer links with North West Recovery Communities, Carers Forum and Childcare Forum;
- lead city wide participation and create engagement opportunities around Adult service priorities and developments;
- support and encourage services and teams to engage and gather comments at the point of service delivery.

To find out more about the NW Locality Engagement Forum please contact: May Simpson, Community Engagement & Development Officer (North West Locality) 0141 314 6250 or may.simpson@ggc.scot.nhs.uk

4. PERFORMANCE

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

Indicator	**April-June 2019 Performance/ Status**	**Jan – March 2019 Performance/Status**
Achievements		
Home Care: % of Older People (65+) reviewed in the last 12 months.	80% (RED)	89% (GREEN)
Prescribing Costs: Annualised Cost Per Weighted List Size	£159.99 (GREEN)	£154.53 (GREEN)

% of Health Plan Indicators (HPIs) allocated by Health Visitor by 24 weeks	96% (GREEN)	96% (GREEN)
% of people who have started a psychological therapy within 18 weeks of referral	83.1% (RED)	89.4% (GREEN)
% Alcohol and Drug service users with an initiated recovery plan following assessment	74% (GREEN)	81% (GREEN)
% of Community Payback Orders with a case management plan within 20 days	87% (GREEN)	84% (GREEN)
% of Unpaid Work requirements completed within timescale	63% (RED)	70% (GREEN)
% of criminal justice social work reports submitted to court	81% (GREEN)	87% (GREEN)
Women Smoking in Pregnancy (General Population)	10.3% (GREEN)	9.4% (GREEN)
Women Smoking in Pregnancy (Deprived Population)	18.8% (GREEN)	17.2% (GREEN)
Exclusive Breastfeeding at 6-8 weeks (General Population)	33.1% (GREEN)	36.5% (GREEN)
% of Social Work Stage 1 Complaints responded to within timescale	55% (RED)	79% (GREEN)
Areas For Improvement		
Total Number of Older People Mental Health Patients Delayed	4 (RED)	3 (RED)
Intermediate Care (Average Length of Stay - Days)	30 (RED)	29 (RED)

Total Number of Acute Delays and Acute Bed Days Lost to Delayed Discharge	N/A	15,288 (citywide)
Number of New Carers identified that have received a Carers Support Plan or Young Carers Statement	N/A	502 (RED) (Target 550)
Flu and Shingles Immunisation Rates	Various for different groups	Various for different groups
Access to Child and Adolescent Mental Health Services	N/A	83.2% (RED)
% of Looked After and Accommodated Children under 5 who have had a permanency review	88% (GREEN)	68% (RED)
% of young people receiving an aftercare service who are known to be in employment, education or training	62% (RED)	63% (RED)
Total Number of Adult Mental Health Delays	N/A (RED)	4 (RED)
% Homelessness Decisions made within 28 days of initial presentation	95% (RED)	86% (RED)
% of Community Payback Order unpaid work placements commenced within 7 days of sentence	71% (RED)	69% (RED)
Exclusive Breastfeeding at 6-8 weeks (Deprived Population)	22.5% (RED)	21.9% (RED)

5. STRATEGIC PRIORITIES & SERVICE ACTIONS

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

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

The following section highlights activities underway for 2019/20 using the key care group / service delivery headings. Each section shows how the care group will deliver the five strategic priorities for the Partnership. The main activities will be delivered consistently across each Locality area and are identified as "City-wide", but these will be delivered and monitored by the Locality teams. Some specific actions will be delivered in a single Locality, but may be subject to wider roll out in future years across the Partnership if appropriate.

5.1 Children's Services

CHILDREN'S SERVICES			
Prevention, early intervention and harm reduction			
City Wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Develop a Family Support Strategy	Work with partner agencies and third sector to improve the range of preventative supports and sustainability of services for families that will provide long-term benefits for local children and families Provide better support to mums, dads and carers in our most vulnerable neighbourhoods.	2019	The aim of the service is to provide community supports to prevent young people being referred to social work and/or taken in to local authority care. Families who do not require statutory support from social care, can access

	Continue to work with third sector agencies to improve the range and sustainability of family support services that will provide long-term benefits for local children and families		a range of preventative third sector services
Work with the Centre for Excellence for Looked After Children in Scotland (CELCIS) and the Robertson's trust to improve our approach to supporting children and young people on the 'edge of care'	Commissioning of services from the third sector to provide intensive family support to children on the edge of care	2019/20	Reduction in the numbers of children being taken into local authority care
Children's services – Whole system change .	Implement a framework to promote child and youth mental well-being Create services that can provide earlier interventions for children at risk of entering the care system and their families Improve families' wellbeing and prevent children from compulsory measures (such as becoming 'looked after') To work with families to build positive relationships, ensure right measures are put in place to improve the family circumstances and the wellbeing and development of the child Test out different approaches in each of the city's three localities during the next three years	2019/20	Children and young people will achieve positive physical and emotional health and wellbeing outcomes

Community based mental health and wellbeing services (children)	Undertake scoping to inform the development of a service model options to address mental health and wellbeing in children Continued delivery of commissioned service to improve the mental health and wellbeing of young people	2019/20	As above
Creating a culture for health reducing alcohol, drugs and tobacco use	Delivery of multiple risk contract to young people comprising curricular programme and 1:1 service delivery of programmed activities to support the prevention and education component of the ADP strategy	2019/20	Support for young people to build resilience Increased capacity for targeted early intervention programmes around drug and alcohol issues
Full implementation of Healthy Children Programme	To begin all additional assessments and visits to all families as per Universal Pathway (including antenatal pathway)	By 31/3/2020	Programme is fully implemented All children have access to Universal pathway which will improve early assessment, planning and intervention Children's needs are met earlier reducing need for specialist or statutory services
Improvement in breast feeding at 6 weeks	Having successfully achieved Gold Award. Maintain and build on this success and continue to work with mothers to encourage breastfeeding	Ongoing	Babies are breast fed longer Fig at Q4 exclusive Breastfeeding 6weeks 22.8%
Development and Implementation of the Glasgow Parenting Framework	Central Parenting Team will continue to widen and strengthen collaborative working with partner agencies to support and enhance parents experience, engagement and participation in Triple P group programmes providing accessible, appropriate, culturally sensitive parenting support in	2019/20	To reduce the levels of parents who DNA group programmes and increase retention and successful programme completion by parents/carers

	Glasgow Expand the development and implementation of a culturally sensitive community based approach to service delivery to identify and respond effectively, efficiently and sensitively to parenting needs within local community groups and settings Develop and implement parenting support pathways for targeted Triple P Teen Discussion Group support within Glasgow Secondary Schools in partnership with Police Scotland Campus Officers and Education Continue the provision of the Glasgow Solihull Approach Workforce training programme expanding the programme development to include the Solihull Plus Trauma Awareness training to support trauma informed practice across Children and Families		Increase parental uptake and engagement in Triple P parenting support within local community groups and services Increased support to families through the provision of accessible Targeted Teen Parenting programmes and workshops available in Glasgow Secondary Schools Children & Families staff across services will understand the impact of trauma on children, young people, families and adults. Use the Solihull Approach model to help and support families
School nursing services are to be reviewed across the city.	Interim plan to pool 3 locality School Nursing team to one Glasgow city school team complete. Glasgow will focus on 2 priority pathways: Emotional health & wellbeing and Child Protection information being shared with key agencies.	July 2019	Glasgow City School Team in place
Develop the Consortium approach with the third sector on a city wide basis, informed by the North East test of	Through the Lottery funding develop a consortium approach: • Third sector organisations coming together as a consortium. • Consortium staff co-located with the social	2019	Early and effective intervention aiming to give all children and young people the best possible start in life

change.	work duty team. • Families not requiring social work involvement immediately referred to the consortium to ensure that they receive the appropriate level of support at the right time. • Co-developed family support delivered by the third sector rather than social work led.		
Third sector interface and engagement	Following outcome of consultation on City-wide family support strategy, consider opportunities to improve third sector interface, including: • Membership of JSTs (Joint Support Teams) • Referral patterns and pathways • Develop outcomes based performance framework for JSTs • Current communication and engagement processes	2020/21	Robust partnership working processes in place to maximise capacity and expertise to target resources effectively and deliver better outcomes
Review of vulnerable pregnancy liaison group	Informed by NE test for change work, consider opportunities to improve support arrangements, in context of current procedures	2020/21	Improved access and planning for women who do not fit child protection criteria but do need additional support in the antenatal period
North West Locality Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Parenting and Family Support Directory	Following on from the exercise to map the range of third sector agency supports available in NW: • Embed the directory information onto the Your Support Your Way Website • Undertake awareness raising and marketing of the directory • Prompt organisations to update the information every 6 months.	2019-22	The directory supports staff and services to direct people to the most appropriate support services in an efficient and timely way

CHILDREN'S SERVICES			
Providing greater self determination and Choice			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Listening to children and young people	Provide the best tools for children and young people looked after by Glasgow City HSCP to enable them to give their views and for these to be listened to and taken into account in decision making	2019/20	Promotion of the participation and engagement of young people in Glasgow which truly informs service provision 93% of looked after children agreed their views were listened to. Annual Performance figs 2017/18/19
Continue to consult with young people and develop contemporary strategies which reflect how young people currently communicate through social media and determine how this can influence child protection and looked after children and processes	Children's Rights Group is exploring innovative ways of consulting with young people including looked after and accommodated children. Review of Viewpoint/Have your Say is ongoing	Ongoing	Involve children in decisions that affect them, have their voices heard

Glasgow Young people's Champion's Board	This board seeks to maximise opportunities for children and young people to get involved and have their voices heard by services and leadership groups. In addition it will seek to identify barriers to participation and work jointly on ways of addressing these, identify issues and concerns and work with children's service decision makers to find solutions, improve young people's leadership skills and help get them ready for employment	Ongoing	Increased numbers of young people being involved in decision making and informing service development
Improve educational attainment and achievement of care experienced children and young people	Narrow the gap between the educational achievements of care experienced young people and their peers.	Ongoing	Continued increase in attainment levels for care experienced young people in the last 3 years across a number of measures. Whilst the general school population in Glasgow out performs the care experienced young people, the attainment levels for Glasgow's care experienced young people are better than the national average for a number of indicators.
Positive Destinations	• Identify potential barriers within NW • Identify young people who should be going to positive destinations and determine what additional support or resources may be required to support them • Ensure robust links in place with employability service	2019-21	More young people are encouraged and supported into positive destinations
Reduction of impact of poverty	To continue to increase the referrals made by Health Visitors to Financial inclusion services Health Visiting teams to discuss the use of food banks as part of general discussions to minimise	Immediate and Ongoing	Income is maximised Stigma for families reduced Staff have up to date information to

	stigma Ensure all staff are kept informed of where to access equipment etc. for children from Third Sector colleagues		share with families

CHILDREN'S SERVICES			
Shifting the Balance of Care			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
High-cost placements for children and young people	Reduce reliance on high-cost residential care placements Re-focus investment on family and community based supports located in Glasgow for young people who are currently 'looked after' by the Council	2021/22	Reduce reliance on high-cost residential care placements Number of children in high cost placements decreased by two-fifths, from 111 the previous year to 67. 2018-19 (to Quarter 3)
Shift the emphasis from placements out with Glasgow	Children and young people who require to be looked after and accommodated by the local authority can expect to remain living in the city and maintain connections important to them.	2019-22	Further reduce the number of children living out with the city by 10%.
Work with families to improve the life chances for children, with a specific focus on family resilience, health improvement, educational attainment and reducing the number of children looked after away from home	Continue to Develop the Intensive Outreach Family Support Service (IOFSS**)** .The aim of the service is to provide intensive community supports to prevent young people being taken in local authority care:	2019/20	Continued reduction in the no's of children placed on the CPR and length of time on the Register, including referrals to high cost placements

CHILDREN'S SERVICES			
Public Protection			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Improve the identification of, and response to, children living with neglect in the City.	City wide training of social work, health staff in the identification of neglect Continue to work across all services and partners to improve our approaches to early identification of neglect Continue to work with colleagues in adult services to raise awareness of children living with neglect. Qualitative analysis to be undertaken with HSCP staff to explore and understand why the Glasgow Neglect Toolkit is not used to its full potential.	Ongoing	Increase in number of children receiving support
Asylum Seeking families	Ensure all new staff have access to training on legislation that impacts on access to services and benefits for asylum seeking families Explore use of translation app to potentially reduce DNA at appointments	End 2020 End 2020	Staff have access to up to date information Families are able to access appointments more easily and DNA rate is reduced
Sexual exploitation and trafficking	Ensure all new staff have access to information sharing on this topic Implement a CSE Community Engagement model to increase awareness of CSE amongst our communities and partner agencies	Ongoing	Protection of vulnerable groups
Tackling Domestic Abuse	Increase coordination and delivery of services supporting vulnerable families affected by domestic abuse	March 2020	Families affected by domestic abuse in the city will receive a timely and multiagency coordinated response

5.2 Adult Services

ADULT SERVICES Prevention, Early Intervention and Harm Reduction			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Mental Health: Suicide Prevention	• Update Glasgow City multi- agency suicide prevention action plan to reflect new National Suicide Prevention Action Plan "Every Life Matters" and Living Works Suicide Safer Communities pillars. • Continue to contribute to NHSGGC Suicide Prevention Group, including work to identify areas/groups for focused activity and development of a GGC-wide suicide prevention concordat. • Continue to provide city wide calendar of suicide prevention training and awareness raising sessions to public, third sector and businesses. • Continue to coordinate multi agency city wide Locations of Concern Group (LOCS) • Contribute to implementation of safety measures to prevent suicides in public places in prioritised LOCS.	August 2019 October 2019 Ongoing Ongoing Ongoing	• Contribute to public awareness of how to prevent suicide. • Contribute to reduction in numbers of deaths by suicide in Glasgow City. • Increased numbers of people briefed/ trained in suicide awareness/ prevention. • Continue to identify locations of concern and contribute to actions to try and reduce numbers of vulnerable people attempting and completing suicide in public places.
Community based mental health and well being services	Deliver preparatory work and commissioning process to determine a service provider for community based adult mental health and well being support from April 2020 Delivery of community based stress service for adults	By March 2020	Adults experiencing poor mental health and well being can access community based support service Delivery of counselling and group work services to over 5000 adults citywide

	In conjunction with both Board-wide and Glasgow City contracts / posts to be established via Action 15 monies, progress mental health based training delivery with multiple partners and service areas, including mental health improvement / awareness training and suicide prevention training		
Mental Health Counselling Service for people who are Deaf	Implement and evaluate a test for change pilot service with Lifelink for people who are deaf that require a mental health counselling service are able to access a counsellor who can communicate through British Sign Language (BSL).	2019/20	The experience of Deaf people is improved. The evaluation will also consider uptake and pathways to other services to determine if this service should be maintained.
Access to Mental Health Awareness Training for Support workers	• Training needs analysis and further scoping exercise • Development of Mental Health Awareness training programme	By October 2021	Support Workers will have increased knowledge and skills to be able to recognise and support individuals who are experiencing mental health issues. People will be supported to live in their owns homes
Addressing Inequalities	Building on previous years' work on equalities development at Board-level for mental health and allied services, which has focused on the priority themes of sensory impairment, financial inclusion and human rights, the appointment of a new post-holder will allow a comprehensive engagement and review of priorities.	2019-22	A refreshed GGC action plan for mental health equalities, in conjunction with relevant HSCP service leads.
Develop robust transition arrangements for young people and older people	• Scope current and predicted service demand • Review current and planned service	2020/21	People have their assessed care and treatment needs met at an early stage, in the most appropriate setting and experience

into and out of adult LD services	capacity • Ensure effective transition protocols are in place		continuity of care
The Keys to Life Implementation Plan 2019-21	Develop multi-service local action plan in response to national implementation plan, focusing on improvements for people with a learning disability in: • Living • Learning • Working • Wellbeing	2019-21	Contribute to the achievement of the priorities set out in the implementation plan, empowering people to • Live healthy and active lives • Learn to reach their potential • Participate in an inclusive economy • Contribute to a fair, equal and safe Scotland
Make progress towards meeting the key objectives within the City's 5 year Rapid Re-Housing and Transition Plan (RRTP) 2019-24	• Reduce time in temporary accommodation by more than 50% • End use of Bed and Breakfast accommodation for homeless people • Develop 600 Housing First tenancies for the most complex and disadvantaged service users • A system change in the homelessness commissioning model from accommodation based services to community based supports	Robust processes and plans in place by 2022 (to achieve full delivery by 2024)	To prevent homelessness, wherever possible. Where it is not possible to prevent homelessness, the priority is to provide a safe and secure home for every homeless household as quickly as possible.
Improve interfaces with Housing Providers to increase access to settled accommodation	• Work with Housing Access Team, continue to coordinate citywide casework input to Local Letting Communities • Monitor number and duration of homelessness applications.	2019/20	Targets being agreed Homeless applications over 6 months duration: target 40% or less.
Increase throughput in temporary and emergency	• Work to agreed targets for provision of initial decision, prospects / resettlement plans and	2019/20	Targets: Provision of 95% of decisions made within

accommodation to settled accommodation	case durations		28 days. Completion of Prospects / Resettlement Plan within 28 days
Develop a sustainable, holistic response to homelessness by ensuring collaboration across housing, health, social work, third and independent sectors	• Working alongside the Flexible Homeless Outreach Support Service (FHOSS), locality Money and Debt Advice Services, and continue to develop integrated working with money and debt advice, mediation, wider support services • Facilitate a broader involvement from HSCP, including mental health, services in supporting tenancy sustainment and preventing homelessness. • Continue to improve partnership working with Registered Social Landlords (RSLs) and local providers of homelessness services • Facilitate housing liaison sessions and training to improve knowledge, access and interface with Health and Social Care Partnership services for people at risk of homelessness • Continue to offer single point of contact for RSLs on tenancy sustainment issues and improve access to third sector support services • Monitor the impact of the GHSCP Hoarding Protocol across the City • Support discharge planning arrangements relating to housing and tenancy sustainment within mental health inpatient services	2019-22	• Improve referrals to FHOSS /Welfare Rights/ Mediation Services • Increased tenancy sustainment and reduced levels of homelessness • Evidence though local Essential Connections Forum and Homeless Provider Forum • High levels of participation and engagement • Efficient response times and qualitative support and advice • Identification of hoarding and then effective support • Tenancy sustainment / improved discharge planning
Reduce drug and alcohol related harms and drug and alcohol related deaths	• Provide open access responsive services within existing alcohol and drug community services to improve assessment and access to appropriate care and treatment • Increased emphasis on assertive outreach and early harm reduction interventions. Performance framework to be established and reviewed to work collaboratively with Deep End GPs to identify patients with	2019-22	Achieve and maintain waiting times targets Reduce drug and alcohol related harms and drug and alcohol related deaths

	problem alcohol use who do not engage with specialist services. • Increase Naloxone supply • Optimise Opiate Replacement Treatment (ORT) dosing: Review the result of ORT staff survey and create action and training plan. • Better understand changes in novel benzodiazepine-type drug use by: - Review drug monitoring in acute presentations at Emergency Departments - Review GADRS audit of lab benzodiazepines and gabapentinoids toxicology audit result, creating an action and staff training plan - Embed "Guidance on the Principles of Benzodiazepine Prescribing with Concomitant Opiate Dependence" into day to day practice - Implement action plan from the Street Drug Summit recommendations • Screening for Early Fibrotic Liver Disease in Alcohol Misusers		Increase the early identification of alcohol-related liver disease
Once approved, implementation of the recommendations from the Sexual Health Services	• Access to service for young people aged up to 18 will be improved with new and more service locations established for them, including early evening and a Saturday afternoon service, resulting in better outcomes for young people. • Introduction of an improved 'tiered' model of	2019-22	- Sexual Health Services are accessible and targeting the most vulnerable groups - Encourage those who could be self-managing to be supported differently - Improved use of existing resources

review (Applicable NHSGGC-wide)	service for adults allowing more appointments to be offered across fewer service locations, more people able to be seen each year, and to have more of their needs met in ways that better suit them and by the right staff at the right time. • People will be able to virtually attend services and access sexually transmitted infection (STI) testing and oral contraception services online. • Improved access to long acting and reversible methods of contraception (LARC) by providing these appointments at all Sandyford locations. • Access to sexual health services will be improved by expanding the provision of Test Express services (fast access testing service provided by Health Care Support Workers for people without symptoms) across all Sandyford locations. • Quicker and easier telephone booking and access, and a comprehensive online booking system introduced.		- Urgent sexual health care should be available within 48 hours
Fewer newly acquired HIV and sexually transmitted infections	• Improve access to testing at clinics, and introduce some test-only walk-in clinics and targeted home or self-testing • Ensure HIV testing is being targeted appropriately at groups who are most at risk	Ongoing	Increase in testing, particularly amongst priority groups. Reduction in HIV infections. Reduction in sexually transmitted infections
Fewer unintended pregnancies	• Increase the uptake of very long acting reversible contraception (vLARC) • Increase the uptake of vLARC in women who have undergone a termination of pregnancy procedure • Reduction in teenage conceptions, with targeted action in areas where there are higher rates	Ongoing	Reduction in unintended pregnancies

North West Locality Areas of Activity	Priority Actions	Timescale	Outcomes Sought
Mental Health: Suicide Prevention	Continue to pilot use of WHO (World Health Organisation) suicide prevention community engagement toolkit in Drumchapel and implement Drumchapel Suicide Safer Communities Neighbourhood Action Plan.	Ongoing	Contribute to reduction in numbers of deaths by suicide in Glasgow City.
Work with RSLs to mitigate against rent arrears occurring from tenancy start dates and tenancy failures.	Progress pilot project commenced with 3 RSLs (NG Homes, Maryhill HA and Queens Cross HA) each agreeing to allow a maximum 2 week 'rent free' moving in period for homeless household's to accept Scottish Welfare Fund furniture package, and move into new home without any rent arrears.	2019/20	Increased tenancy sustainment
ADULT SERVICES **Providing Greater Self Determination and Choice**			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Continue to develop a Recovery Orientated System of Care (ROSC) model	Embed the Scottish Government Strategy 'Rights, Respect and Recovery' published 2018 actively promote ROSC.	2019-22	People access and benefit from effective, integrated person-centred support to achieve their recovery

Provide a range of person centred alcohol and drug care and treatment options	New Residential Rehabilitation and Stabilisation Services to be established in 2019. Monitoring and review of the new services will take place in 2020. Work in close partnership with Recovery Hubs as part of the addiction continuum, offering recovery opportunities. Explore new developments in Opiate Replacement Treatment: review of injectable Buprenorphine pilot. Establish Buprenorphine wafer. Embed the recently commissioned new advocacy service and monitor the uptake	2019-21 Ongoing	Qualitative feedback from service users Continue to increase referrals. Qualitative feedback from service users. Achieve target uptake numbers.
Personalisation: Maintain a continuing focus on delivering the best possible outcomes and quality of life to all people in the City that require support from the HSCP and Locality services	• A continued emphasis on family and carer support building on the significant progress made in this area over recent years and the new Carers Act requirements. • Develop a sensitive approach to allow service users to move to more economically efficient models of support. • A greater and more effective application of technology to help sustain that carer role and community living in general. This will combine the use of technology enabled care for people with higher level care needs. • Embed the resource allocation policy guidance to support the delivery of a consistent approach to personalisation and the ongoing commitment required by the HSCP to funding the “relevant amount” (the level of funding required to meet each individuals assessed care needs and their	2019-22	People are supported to live safely and as independently as possible in a community setting

	outcome based support plan within a community setting).		
Access to Psychological Therapies	• To provide Mental Health Services that will maintain patients seen within 18 weeks performance • Promote use of cCBT (computerised cognitive behaviour therapy)	Ongoing Ongoing	To achieve the Psychological Therapies 18 week Referral to Treatment standard Equality of access of cCBT
Reprovision of Mental Health Advocacy Service for Glasgow City	• Review and develop new service specification in partnership with relevant stakeholders	October 2021	Appropriately independent commissioned service in place
Review of Mental Health employability and meaningful activity services within Glasgow City	• Review and develop new service specification in partnership with relevant stakeholders	March 2020	Employability services that supports the recovery and resilience of individuals

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

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

Effective and Efficient Community Mental Health Services	• Improve the Effectiveness and Efficiency in Adult Community Mental Health Services	2022	Adult Community Mental Health Services are effective and efficient
Integration of secondary care services in community teams. Making secondary care treatment more accessible to service users in the community	Continue to develop HCV (Hep C) clinics and further promote and support the BBV (blood-borne virus) agenda. Review of fibroscan pilot to detect early liver disease and to provide early interventions, with a view to expanding city wide. Promote harm reduction with Injecting Equipment Programme (IEP) and foil. Continue to work closely with GP colleagues to review all service users and identify how best to meet the needs of service users who are prescribed Opiate Replacement Treatment (ORT) Shared Care teams to continue to promote referrals into Recovery Hubs	2019-22	Reduction and eventual eradication of HCV (Hep C) Better early detection rates Increase HIV testing within teams. Increase numbers of individual being prescribed ORT via their GP. Increase in referrals
Alcohol & Drugs inpatient and day service provision	Explore potential to improve the standard of existing accommodation and the scope to see further shifts towards community alternatives	2019-22	People are supported to live safely and as independently as possible in a community setting.

ADULT SERVICES Enabling Independent Living for Longer			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Implementation of Assisted Technology (TECS) and, where appropriate, alternative models for overnight support	• Progress transformational change programme to embed consideration of TECS within assessment processes and explore alternative arrangements to sleepovers. • Pending evaluation of Connecting Neighbourhoods test for change work in Castlemilk and Shettleston, roll out new responder service for overnight care elsewhere in the City	2019/20 2021/22	People are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community Reduction in the volume and cost of sleepover provision
Modernising Learning Disability Day Services	• Extend the range of health clinics offered at day centres • Improve access to health checks • Consider alternative and quicker responses to service users or carers in times of 'social or care crisis' • "Respite" or increased support for short periods within a structured environment. • Undertake an option appraisal to consider the replacement of 2 Learning Disability day care centres	2020/21	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
Integration of Learning Disability services	Informed by test for change work in North East, implement and evaluate new processes, protocols and systems that support the delivery of more integrated Learning Disability services throughout the City, including improved access to and experience of 'mainstream' services	2019-21	People who use health and social care services have positive experiences of those services, and have their dignity respected Reduction in waiting times to access

			services
Improve links between Alcohol & Drug Recovery services and with housing support services.	• Continue to work closely with housing providers and housing support services to identify individuals who require alcohol and/or drug interventions to assist in tenancy sustainment.	Ongoing	Early access to care and treatment. Tenancy sustainment
Review frequent Emergency Department presentations and aim to support to reduce attendances	Continue to review and audit frequent Emergency Department attenders.	2019/20	Reduction in A&E attendances

ADULT SERVICES Public Protection			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Adult Support and Protection (ASP) Act	• Ensure staff continue to be supported to meet ASP standards and requirements • Contribute to maintaining and where necessary, improving practice arising from the annual joint self evaluations	Ongoing	Continue to ensure people, particularly the most vulnerable, are kept safe from harm and that risks to individuals or groups are identified and managed appropriately.

Develop more integrated working practices between Criminal Justice and other services to better manage vulnerability	• Develop more integrated risk assessment and risk management processes with Alcohol and Drug Recovery Services (and ensure all MAPPA clients with alcohol and /or addiction issues are able to access local services). • Ensure criminal justice staff have a full understanding of processes and supports aimed at preventing homelessness • Review referral pathways with Mental Health and promote best practice with service users with complex mental health needs • Ensure follow-up for non-engagement, with particular consideration to vulnerability and risk • Develop more robust links and working practices with Scottish Prison Service	2019-21	Clients have timely access to appropriate services, including better access to Addiction and Homelessness services Criminal Justice staff to be aware of the housing first model and be able to support service users to access / utilise this service when appropriate Criminal Justice staff have a better understanding of complex mental health issues (eg personality disorder) and the best approach to manage / address these needs Early identification of vulnerability.
The efficient processing of community payback orders (CPOs) and criminal justice social work reports	• Ensure all CPOs are reviewed by a Team Leader at the 3 month stage and throughout the order. • Ensure service users have a comprehensive risk assessment and supervised action plan in place within 20 days of a CPO.	Ongoing	75% of CPOs 3 month Reviews held within timescale Compliance target of 85%
Increase BBV testing and support access to Hepatitis C and HIV treatment	• Continue to increase testing and access to BBV (blood-borne virus) treatment. • Increase staff trained in Dry Blood Spot testing (DBST)	2019-22	Reduction in the number of people infected with Hep C and HIV
Establish the Enhanced Drug Treatment Service	• The Enhanced Drug Treatment Service will commence in September 2019 with a focus on prescribed diamorphine treatment for a	2019/20	Reduction in drug deaths and supporting people to access other care and

(EDTS)	small group of people who inject drugs within the city centre.		treatment pathways as necessary
Develop a service improvement programme for Prison Healthcare	• The development of Advanced Nurse Practitioner posts across the service to address the challenge of providing accessible medical cover. • The review of recruitment practice around nursing and medical staff to support retention and vacancy management. • A review of the workforce to enable improved service delivery, including enhanced mental health /psychology provision funded through 'Action 15' monies. • A robust Health Improvement approach is in place • The development of enhanced IT provision to assist service improvement opportunities •	2019-22	Performance framework to be developed Within available parameters, people in prisons have equity of access to safe, effective and responsive healthcare
Continue to provide a combined high quality Police Custody healthcare service, including delivery of Forensic Medical Service provision	• Be responsive to the health care needs of people in custody and to ensure appropriate links are made to other services (e.g. Addiction, Mental Health Services) to meet individuals' on-going health needs. • Enhance mental health service provision through 'Action 15' monies. • The development of enhanced IT provision to assist service improvement opportunities • The development and implementation of a robust Health Improvement approach	2019-22	Performance framework to be developed Within available parameters, people in police custody have equity of access to safe, effective and responsive healthcare
Development of Archway Sexual Assault and Referral Centre (ASARC)	Work with partners to maintain the high standard of forensic care and increased opening hours in the Archway sexual assault and referral centre. Progress development of a new West of Scotland regional service, including transfer of ASARC from Sandyford	2020	Improved access to specialist care and support

	to upgraded accommodation at William Street Clinic.		
Development of Community Custody Unit for women	Work in partnership with Scottish Prison Service to develop the HSCP service and staffing model required to provide effective care and support to women in the new facility to be developed in Maryhill.	2020	Provide safe accommodation and support the needs of women who are suitable for, and would benefit from, closer community contact and access to local services, to create and sustain independence in preparation for successful reintegration into the community.

5.3 Older People's & Physical Disability Services

OLDER PEOPLE'S & PHYSICAL DISABILITY SERVICES			
Prevention Early Intervention and Harm Reduction			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Anticipatory care plans ACP)	1089 were completed last year which is more than doubled since 2017. Relaunch ACP resources using the National material (My ACP) as a mechanism to introduce people to ACP and implement the agreed NHSGGC partnership ACP summary document to capture the summarised content of the person held ACP is being introduced • Complete staff awareness sessions • Develop and implement Clinical Portal Version of ACP summary in collaboration with eHealth • Raise public awareness	Introduced this financial year.	Targeted use of ACP within Health and Social Care teams and relevant partners. Introduce people to ACP through ACP conversations. Share ACP summaries with GPs and other relevant professionals involved in the persons care. Empower people through greater awareness, control, choice and self management of their Long Term

	• Provision of additional support to Partnership staff from MacMillan ACP Facilitator • ACP clinical lead engaging with GPs scoping ACP work within Local Enhanced Service (LES) Care Homes • Develop and agree new HSCP ACP Booklet • Work with HIS to form and develop a Living and Dying Well Frailty Collaborative		Condition. Test new approaches to the identification and management of Frailty
The use of falls prevention and projects to support frail older people.	Glasgow's target rate is 6.75 per 1,000 but the current rate is 7.5: a number of actions are identified including; • Develop a referral pathway with Scottish Fire and Rescue to carry out level one conversations and refer into NHS falls and rehab services Introduce a frailty tool with specific focus on evidence based interventions. • Promote the use of the "Up and About" resources on prevention of falls • Agree ways of improving data collection for falls including determining a realistic and meaningful baseline. • Continue to support Scottish Ambulance to reduce the number of non injured fallers conveyed to hospital • Contribute to the response to the Falls and Fracture Prevention Strategy for Scotland 2019 -2024 consultation document • Contribute to the development of the NHSGGC Falls Strategy • Promote the use of Technology Enabled Care for those who are at risk of falling • Connect various sources of information on people who fall to services i.e. homecare and	Actions to be progressed in 2019/20	Increased referrals to rehab services and community falls team. and established use of frailty tool

	rehab		
Maximise use of Link worker capacity within Primary care, Dementia Services and Community Connectors	• Raise awareness of roles of links workers • Promote networking of Links Workers to make efficient use of capacity	Progress in 2019/20	More efficient use of links worker roles
NW Locality Specific Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Knightswood Connects: an initiative to develop a community response to frailty, isolation and loneliness experienced by some older people living in the Knightswood area.	• Continue to promote services to key partners, encourage referrals to project and organise Knightswood Connects networking events • Continue to develop and support sustainable local social activities and recreational opportunities in partnership with community organisations and service providers • Develop and implement volunteering plan • Develop services for carers • Encourage and create volunteering opportunities and signpost to local partner organisations	2019-21	Ambition is to contribute to reducing hospital admission, encourage self management of age related health concerns and promote health and wellbeing for the 50+ age group.

OLDER PEOPLE'S & PHYSICAL DISABILITY SERVICES			
Shifting the Balance of Care			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Delayed Discharge	Target to reduce the number of lost bed days to under 1910 per annum. Above target currently not being met. A working group has been established to develop an action plan and take forward specific priorities related to 13ZA and AWI issues.	Progress required this financial year.	Reduction in delays and bed days associated with delays
Evidencing shifting the balance of care and	2,706 telecare referrals were taken during 2018/19 which was above the target of 2248.	Track referral rates during	Increase of uptake of telecare

evidencing projects that support independent living (Telecare).	1,337 advanced telecare referrals were implemented which is above the target of 304. Referrals are above the performance targets but the strategic plan highlights the need to increase the pace of telecare uptake.	2019/20	
The role of neighbourhood teams in supporting older people in the community.	Neighbourhood teams will develop a delivery model to deliver more joined up and integrated health and social care services for older people/people with physical disabilities in partnership with GPs, housing providers, community and voluntary sectors to take a proactive and preventative approach to care, delivering better outcomes for older people and people with physical disabilities, their families and carers, The neighbourhood model will assist in the development of multi-disciplinary front line teams to deliver on the strategic priorities of the HSCP	Work to address recruitment issues and pathways to be undertaken during 2019/20	Delivery of 75% target for re-ablement
Develop more alternatives to acute hospital admissions.	4 intermediate care step up beds provided in North East. Explore short term home based alternatives to hospital admission out of hours Telecare and emerging assistive technologies are key factors in preventing and delaying hospital admissions. The use of reablement and Anticipatory Care plans are significant factors in reducing hospital admissions. Further develop role of Community Respiratory Service to prevent admission, reduce delays and intervene at an early stage	Further work on the transformational change programme will be ongoing throughout 2019/20.	Reduced attendance at Emergency Department and Assessment Units by use of alternative routes for support
Need to reduce	Work is primarily led via the unscheduled care group	2019/20	Reduced attendance, admission and length of stay for care home residents within acute

admissions to hospital from care and residential settings.	examples of work related to this are; • The red bag programme • Work underway around the GP Consultant Geriatrician interface in the community. • A review of admissions from a care home in NE to Glasgow Royal Infirmary. • Work with residential and nursing care settings to develop awareness and intervention to support service users with dementia • Further develop Advanced Nurse Practitioner role within Partnership Residential Homes • Provide support and advice from mainstream community services to inform care home staff about a variety of clinical conditions including continence care, tissue viability etc		system
Continue to develop the Community Respiratory Team and to maintain / increase the positive impact on admissions to hospital and length of stay. Reduce attendances at ED and AU.	• Review data from the Community Respiratory team to identify areas for improvement and greater efficiency • Formulate develop plan and resource required	2019/20	Improvement Programme for Community Respiratory Team
Link with the five year strategy for older people's mental health	The OPMH 5 year strategy is currently in development and will have a focus on shifting the balance of care including looking at alternatives to admission to inpatient care. Dementia is one strand of the above.	To be progressed during 2019/20	Improved co-ordination across acute and mental health systems

	Technology Ensure all staff have the knowledge, skills & competencies around the availability of technology to support individuals at the different stages of dementia. **Promoting Excellence** All HSCP employees in contact with people with dementia will have a level of training appropriate to the promoting excellence framework. **Advanced Dementia/sharing good practice** Sustainability around good practice in the area of dementia service delivery, shared learning across the HSCP and third sector. **Dementia Public Awareness** Through public awareness and involvement of third sector organisations. People will have a better understanding of basic rights and entitlements, ensuring more resilience and less likelihood of delays in hospital. People have a better understanding of lifestyle choices which could impact of the onset of dementia People will feel they can live well with dementia People experience a positive approach to dementia where they live. **Post Diagnostic Support.** Patients and service users receive timely post diagnosis support **Specialist dementia Unit improvement programme.** A national improvement programme will continue to		

	ensure continuing improvements in the provision of specialist dementia units using and Experience based on a co-design model. **Effective and Efficient Community Mental Health Teams** Ensure that Community Mental Health Teams are operating effectively and efficiently to meet the needs of the current population and improve outcomes for people living with dementia and or functional mental health illness		
Integration of Occupational Therapy (OT) within Older People's services	The review of OT has focused on an integrate approach to the provision of Occupational Therapy Services across all care groups within the HSCP, streamline processes, to ensure the reduction in duplications and create simplified service delivery to the service user. This work has initially focused on Occupational Therapists working within Older People and Primary Care Group. A piece of work to identify competencies has been undertaken and will be rolled out following a successful test of change. This aim of this is to ensure that we can make best and full use of all the skills of OTs, and reduce onward referral to OT colleagues to a minimum There is also a data and performance work stream that has tested out a number of measures to assess the impact of OT on services user health and well - being and assess the impact of individual OT's. In addition plans are underway to measure waiting times across all services in a consistent way.	2019/20	Consistent and effective use of services and Occupational Therapy resources and skills

OLDER PEOPLE'S & PHYSICAL DISABILITY SERVICES Enabling Independent Living for Longer			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Increases in the amount of homecare reviews undertaken and offered.	During 18/19 83% of those aged over 65 receiving home care were reviewed. This above the target figure of 81%. However South area averaged 78% due to staff shortages and this is an area for improvement.	During 2019/20	Regular review of homecare and maintenance or improvement of target figures
Increases in the amount of supported living placements including the living well project.	The number of people in supported living services increased during 18/19 to 878 which is above the target rate of 830 per annum. The increase in the number of Older People personalisation packages is a driver for this. Further increases during 2019/20 are sought.	2019/20	Delivery of supported living placements
Development of bespoke OP residential housing with care in the form of Clustered Supported Living.	202 service users are currently supported with care and support packages via housing providers. 75 more properties are coming on stream during this financial year.	Track occupancy progress during 19/20.	Delivery of supported living placements in partnership with Housing providers
Increase take up and support for palliative care.	Palliative Care services have been a factor in increasing the percentage of people who spend the last 6 months of their life in the community. Target for 2019/20 is to increase those spending the last 6 months of their life in the community by 2%. • Progression of year 2 of 5 year plan • Priorities for Children's services and prison • Roll out of SPAR tool in Partnership Residential Care Homes	Further work during 2019/20 to improve RAG classifications and data collection.	Increased use of palliative care provision and choice for people to spend last 6 months of life in home or community setting
Creating a safer home environment through Improving identification of vulnerable Older	Maximise the use of RSLs and HOs to support HSCP in identifying vulnerable older people and assist them in identifying where housing options, Telecare, ACP, adaptations etc.	Measures to be developed around Use of Clustered	Review through Essential connection forum with partner organisations and develop measures for uptake of Telecare and use of Anticipatory Care Plans with appropriate people

People through Housing and relationship with Registered Social Landlords and Housing Options (HO)		Supported Living Placements and uptake of appropriate support	

5.4 Primary Care

PRIMARY CARE			
Prevention Early Intervention and Harm Reduction			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Primary Care Improvement Programme (PCIP) – General Practice Multi-Disciplinary Team Workflow	• Agree process for application to Health Improvement Scotland Practice Administrative Staff Collaborative (PASC) collaborative for general Practice in Glasgow • Support applications under PASC – signposting training • Support roll successful practices in the roll out and implementation of the PASC Collaborative	Aug 2019 Autumn 2019 and ongoing for successful applications	Glasgow City practices successfully in a national collaborative to promote signposting as a way of working and increasing the number of people seeking consultations who are seen first by the person / service most able to help
PCIP - Improve communication and working relationships between the HSCP and General Practices.	• Increasing contact between HSCP and GPs using the cluster guidance, Cluster Quality Leads to be offered by PCIP Team • Agree implementation of cluster guidance for up to 4 sessions per month for clusters • Increase frequency of meetings between HSCP & GPs to boost tripartite arrangements.	12 months	Increased and improved collaboration between HSCP and GPs.

PCIP - Pharmacotherapy	• Continue close working with pharmacy colleagues to ensure that all practices have some pharmacotherapy input by Spring 2020	April 2020	All practices aware by end 2019 of the level of input they can expect
PCIP – Musculo-Skeletal (MSK) Physiotherapy	• To co-ordinate use of Advanced Practice Physiotherapists (APPs) to improve patient care and reduce GP workload. • To embed the learning gained from experience in north east practices.	March 2020	To offer APP to appropriate practices in north east and across the city.
Housebound Seasonal Flu Vaccination Programme 2019 -2020	• To deliver a programme of activity of seasonal flu and pneumonoccal vaccination to housebound patients aged 18 and over registered with a Glasgow City HSCP GP • To deliver the above to Glasgow City HSCP residential Care Homes • To deliver the above to residential care homes with no registered nursing staff excluding residential care homes on a shared campus where registered nursing staff are employed. • To plan and deliver the 2019 Programme with a timeframe for delivery of vaccinations of 1st October 2019 to 31st December 2019. • To initiate an HSCP Planning Group and Locality Delivery Groups • To identify the potential Nursing and Business Support Resource required to support the programme in 2019. • To share feedback and learning as part of the ongoing vaccination transformation programme	2019/20	• Delivery of seasonal flu vaccination programme for housebound patients aged 18 and over 19/20
PCIP Urgent Care	Know Who To Turn To banners in GP practices	Autumn 2019	Raise patient awareness of alternatives to GP visit

PRIMARY CARE			
Providing greater determination and choice			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
PCIP – Community Care & Treatment; Phlebotomy	Continued roll out of phlebotomy service to areas of the City/ Locality not served by Health Centres providing patients with more choice about where they attend to have their bloods taken	Autumn 2019 and ongoing	Provision of service to increased number of practices with an initial emphasis on those practices who do not have access to existing Treatment Rooms
PCIP Community Care and Treatment/Phlebotomy/Premises Work stream	Support sourcing of suitable accommodation for Phlebotomy service	Autumn 2019	Provision of service to increased number of practices with an initial emphasis on those practices who do not have access to existing Treatment Rooms

PRIMARY CARE			
Shifting the Balance of Care			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
PCIP - Primary Care Sustainability	• Test more systematic and proactive approach to the identification of sustainability challenges e.g. combining our current intelligence with the offer of a proactive survey of all practices in one Locality. • Strengthening support to practices could primarily take the form of ensuring that the wider supports are available to the practices in greatest need, examples of these include; Multi-Disciplinary Team (MDT), workflow, administration support, training and other ways of meeting practice specific needs. • Quantify GP time freed up and time spent with those with more complex needs	April 2020	Ensuring continuity of care as implementation of PCIP
PCIP – Urgent Care	• Support the roll out of the Advanced Nurse Practitioner (ANP) model into HSCP care homes. • Develop and provide ANP to new residential units opening in the North West in late summer 2019	Autumn 2019 and ongoing	Enhanced support for care home residents and reduced workload including house calls for GPs
PCIP – Urgent Care	Support new ANPs working in current and new residential units	Autumn 2019	Enhanced support for care home residents and reduced workload including house calls for GPs

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

5.5 Health Improvement

HEALTH IMPROVEMENT ***Please note that a number of Health Improvement actions are already located in the earlier care group sections***			
City-wide Areas of Activity	Priority Actions	Timescale	Outcomes Sought
Community Link Worker programme (Primary Care Improvement Plan)	Support the phased rollout of the community link worker programme; working closely with primary care Refine curent operational model and data collection Delivery of the procurement processes to determine allocation of additional link workers	Phased 2019-20	Improved collaboration with GP practices and the Alliance Increased uptake of social prescribing in areas of deprivation Improved connectivity into relevant services and local community supports
Tackling Poverty and	Delivery of financial inclusion & employability services		Work to increase referrals across

Inequalities	including income maximisation, debt management and building financial capability.		service areas.
NW Locality Specific Areas of Activity	Priority Actions	Timescale	Outcomes Sought
Placed based work	Contribute to the development of Thriving Places action plans in Ruchill/ Possilpark, Lambhill/Milton/Cadder and Drumchapel with community planning partners Utilise and share the data from the 2018/19 adult Health survey to support place based work	September 2019 Ongoing	Neighbourhoods inform priorities for local development NHS data is utilised by partners and forms part of the basis for planning along with qualitative data gathered locally
Financial inclusion	Deliver financial inclusion embedded into GP practices in Possil and Drumchapel	April 2019-March 2020	Maximise income and address debt to support health and well being

5.6 Carers

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

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

		preventative support early in their caring role is 70%. Monitor and report the effectiveness of the carer Strategy including protected Characteristics data.	preventative Equalities Impact Assessment (EQIA) will be included in performance Monitoring from 2019 onwards. Carefirst e-forms and changes required for Carers (Scotland) Act 2016 expected to be completed August 2019

6. PROMOTING EQUALITY

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

- Maintaining accessibility audits of new buildings
- Participation in Equality Impact Assessments of cost savings, service redesigns, service developments and policies
- Hate crime awareness and reporting
- Routine enquiry money worries, gender based violence (GBV), employability and appropriate onward referral
- Promote multi-agency working to address violence against women through the Glasgow Violence Against Women Partnership and the locality implementation group, helping to deliver the City-wide strategic delivery plan and the national Equally Safe Strategy.
- Participation in age discrimination audits as required
- Responding to findings of the Fairer NHS staff survey alongside staff training priorities (Asylum seekers & Refugees, Poverty e-learning module, Key care groups, GBV)

- Meeting the requirements of the HSCP's participation and engagement strategy including equalities monitoring of community engagement
- Analysing performance monitoring and patient experience by protected characteristics as required
- Provision of a programme of equality and diversity training for HSCP staff and local organisations

7. RESOURCES

7.1 Accommodation

New Health and Care Centre

The new £20m Woodside Health and Care Centre opened on 1st July 2019. A broad range of services will be provided from the new facility, including 8 GP practices, children's services, district nursing, health visiting, alcohol and drug recovery services, a day care centre for older people, a dental practice, as well as physiotherapy, podiatry and sexual health services. As well as transforming the standard of accommodation, this new facility will deliver more integrated health and social care services for the benefit of patients and service users

Sandyford Sexual Health Services

Sandyford, located in Sauchiehall Street, Glasgow is currently the NHS Greater Glasgow & Clyde hub for the provision of a wide range of specialist sexual health care services and advice. However, limitations with the current accommodation are restricting the volume of patients that the service can see, resulting in waiting time pressures. NW Locality is leading a piece of work to explore the feasibility of finding alternative, suitable accommodation to Sandyford. Pending full approval of the Sexual Health Service Review recommendations, some urgent and complex care services will relocate to the new Woodside Health and Care Centre later in 2019. Also, as part of the development of a new West of Scotland regional service, arrangements are underway to transfer the Archway Sexual Assault and Referral Centre from Sandyford to upgraded accommodation at William Street Clinic in early 2020.

Reviewing Accommodation Requirements and Promoting Co-location

As part of the drive to maximise efficiency, effectiveness and integrated working, there will be an ongoing review of the accommodation needs and requirements across North West Locality. This will be undertaken in the context of supporting integrated working and efficient working practices, such as agile working and co-locating health and social care staff where possible. This will include a review of social work accommodation needs at Church Street and Gullane Street.

7.2 Human Resources

North West Locality directly manages a staffing compliment of approximately 2300 wte (c2800 headcount) people across a range of services and disciplines. This includes services where North West Locality has a 'hosted' management responsibility on behalf of HSCPs or NHS Greater Glasgow and Clyde. The hosted services are Sandyford Sexual Health Services, Prison Healthcare and Police Custody services.

7.3 Finance

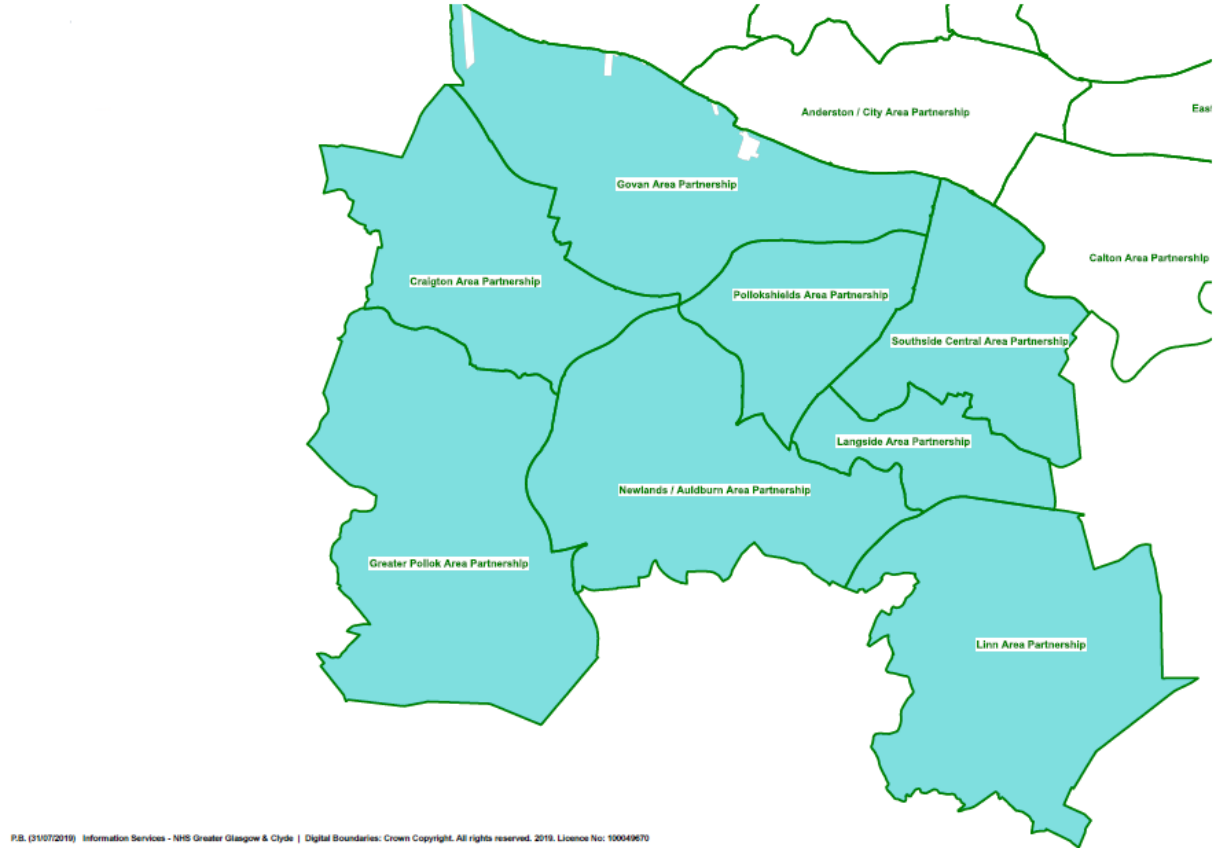
North West Locality has a total recurring budget for service provision of approximately £255m. The budget for North West Locality in 2019/20 is set out below.

	North West Locality		
Services	**Health Annual Budget £'000**	**SW Annual Budget £'000**	**Total Annual Budget £'000s**
Children & Families	5,282.6	8,022.6	13,305.2
Prison Services & Criminal Justice		2,782.8	2,782.8
Carers		863.1	863.1
Older people		24,747.0	24,747.0
Elderly Mental Health	6111.6		6,111.6
Learning Disability	1,080.2	16,185.9	17,266.1
Physical Disability		4,689.4	4,689.4
Mental Health	21,959.4	2,810.8	24,770.2
Alcohol + Drugs	1,754.0	1,742.6	3,496.6
Homelessness		1,121.0	1,121.0
GP Prescribing	38,778.3		38,778.3
Family Health Services	65,856.6		65,856.6
Hosted Services	35,060.8		35,060.8
Other Services	14,193.0	2,301.6	16,494.6
Total NW Expenditure	**190,076.5**	**65,266.8**	**255,343.3**

Glasgow City HSCP
Health and Social Care Partnership

South Locality

Draft Locality Plan 2019-22



FOREWORD

Foreword by Assistant Chief Officer

2019/20 will be an exciting time for continuing the transformation journey in the Health and Social Care Partnership (HSCP) and for taking forward Locality developments in each of the care groups and in progressing integration across health and social care. It will also be a challenging time for the organisation from a financial perspective as well as managing significant change that aims to provide more effective services for our patients and service users.

The actions within this 2019/20 Locality plan support the second Strategic Plan for Glasgow City Health and Social Care Partnership, which was widely consulted upon with many stakeholders, including patients and service users. We have identified areas for improvement and also to maintain some existing excellent performance within the South Locality. There is a particular emphasis on equality of access and service provision, community engagement, partnership working and also in using information and data to support improvement.

New services, such as the New Gorbals Health and Care Centre, staff and changes to our facilities will help us to deliver the high quality care and planned developments. The South Locality Plan will be subject to ongoing review and we will aim to ensure that any in-year developments are also communicated to our stakeholders.

I recognise the commitment from Partnership staff, independent contractors and also our key partners across acute services, housing, community planning, care homes and the Third Sector, and I look forward to working closely with the Locality staff, partner organisations and also patients, service users and carers in delivering this plan.

Stephen Fitzpatrick, Assistant Chief Officer, Older People's Services and South Operations

1. LOCALITY PROFILE

Glasgow City is the largest HSCP in Scotland by population and budget and is responsible for health and social care provision across 3 localities in the City; North West, North East and South Glasgow. The South Locality covers a population of 220,000. Its boundary is coterminous with the community planning boundary for the South Sector, inclusive of 8 Area Partnerships, below:

- GREATER POLLOK AREA PARTNERSHIP
- CRAIGTON AREA PARTNERSHIP
- GOVAN AREA PARTNERSHIP
- SOUTHSIDE CENTRAL AREA PARTNERSHIP
- POLLOKHIELDS AREA PARTNERSHIP
- LANGSIDE AREA PARTNERSHIP
- NEWLANDS / AULDBURN AREA PARTNERSHIP
- LINN AREA PARTNERSHIP

A significant feature of the South Locality is the very marked difference in the social and economic circumstances of people living in different areas in the locality. This includes some of the most affluent areas in Scotland and also some of the most deprived areas, as well as representing significant cultural and ethnic variance. A key responsibility of localities is to produce a locality plan for the area they serve. This document is the locality plan for South Glasgow and is guided by the overarching priorities set out in the HSCP's Strategic Plan.

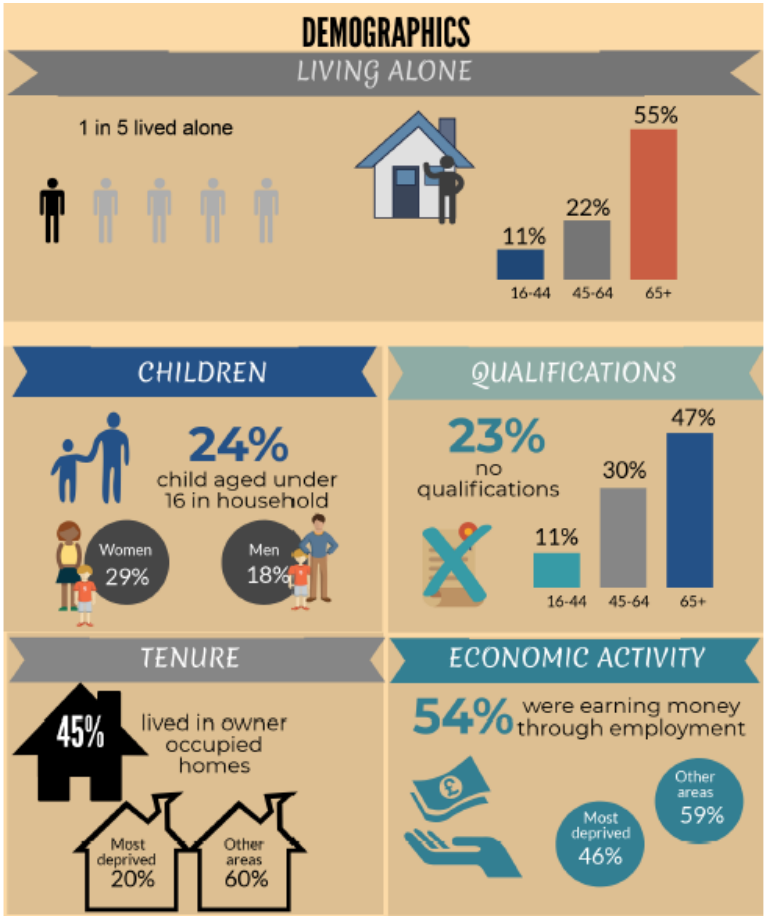
As well as having responsibility for supporting the delivery of the range of services set out within this plan to our local population, the Assistant Chief Officer for the South Locality also has a lead responsibility within Glasgow City HSCP for managing all Older people, Physical Disability and Unscheduled Care Services. This includes Sphere, the Continence Service that is hosted by Glasgow City HSCP on behalf of all HSCPs in Greater Glasgow and Clyde.

We are keen to ensure that there is a strong and effective connection between our services and the local communities we serve. To further assist this, we have structured our community services for older people into 4 Neighbourhood Teams within South. This will also help to improve joint working with GP Clusters and other partner organisations, such as Housing providers. These Neighbourhood Teams will broadly work within the 4 boundary areas shown in the following map

The 4 Neighbourhood Team Areas within South for Older People's Services

HEALTH & WELL BEING

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



Upward trend in number of people in South feeling in control, increasing from 62% in 2014/15 to 72% in 2018

People feeling valued as a memeber of their community is 67% which is higher than the Glasgow City rate of 61%

Positive trends in tobacco prevalence and exposure to second hand smoke: South prevalence down by 5.9% to 22% and exposure down by 8.5% to 28% in South

10% of South respondents experienced food insecurity in the last year (14% in most deprived areas)

30% of people have difficulty meeting necessary expenses (more common in those aged 16-24 at 50%) and this rose to 39% in the most deprived areas

2. HSCP STRATEGIC PRIORITIES

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

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

It also recognised that delivering 'more of the same' will not be enough to meet the challenges of rising demand, budget pressures and inequalities. Transformational change is therefore needed to the way health and social care services are planned, delivered and accessed in the City. Within Glasgow City HSCP, localities play a vital role in delivering better, integrated health and social care services for the people of Glasgow.

The purpose of this locality plan is to:

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

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

The locality plan is based on:

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

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

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

3. COMMUNITY ENGAGEMENT – LOCALITY ENGAGEMENT FORUM

The South locality engagement model has been in place since April 2017. The model was developed to meet the engagement requirements set out in the HSCP Participation and Engagement Strategy, and was widely consulted on at the time of its introduction. It has three strands:

1. Strand 1: a communication and engagement network through which to share information about HSCP policies, service developments, opportunities for engagement, news and consultation activity
2. Strand 2: a schedule of public facing events and sessions, reflecting HSCP priorities and locality issues
3. Strand 3: a programme of project based work supporting services to deliver feedback, engagement and involvement work at the point where people access services

This model offers local people, service users and community and third sector organisations different levels of engagement, depending on their area of interest, expertise and capacity. Engagement activity during 2018 - 19 included;

- Two public facing newsletters and routine mailings to all 300 members of the South Locality Engagement Network, sharing news, information and engagement opportunities from the HSCP and other partners/stakeholders
- Three outreach sessions delivered in partnership with local community and third sector organisations on issues including mental health, neighbourhood teams, primary care improvement plans and Know Who To Turn To messaging
- Two public facing events discussing key HSCP priorities including the review of Out of Hours Services, the Moving Forward Together programme and the Glasgow City HSCP Strategic Plan
- An engagement session with community representatives, community and third sector organisations on the HSCP programme of reform for older people's services
- A number of specific activities including an extensive programme of communication engagement in connection with the opening of the New Gorbals Health and Care Centre and a programme of work with local carers to develop an admission pack for a local Specialist Dementia Unit

Further to a review of the South Locality engagement model a key priority in 2019/2020 is to extend the model to include a quarterly forum, led by senior staff within the locality, offering further opportunities for local people, community stakeholders and other partners to be involved in decision making at a more strategic level. It is envisaged that this group will meet in Autumn 2019 to develop key areas for discussion and agree a terms of reference.

Other priorities key priorities include;

- Continue to offer different levels of engagement across all services and in particular, with neighbourhood teams
- Continue to work in partnership with key local networks and stakeholders, and support HSCP staff and services to promote greater participation and involvement of vulnerable people and groups
- Continue to support HSCP strategic priorities and facilitate consultation and engagement at a locality and citywide level as appropriate

- Lead city wide participation and engagement opportunities in connection to the Older People's Transformational Change Programme

To find out more about the South Locality Engagement Network and other locality engagement opportunities please contact: Lisa Martin, Community Engagement Officer (South Locality) on 0141 427 8269 or Lisa Martin@ggc.scot.nhs.uk

4. PERFORMANCE INFORMATION

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

Indicator	**Q1 Performance/ Status**	**Q4 Performance/ Status**
Achievements		
Number of New Carers identified that have received a Carers Support Plan	N/A	783 (GREEN) (Target 550)
Prescribing Costs: Annualised Cost Per Weighted List Size	£167.12 (GREEN)	£160.80 (GREEN)
% of HPIs allocated by Health Visitor by 24 weeks	96% (GREEN)	99% (GREEN)
% of young people receiving an aftercare service who are known to be in employment, education or training	68% (AMBER)	75% (GREEN)
% of people who have started a psychological therapy within 18 weeks of referral	94.7% (GREEN)	97.6% (GREEN)
% Alcohol and Drug service users with an initiated recovery plan following assessment	75% (GREEN)	78% (GREEN)
Women Smoking in Pregnancy (General Population)	12.1% (GREEN)	9.9% (GREEN)

Women Smoking in Pregnancy (Deprived Population)	18.4% (GREEN)	17.6% (GREEN)
Exclusive Breastfeeding at 6-8 weeks (General Population)	30.1% (GREEN)	32.8% (GREEN)
Exclusive Breastfeeding at 6-8 weeks (Deprived Population)	22.2% (GREEN)	22.4% (GREEN)
Areas For Improvement		
Home Care: % of Older People (65+) reviewed in the last 12 months.	76% (RED)	78%(RED)
% of service users leaving reablement with no further home care support	18.7% (RED)	31.7% (RED)
Total Number of Older People Mental Health Patients Delayed	7 (RED)	3 (RED)
Intermediate Care (Average Length of Stay - Days)	41 (RED)	34 (RED)
Total Number of Acute Delays and Acute Bed Days Lost to Delayed Discharge	N/A	15,288 (citywide) 4794 (NE)
Flu and Shingles Immunisation Rates	Various for different groups	Various for different groups
Access to CAMHS Services	N/A	86% (RED)
% of Looked After and Accommodated Children under 5 who have had a permanency review	61% (RED)	70% (RED)
Total Number of Adult Mental Health Delays	N/A (RED)	8 (RED)
% Homelessness Decisions made within 28 days of initial presentation	74% (RED)	83% (RED)
% of live homeless applications over 6 months duration at quarter end	47% (RED)	47% (RED)
% of Community Payback Order unpaid work placements commenced	62% (RED)	64% (RED)

within 7 days of sentence		
% of Community Payback Orders with a case management plan within 20 days	94% (GREEN)	73% (RED)
% of Community Payback Order 3 month reviews held within timescale	73% (AMBER)	66% (RED)
% of Unpaid Work requirements completed within timescale	69% (GREEN)	62% (RED)
% of SW Stage 1 Complaints responded to within timescale	88% (GREEN)	58% (RED)

5. STRATEGIC PRIORITIES & SERVICE ACTIONS

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

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

The following section highlights activities underway for 2019/20 using the key care group / service delivery headings. Each section shows how the care group will deliver the five strategic priorities for the Partnership. The main activities will be delivered consistently across each Locality area and are identified as "City-wide", but these will be delivered and monitored by the Locality teams. Some specific actions will be delivered in a single Locality, but may be subject to wider roll out in future years across the Partnership if appropriate.

CHILDREN AND YOUNG PEOPLE

Children's Services			
Prevention, early intervention and harm reduction			
City Wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Develop a Family Support Strategy	Work with partner agencies and third sector to improve the range of preventative supports and sustainability of services for families that will provide long-term benefits for local children and families Provide better support to mums, dads and carers in our most vulnerable neighbourhoods. Continue to work with third sector agencies to improve the range and sustainability of family support services that will provide long-term benefits for local children and families	2019	The aim of the service is to provide community supports to prevent young people being referred to social work and/or taken in to local authority care. Families who do not require statutory support from social care, can access a range of preventative third sector services
Work with the Centre for Excellence for Looked After Children in Scotland (CELCIS) and the Robertson's trust to improve our approach to supporting children and young	Commissioning of services from the third sector to provide intensive family support to children on the edge of care	2019/20	Reduction in the numbers of children being taken into local authority care

people on the 'edge of care'			
Children's services – Whole system change .	Implement a framework to promote child and youth mental well-being Create services that can provide earlier interventions for children at risk of entering the care system and their families Improve families' wellbeing and prevent children from compulsory measures (such as becoming 'looked after') To work with families to build positive relationships, ensure right measures are put in place to improve the family circumstances and the wellbeing and development of the child Test out different approaches in each of the city's three localities during the next three years	2019/20	Children and young people will achieve positive physical and emotional health and wellbeing outcomes
Community based mental health and wellbeing services (children)	Undertake scoping to inform the development of a service model options to address mental health and wellbeing in children Continued delivery of commissioned service to improve the mental health and wellbeing of young people	2019/20	As above
Creating a culture for health reducing alcohol, drugs and tobacco use	Delivery of multiple risk contract to young people comprising curricular programme and 1:1 service delivery of programmed activities to support the prevention and education component of the ADP strategy	2019/20	Support for young people to build resilience Increased capacity for targeted early intervention programmes around drug and alcohol issues
Full implementation of Healthy Children Programme	To begin all additional assessments and visits to all families as per Universal Pathway (including antenatal pathway)	By 31/3/2020	Programme is fully implemented All children have access to Universal pathway which will improve early assessment, planning and intervention Children's needs are met earlier reducing need for specialist or statutory services
Improvement in breast feeding at 6 weeks	Having successfully achieved Gold Award. Maintain and build on this success and continue to work with mothers to	Ongoing	Babies are breast fed longer Fig at Q4 exclusive

	encourage breastfeeding		Breastfeeding 6weeks 22.8%
Development and Implementation of the Glasgow Parenting Framework	Central Parenting Team will continue to widen and strengthen collaborative working with partner agencies to support and enhance parents experience, engagement and participation in Triple P group programmes providing accessible, appropriate, culturally sensitive parenting support in Glasgow	2019/20	To reduce the levels of parents who Did Not Attend group programmes and increase retention and successful programme completion by parents/carers
	Expand the development and implementation of a culturally sensitive community based approach to service delivery to identify and respond effectively, efficiently and sensitively to parenting needs within local community groups and settings	2019/20	Increase parental uptake and engagement in Triple P parenting support within local community groups and services
	Develop and implement parenting support pathways for targeted Triple P Teen Discussion Group support within Glasgow Secondary Schools in partnership with Police Scotland Campus Officers and Education Services	2019/20	Increased support to families through the provision of accessible Targeted Teen Parenting programmes and workshops available in Glasgow Secondary Schools
	Continue the provision of the Glasgow Solihull Approach Workforce training programme expanding the programme development to include the Solihull Plus Trauma Awareness training to support trauma informed practice across Children and Families	2019/20	Children & Families staff across services will understand the impact of trauma on children, young people, families and adults. Use the Solihull Approach model to help and support families.

Develop the Consortium approach with the third sector on a city wide basis, informed by the North East test of change.	Through the Lottery funding develop a consortium approach: • Third sector organisations coming together as a consortium. • Consortium staff co-located with the social work duty team. • Families not requiring social work involvement immediately referred to the consortium to ensure that they receive the appropriate level of support at the right time. • Co-developed family support delivered by the third sector rather than social work led.	2019	Early and effective intervention aiming to give all children and young people the best possible start in life
Third sector interface and engagement	Following outcome of consultation on City-wide family support strategy, consider opportunities to improve third sector interface, including: • Membership of JSTs (Joint Support Teams) • Referral patterns and pathways • Develop outcomes based performance framework for JSTs • Current communication and engagement processes	2020/21	Robust partnership working processes in place to maximise capacity and expertise to target resources effectively and deliver better outcomes
Review of vulnerable pregnancy liaison group	Informed by North East test for change work, consider opportunities to improve support arrangements, in context of current procedures	2020/21	Improved access and planning for women who do not fit child protection criteria but do need additional support in the antenatal period
South Locality Specific Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Extend JST to support Castlemilk area. Support a second JST in Govan due level of need and availability of third sector services to support	Validated self-evaluation exercise to be undertaken with the Pollok and Gorbals Early Years-JST's (Govan complete 2017).	March 2019	Early Years Joint Support Teams (EY-JST's) will continue to provide co-ordinated early help for pre-school children living in the most deprived neighbourhoods in the South of the city

Children's Services			
Providing Greater Self Determination and Choice			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Listening to children and young people	Provide the best tools for children and young people looked after by Glasgow City HSCP to enable them to give their views and for these to be listened to and taken into account in decision making	2019/20	Promotion of the participation and engagement of young people in Glasgow which truly informs service provision 93% of looked after children agreed their views were listened to. Annual Performance figs 2017/18/19
Continue to consult with young people and develop contemporary strategies which reflect how young people currently communicate through social media and determine how this can influence child protection and looked after children and processes	Children's Rights Group is exploring innovative ways of consulting with young people including looked after and accommodated children. Review of Viewpoint/Have your Say is ongoing	Ongoing	Involve children in decisions that affect them, have their voices heard
Glasgow Young people's Champion's Board	This board seeks to maximise opportunities for children and young people to get involved and have their voices heard by services and leadership groups. In addition it will seek to identify barriers to participation and work jointly on ways of addressing these, identify issues and concerns and work with children's service decision makers to find solutions, improve young people's leadership skills and help get them ready for employment	Ongoing	Increased numbers of young people being involved in decision making and informing service development

Improve educational attainment and achievement of care experienced children and young people	Narrow the gap between the educational achievements of care experienced young people and their peers.	Ongoing	Continued increase in attainment levels for care experienced young people in the last 3 years across a number of measures. Whilst the general school population in Glasgow out performs the care experienced young people, the attainment levels for Glasgow's care experienced young people are better than the national average for a number of indicators.
Positive Destinations	Increase the number of care experienced young people achieving a sustained positive destination • Identify potential barriers within NW • Identify young people who should be going to positive destinations and determine what additional support or resources may be required to support them • Ensure robust links in place with employability service	Ongoing	In 2018/19 Q3 Percentage of young people receiving an aftercare service who are known to be in employment, education or training increased by six percentage points, to 67% to 74% from the previous year.
Reduction of impact of poverty	To continue to increase the referrals made by Health Visitors to Financial inclusion services Health Visiting teams to discuss the use of food banks as part of general discussions to minimise stigma Ensure all staff are kept informed of where to access equipment etc. for children from Third Sector colleagues	Immediate and Ongoing	Income is maximised Stigma for families reduced Staff have up to date information to share with families
South Locality Specific Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Improving communication with Children and young people	Key action direct work bag created and piloted by South practitioners will have a full South and subsequent city wide implementation.		All HSCP SW sub teams will have a Direct Work Bag for to assist creative ways in their communication with children.

Children and Families will determine their future	Children and families living in the Govan area will be meaningfully consulted in relation to disadvantage, and supports delivered accordingly		NSPCC, in partnership with South HSCP will deliver the NSPCC "Together for Childhood" model of community partnership and sustainable change.
Children's Services			
Shifting the Balance of Care			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
High-cost placements for children and young people	Reduce reliance on high-cost residential care placements Re-focus investment on family and community based supports located in Glasgow for young people who are currently 'looked after' by the Council	2021/22	Reduce reliance on high-cost residential care placements Number of children in high cost placements decreased by two-fifths, from 111 the previous year to 67. 2018-19 (to Quarter 3)
Shift the emphasis from placements outwith Glasgow	Children and young people from the Glasgow City who require to be looked after and accommodated by the local authority can expect to remain living in the city and maintain connections important to them.		Further reduce the number of children living outwith the city by 10%.
Work with families to improve the life chances for children, with a specific focus on family resilience, health improvement, educational attainment and reducing the number of children looked after away from home	Continue to Develop the Intensive Outreach Family Support Service (IOFSS**)** .The aim of the service is to provide intensive community supports to prevent young people being taken in local authority care:	2019/20	Continued reduction in the numbers of children placed on the CPR and length of time on the Register, including referrals to high cost placements
Children's Services			
Public Safety Keeping Children Safe			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Improve the identification of, and response to, children living with neglect in the City.	City wide training of social work, health staff in the identification of neglect Continue to work across all services and partners to improve our approaches to early identification of neglect	Ongoing	Increase in numbers of children receiving support

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

ADULT SERVICES

ADULT SERVICES Prevention, Early Intervention and Harm Reduction			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Mental Health: Suicide Prevention	• Update Glasgow City multi- agency suicide prevention action plan to reflect new National Suicide Prevention Action Plan "Every Life Matters" and Living Works Suicide Safer Communities pillars. • Continue to contribute to NHSGGC Suicide Prevention Group, including work to identify areas/groups for focused activity and	August 2019 October 2019	• Contribute to public awareness of how to prevent suicide. • Contribute to reduction in numbers of deaths by suicide in Glasgow City. • Increased numbers of people

	development of a Greater Glasgow & Clyde-wide suicide prevention concordat. • Continue to provide city wide calendar of suicide prevention training and awareness raising sessions to public, third sector and businesses. • Continue to coordinate multi agency city wide Locations of Concern Group (LOCS) • Contribute to implementation of safety measures to prevent suicides in public places in prioritised LOCS.	Ongoing Ongoing Ongoing	briefed/ trained in suicide awareness/ prevention. • Continue to identify locations of concern and contribute to actions to try and reduce numbers of vulnerable people attempting and completing suicide in public places.
Community based mental health and well being services	Deliver preparatory work and commissioning process to determine a service provider for community based adult mental health and well being support from April 2020 Delivery of community based stress service for adults In conjunction with both Board-wide and Glasgow City contracts / posts to be established via Action 15 monies, progress mental health based training delivery with multiple partners and service areas, including mental health improvement / awareness training and suicide prevention training	By March 2020	Adults experiencing poor mental health and well being can access community based support service Delivery of counselling and group work services to over 5000 adults citywide
Mental Health Counselling Service for people who are Deaf	Implement and evaluate a test for change pilot service with Lifelink for people who are deaf that require a mental health counselling service are able to access a counsellor who can communicate through British Sign Language (BSL).	2019/20	The experience of Deaf people is improved. The evaluation will also consider uptake and pathways to other services to determine if this service should be maintained.
Access to Mental Health Awareness Training for Support workers	• Training needs analysis and further scoping exercise • Development of Mental Health Awareness training programme	By October 2021	Support Workers will have increased knowledge and skills to be able to recognise and support individuals who are experiencing mental health issues. People will be supported to live in their

			owns homes
Addressing Inequalities	Building on previous years' work on equalities development at Board-level for mental health and allied services, which has focused on the priority themes of sensory impairment, financial inclusion and human rights, the appointment of a new post-holder will allow a comprehensive engagement and review of priorities.	2019-22	A refreshed GGC action plan for mental health equalities, in conjunction with relevant HSCP service leads.
Develop robust transition arrangements for young people and older people into and out of adult LD services	• Scope current and predicted service demand • Review current and planned service capacity • Ensure effective transition protocols are in place	2020/21	People have their assessed care and treatment needs met at an early stage, in the most appropriate setting and experience continuity of care
The Keys to Life Implementation Plan 2019-21	Develop multi-service local action plan in response to national implementation plan, focusing on improvements for people with a learning disability in: • Living • Learning • Working • Wellbeing	2019-21	Contribute to the achievement of the priorities set out in the implementation plan, empowering people to • Live healthy and active lives • Learn to reach their potential • Participate in an inclusive economy • Contribute to a fair, equal and safe Scotland
Make progress towards meeting the key objectives within the City's 5 year Rapid Re-Housing and Transition Plan (RRTP) 2019-24	• Reduce time in temporary accommodation by more than 50% • End use of Bed and Breakfast accommodation for homeless people • Develop 600 Housing First tenancies for the most complex and disadvantaged service users • A system change in the homelessness commissioning model from accommodation based services to community based supports	Robust processes and plans in place by 2022 (to achieve full delivery by 2024)	To prevent homelessness, wherever possible. Where it is not possible to prevent homelessness, the priority is to provide a safe and secure home for every homeless household as quickly as possible.

Improve interfaces with Housing Providers to increase access to settled accommodation	• Work with Housing Access Team, continue to coordinate citywide casework input to Local Letting Communities • Monitor number and duration of homelessness applications.	2019/20	Targets being agreed Homeless applications over 6 months duration: target 40% or less.
Increase throughput in temporary and emergency accommodation to settled accommodation	• Work to agreed targets for provision of initial decision, prospects / resettlement plans and case durations	2019/20	Targets: Provision of 95% of decisions made within 28 days. Completion of Prospects / Resettlement Plan within 28 days
Develop a sustainable, holistic response to homelessness by ensuring collaboration across housing, health, social work, third and independent sectors	• Working alongside the Flexible Homeless Outreach Support Service (FHOSS), locality Money and Debt Advice Services, and continue to develop integrated working with money and debt advice, mediation, wider support services • Facilitate a broader involvement from HSCP, including mental health, services in supporting tenancy sustainment and preventing homelessness. • Continue to improve partnership working with Registered Social Landlords (RSLs) and local providers of homelessness services • Facilitate housing liaison sessions and training to improve knowledge, access and interface with Health and Social Care Partnership services for people at risk of homelessness • Continue to offer single point of contact for RSLs on tenancy sustainment issues and improve access to third sector support services • Monitor the impact of the GHSCP Hoarding Protocol across the City • Support discharge planning arrangements	2019-22	• Improve referrals to FHOSS /Welfare Rights/ Mediation Services • Increased tenancy sustainment and reduced levels of homelessness • Evidence though local Essential Connections Forum and Homeless Provider Forum • High levels of participation and engagement • Efficient response times and qualitative support and advice • Identification of hoarding and then effective support • Tenancy sustainment / improved discharge planning

	relating to housing and tenancy sustainment within mental health inpatient services		
Reduce drug and alcohol related harms and drug and alcohol related deaths	• Provide open access responsive services within existing alcohol and drug community services to improve assessment and access to appropriate care and treatment • Increased emphasis on assertive outreach and early harm reduction interventions. Performance framework to be established and reviewed to work collaboratively with Deep End GPs to identify patients with problem alcohol use who do not engage with specialist services. • Increase Naloxone supply • Optimise Opiate Replacement Treatment (ORT) dosing: Review the result of ORT staff survey and create action and training plan. • Better understand changes in novel benzodiazepine-type drug use by: - Review drug monitoring in acute presentations at Emergency Departments - Review Glasgow Alcohol and Drug Recovery Service (GADRS) audit of lab benzodiazepines and gabapentinoids toxicology audit result, creating an action and staff training plan - Embed “Guidance on the Principles of Benzodiazepine Prescribing with Concomitant Opiate Dependence” into day to day practice - Implement action plan from the Street Drug Summit recommendations • Screening for Early Fibrotic Liver Disease in Alcohol Misusers	2019-22	Achieve and maintain waiting times targets Reduce drug and alcohol related harms and drug and alcohol related deaths Increase the early identification of alcohol-related liver disease

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

	• Increase the uptake of vLARC in women who have undergone a termination of pregnancy procedure • Reduction in teenage conceptions, with targeted action in areas where there are higher rates		
ADULT SERVICES **Providing Greater Self Determination and Choice**			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Continue to develop a Recovery Orientated System of Care (ROSC) model	Embed the Scottish Government Strategy 'Rights, Respect and Recovery' published 2018 actively promote ROSC.	2019-22	People access and benefit from effective, integrated person-centred support to achieve their recovery
Provide a range of person centred alcohol and drug care and treatment options	New Residential Rehabilitation and Stabilisation Services to be established in 2019. Monitoring and review of the new services will take place in 2020. Work in close partnership with Recovery Hubs as part of the addiction continuum, offering recovery opportunities. Explore new developments in Opiate Replacement Treatment: review of injectable Buprenorphine pilot. Establish Buprenorphine wafer. Embed the recently commissioned new advocacy service and monitor the uptake	2019-21 Ongoing	Qualitative feedback from service users Continue to increase referrals. Qualitative feedback from service users. Achieve target uptake numbers.
Personalisation: Maintain a continuing	• A continued emphasis on family and carer support building on the significant progress made in this area over recent years and the	2019-22	People are supported to live safely and as independently as possible in a community setting

focus on delivering the best possible outcomes and quality of life to all people in the City that require support from the HSCP and Locality services	new Carers Act requirements. • Develop a sensitive approach to allow service users to move to more economically efficient models of support. • A greater and more effective application of technology to help sustain that carer role and community living in general. This will combine the use of technology enabled care for people with higher level care needs. • Embed the resource allocation policy guidance to support the delivery of a consistent approach to personalisation and the ongoing commitment required by the HSCP to funding the "relevant amount" (the level of funding required to meet each individuals assessed care needs and their outcome based support plan within a community setting).		
Access to Psychological Therapies	• To provide Mental Health Services that will maintain patients seen within 18 weeks performance • Promote use of cCBT (computerised cognitive behaviour therapy)	Ongoing Ongoing	To achieve the Psychological Therapies 18 week Referral to Treatment standard Equality of access of cCBT
Reprovision of Mental Health Advocacy Service for Glasgow City	• Review and develop new service specification in partnership with relevant stakeholders	October 2021	Appropriately independent commissioned service in place
Review of Mental Health employability and meaningful activity services within Glasgow City	• Review and develop new service specification in partnership with relevant stakeholders	March 2020	Employability services that supports the recovery and resilience of individuals

ADULT SERVICES Shifting the Balance of Care			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Identify suitable and sustainable community provision to reduce reliance on NHS inpatient services (Tier 4) for people with a learning disability.	• Commission specialist residential services for adults with learning disabilities requiring complex care, with an emphasis on supporting individuals to potentially move on to more independent models of care. • Explore the development of specialist robust supported living models for people requiring complex care.	2021/22	People are cared for in a homely environment that maximises their independence and the opportunity to progress to more independent models of care The discharge of all Glasgow City patients currently in NHS Learning Disability long stays beds. Reducing delays in the discharge of people from Learning Disability assessment and treatment beds
Implementation of 5 Year Adult Mental Health Strategy 2018-23	• Develop suitable community alternatives (statutory and non-statutory services) to support people to be discharged from hospital, and prevent hospital admissions. • Linked to the above, reduce the level of mental health inpatient beds across acute, rehabilitation and hospital based complex care beds, freeing up resources for reinvestment in community services. • Reduce average length of stay ensure effective use of beds • Ensure delayed discharges are within target range • Unscheduled Care – ensure early identification of barriers to discharge	Significant progress by 2022 (full implementation of strategy by 2023	People are supported to live safely and as independently as possible in a community setting. Achieve bed number targets set out in Mental Health Strategy Target of zero delayed discharges

Linked to the Mental Health strategy: Procure and commission a new service to provide an alternative distress response for individuals within Glasgow City Effective and Efficient Community Mental Health Services	• Develop a service specification in partnership with key multiagency stakeholders that will meet the needs of individuals in distress • Improve the Effectiveness and Efficiency in Adult Community Mental Health Services	April 2020 2022	An accessible alternative distress response service will be available Adult Community Mental Health Services are effective and efficient
Integration of secondary care services in community teams. Making secondary care treatment more accessible to service users in the community	Continue to develop HCV (Hep C) clinics and further promote and support the BBV (blood-borne virus) agenda. Review of fibroscan pilot to detect early liver disease and to provide early interventions, with a view to expanding city wide. Promote harm reduction with Injecting Equipment Programme (IEP) and foil. Continue to work closely with GP colleagues to review all service users and identify how best to meet the needs of service users who are prescribed Opiate Replacement Treatment (ORT) Shared Care teams to continue to promote referrals	2019-22	Reduction and eventual eradication of HCV (Hep C) Better early detection rates Increase HIV testing within teams. Increase numbers of individual being prescribed ORT via their GP.

	into Recovery Hubs		Increase in referrals
Alcohol & Drugs inpatient and day service provision	Explore potential to improve the standard of existing accommodation and the scope to see further shifts towards community alternatives	2019-22	People are supported to live safely and as independently as possible in a community setting.

ADULT SERVICES Enabling Independent Living for Longer			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Implementation of Assisted Technology (TECS) and, where appropriate, alternative models for overnight support	• Progress transformational change programme to embed consideration of TECS within assessment processes and explore alternative arrangements to sleepovers. • Pending evaluation of Connecting Neighbourhoods test for change work in Castlemilk and Shettleston, roll out new responder service for overnight care elsewhere in the City	2019/20 2021/22	People are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community Reduction in the volume and cost of sleepover provision
Modernising Learning Disability Day Services	• Extend the range of health clinics offered at day centres • Improve access to health checks • Consider alternative and quicker responses to service users or carers in times of 'social or care crisis' • "Respite" or increased support for short periods within a structured environment. • Undertake an option appraisal to consider the replacement of 2 Learning Disability day care centres	2020/21	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
Integration of Learning Disability services	Informed by test for change work in North East, implement and evaluate new processes, protocols and systems that support the delivery of more integrated Learning Disability services throughout the City, including improved access to and experience of 'mainstream' services	2019-21	People who use health and social care services have positive experiences of those services, and have their dignity respected Reduction in waiting times to access services
Improve links between Alcohol & Drug Recovery	• Continue to work closely with housing providers and housing support services to identify individuals who require alcohol	Ongoing	Early access to care and treatment. Tenancy sustainment

services and with housing support services.	and/or drug interventions to assist in tenancy sustainment.		
Review frequent Emergency Department presentations and aim to support to reduce attendances	Continue to review and audit frequent Emergency Department attenders.	2019/20	Reduction in A&E attendances

ADULT SERVICES Public Protection			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Adult Support and Protection (ASP) Act	• Ensure staff continue to be supported to meet ASP standards and requirements • Contribute to maintaining and where necessary, improving practice arising from the annual joint self evaluations	Ongoing	Continue to ensure people, particularly the most vulnerable, are kept safe from harm and that risks to individuals or groups are identified and managed appropriately.
Develop more integrated working practices between Criminal Justice and other services to better manage vulnerability	• Develop more integrated risk assessment and risk management processes with Alcohol and Drug Recovery Services (and ensure all MAPPA clients with alcohol and /or addiction issues are able to access local services). • Ensure criminal justice staff have a full understanding of processes and supports aimed at preventing homelessness • Review referral pathways with Mental Health and promote best practice with service users with complex mental health needs • Ensure follow-up for non-engagement, with particular consideration to vulnerability and risk • Develop more robust links and working practices with Scottish Prison Service	2019-21	Clients have timely access to appropriate services, including better access to Addiction and Homelessness services Criminal Justice staff to be aware of the housing first model and be able to support service users to access / utilise this service when appropriate Criminal Justice staff have a better understanding of complex mental health issues (eg personality disorder) and the best approach to manage / address these needs Early identification of vulnerability.
The efficient processing of community payback orders (CPOs) and criminal justice social work reports	• Ensure all CPOs are reviewed by a Team Leader at the 3 month stage and throughout the order. • Ensure service users have a comprehensive risk assessment and supervised action plan in	Ongoing	75% of CPOs 3 month Reviews held within timescale Compliance target of 85%

	place within 20 days of a CPO.		
Increase BBV testing and support access to Hepatitis C and HIV treatment	• Continue to increase testing and access to BBV (blood-borne virus) treatment. • Increase staff trained in Dry Blood Spot testing (DBST)	2019-22	Reduction in the number of people infected with Hep C and HIV
Establish the Enhanced Drug Treatment Service (EDTS)	• The Enhanced Drug Treatment Service will commence in September 2019 with a focus on prescribed diamorphine treatment for a small group of people who inject drugs within the city centre.	2019/20	Reduction in drug deaths and supporting people to access other care and treatment pathways as necessary
Develop a service improvement programme for Prison Healthcare	• The development of Advanced Nurse Practitioner posts across the service to address the challenge of providing accessible medical cover. • The review of recruitment practice around nursing and medical staff to support retention and vacancy management. • A review of the workforce to enable improved service delivery, including enhanced mental health /psychology provision funded through 'Action 15' monies. • A robust Health Improvement approach is in place • The development of enhanced IT provision to assist service improvement opportunities •	2019-22	Performance framework to be developed Within available parameters, people in prisons have equity of access to safe, effective and responsive healthcare
Continue to provide a combined high quality Police Custody healthcare service, including delivery of Forensic Medical Service provision	• Be responsive to the health care needs of people in custody and to ensure appropriate links are made to other services (e.g. Addiction, Mental Health Services) to meet individuals' on-going health needs. • Enhance mental health service provision through 'Action 15' monies. • The development of enhanced IT provision to	2019-22	Performance framework to be developed Within available parameters, people in police custody have equity of access to safe, effective and responsive healthcare

	assist service improvement opportunities • The development and implementation of a robust Health Improvement approach		
Development of Archway Sexual Assault and Referral Centre (ASARC)	Work with partners to maintain the high standard of forensic care and increased opening hours in the Archway sexual assault and referral centre. Progress development of a new West of Scotland regional service, including transfer of ASARC from Sandyford to upgraded accommodation at William Street Clinic.	2020	Improved access to specialist care and support
Development of Community Custody Unit for women	Work in partnership with Scottish Prison Service to develop the HSCP service and staffing model required to provide effective care and support to women in the new facility to be developed in Maryhill.	2020	Provide safe accommodation and support the needs of women who are suitable for, and would benefit from, closer community contact and access to local services, to create and sustain independence in preparation for successful reintegration into the community.

OLDER PEOPLE AND PHYSICAL DISABILITY

Older People Locality Plan – City Wide and Locality Actions

OLDER PEOPLE'S & PHYSICAL DISABILITY SERVICES			
Prevention Early Intervention and Harm Reduction			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Anticipatory care plans ACP)	1089 were completed last year which is more than doubled since 2017. Relaunch ACP resources using the National material (My ACP) as a mechanism to introduce people to ACP and implement the agreed NHSGGC partnership ACP summary document to capture the summarised content of the person held ACP is being introduced • Complete staff awareness sessions • Develop and implement Clinical Portal Version of ACP summary in collaboration with eHealth • Raise public awareness • Provision of additional support to Partnership staff from MacMillan ACP Facilitator • ACP clinical lead engaging with GPs scoping ACP work within Local Enhanced Service (LES) Care Homes • Develop and agree new HSCP ACP Booklet • Work with HIS to form and develop a Living and Dying Well Frailty Collaborative	Introduced this financial year.	Targeted use of ACP within Health and Social Care teams and relevant partners. Introduce people to ACP through ACP conversations. Share ACP summaries with GPs and other relevant professionals involved in the persons care. Empower people through greater awareness, control, choice and self management of their Long Term Condition. Test new approaches to the identification and management of Frailty
The use of falls prevention and projects to support frail older people.	Glasgow's target rate is 6.75 per 1,000 but the current rate is 7.5: a number of actions are identified including; • Develop a referral pathway with Scottish Fire and Rescue to carry out level one conversations and refer into NHS falls and rehab services Introduce a frailty tool with specific focus on	Actions to be progressed in 2019/20	Increased referrals to rehab services and community falls team. and established use of frailty tool

	evidence based interventions. • Promote the use of the “Up and About” resources on prevention of falls • Agree ways of improving data collection for falls including determining a realistic and meaningful baseline. • Continue to support Scottish Ambulance to reduce the number of non injured fallers conveyed to hospital • Contribute to the response to the Falls and Fracture Prevention Strategy for Scotland 2019 - 2024 consultation document • Contribute to the development of the NHSGGC Falls Strategy • Promote the use of Technology Enabled Care for those who are at risk of falling • Connect various sources of information on people who fall to services i.e. homecare and rehab		
Maximise use of Link worker capacity within Primary care, Dementia Services and Community Connectors	• Raise awareness of roles of links workers • Promote networking of Links Workers to make efficient use of capacity	Progress in 2019/20	More efficient use of links worker roles

OLDER PEOPLE'S & PHYSICAL DISABILITY SERVICES			
Shifting the Balance of Care			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Delayed Discharge	Target to reduce the number of lost bed days to under 1910 per annum. Above target currently not being met. A working group has been established to develop an action plan and take forward specific priorities related to 13ZA and AWI issues.	Progress required this financial year.	Reduction in delays and bed days associated with delays
Evidencing shifting the balance of care and evidencing projects that support independent living (Telecare).	2,706 telecare referrals were taken during 2018/19 which was above the target of 2248. 1,337 advanced telecare referrals were implemented which is above the target of 304. Referrals are above the performance targets but the strategic plan highlights the need to increase the pace of telecare uptake.	Track referral rates during 2019/20	Increase of uptake of telecare
The role of neighbourhood teams in supporting older people in the community.	Neighbourhood teams will develop a delivery model to deliver more joined up and integrated health and social care services for older people/people with physical disabilities in partnership with GPs, housing providers, community and voluntary sectors to take a proactive and preventative approach to care, delivering better outcomes for older people and people with physical disabilities, their families and carers, The neighbourhood model will assist in the development of multi-disciplinary front line teams to deliver on the strategic priorities of the HSCP	Work to address recruitment issues and pathways to be undertaken during 2019/20	Delivery of 75% target for re-ablement
Develop more alternatives to acute hospital admissions.	• 4 intermediate care step up beds provided in North East. • Explore short term home based alternatives to hospital admission out of hours • Telecare and emerging assistive technologies are key factors in preventing and delaying hospital admissions.	Further work on the transformational change programme will be ongoing throughout	Reduced attendance at Emergency Department and Assessment Units by use of alternative routes for support

	• The use of reablement and Anticipatory Care plans are significant factors in reducing hospital admissions. • Further develop role of Community Respiratory Service to prevent admission, reduce delays and intervene at an early stage	2019/20.	
Need to reduce admissions to hospital from care and residential settings.	Work is primarily led via the unscheduled care group examples of work related to this are; • The red bag programme • Work underway around the GP Consultant Geriatrician interface in the community. • A review of admissions from a care home in NE to Glasgow Royal Infirmary. • Work with residential and nursing care settings to develop awareness and intervention to support service users with dementia • Further develop Advanced Nurse Practitioner role within Partnership Residential Homes • Provide support and advice from mainstream community services to inform care home staff about a variety of clinical conditions including continence care, tissue viability etc	2019/20	Reduced attendance, admission and length of stay for care home residents within acute system
Continue to develop the Community Respiratory Team and to maintain / increase the positive impact on attendances / admissions to hospital and length of stay.	• Review data from the Community Respiratory team to identify areas for improvement and greater efficiency • Formulate develop plan and resource required	2019/20	Improvement Programme for Community Respiratory Team
Link with the five year strategy for older people's mental health	The OPMH 5 year strategy is currently in development and will have a focus on shifting the balance of care including looking at alternatives to admission to inpatient care.	To be progressed during 2019/20	Improved co-ordination across acute and mental health systems

	Dementia is one strand of the above. **Technology** Ensure all staff have the knowledge, skills & competencies around the availability of technology to support individuals at the different stages of dementia. **Promoting Excellence** All HSCP employees in contact with people with dementia will have a level of training appropriate to the promoting excellence framework. **Advanced Dementia/sharing good practice** Sustainability around good practice in the area of dementia service delivery, shared learning across the HSCP and third sector. **Dementia Public Awareness** Through public awareness and involvement of third sector organisations . People will have a better understanding of basic rights and entitlements, ensuring more resilience and less likelihood of delays in hospital. People have a better understanding of lifestyle choices which could impact of the onset of dementia People will feel they can live well with dementia People experience a positive approach to dementia where they live. **Post Diagnostic Support.** Patients and service users receive timely post diagnosis support **Specialist dementia Unit improvement programme.** A national improvement programme will continue to		

	ensure continuing improvements in the provision of specialist dementia units using and Experience based on a co-design model. **Effective and Efficient Community Mental Health Teams** Ensure that Community Mental Health Teams are operating effectively and efficiently to meet the needs of the current population and improve outcomes for people living with dementia and or functional mental health illness		
Integration of Occupational Therapy (OT) within Older People's services	The review of OT has focused on an integrate approach to the provision of Occupational Therapy Services across all care groups within the HSCP, streamline processes, to ensure the reduction in duplications and create simplified service delivery to the service user. This work has initially focused on Occupational Therapists working within Older People and Primary Care Group. A piece of work to identify competencies has been undertaken and will be rolled out following a successful test of change. This aim of this is to ensure that we can make best and full use of all the skills of OTs, and reduce onward referral to OT colleagues to a minimum There is also a data and performance work stream that has tested out a number of measures to assess the impact of OT on services user health and well - being and assess the impact of individual OT's. In addition plans are underway to measure waiting times across all services in a consistent way.	2019/20	Consistent and effective use of services and Occupational Therapy resources and skills

OLDER PEOPLE'S & PHYSICAL DISABILITY SERVICES			
Enabling Independent Living for Longer			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Increases in the amount of homecare reviews undertaken and offered.	During 18/19 83% of those aged over 65 receiving home care were reviewed. This above the target figure of 81%. However South area averaged 78% due to staff shortages and this is an area for improvement.	During 2019/20	Regular review of homecare and maintenance or improvement of target figures
Increases in the amount of supported living placements including the living well project.	The number of people in supported living services increased during 18/19 to 878 which is above the target rate of 830 per annum. The increase in the number of Older People personalisation packages is a driver for this. Further increases during 2019/20 are sought.	2019/20	Delivery of supported living placements
Development of bespoke OP residential housing with care in the form of Clustered Supported Living.	202 service users are currently supported with care and support packages via housing providers. 75 more properties are coming on stream during this financial year.	Track occupancy progress during 19/20.	Delivery of supported living placements in partnership with Housing providers
Increase take up and support for palliative care.	Palliative Care services have been a factor in increasing the percentage of people who spend the last 6 months of their life in the community. Target for 2019/20 is to increase those spending the last 6 months of their life in the community by 2%. • Progression of year 2 of 5 year plan • Priorities for Children's services and prison • Roll out of SPAR tool in Partnership Residential Care Homes	Further work during 2019/20 to improve RAG classifications and data collection.	Increased use of palliative care provision and choice for people to spend last 6 months of life in home or community setting
Creating a safer home environment through Improving identification of vulnerable Older People through Housing and relationship with Registered Social Landlords and Housing	Maximise the use of RSLs and HOs to support HSCP in identifying vulnerable older people and assist them in identifying where housing options, Telecare, ACP, adaptations etc.	Measures to be developed around Use of Clustered Supported Living	Review through Essential connection forum with partner organisations and develop measures for uptake of Telecare and use of Anticipatory Care Plans with appropriate people

Options (HO)		Placements and uptake of appropriate support	

PRIMARY CARE

PRIMARY CARE			
Prevention Early Intervention and Harm Reduction			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
Primary Care Improvement Programme (PCIP) – General Practice Multi-Disciplinary Team Workflow	• Agree process for application to Health Improvement Scotland Practice Administrative Staff Collaborative (PASC) collaborative for general Practice in Glasgow • Support applications under PASC – signposting training • Support roll successful practices in the roll out and implementation of the PASC Collaborative	Aug 2019 Autumn 2019 and ongoing for successful applications	Glasgow City practices successfully in a national collaborative to promote signposting as a way of working and increasing the number of people seeking consultations who are seen first by the person / service most able to help
PCIP - Improve communication and working relationships between the HSCP and General Practices.	• Increasing contact between HSCP and GPs using the cluster guidance, Cluster Quality Leads to be offered by PCIP Team • Agree implementation of cluster guidance for up to 4 sessions per month for clusters • Increase frequency of meetings between HSCP & GPs to boost tripartite arrangements.	12 months	Increased and improved collaboration between HSCP and GPs.
PCIP - Pharmacotherapy	• Continue close working with pharmacy colleagues to ensure that all practices have	April 2020	All practices aware by end 2019 of the level of input

	some pharmacotherapy input by Spring 2020		they can expect
PCIP – Musculo-Skeletal (MSK) Physiotherapy	• To co-ordinate use of Advanced Practice Physiotherapists (APPs) to improve patient care and reduce GP workload. • To embed the learning gained from experience in north east practices.	March 2020	To offer APP to appropriate practices in north east and across the city.
PCIP - Vaccination Transformation Programme (VTP)	• To link Glasgow City VTP to Greater Glasgow & Clyde priorities and programme board. • To effectively and safely transfer current vaccination programme to new service models under PCIP to improve vaccination uptake.	Ongoing April 2021	To maintain / improve vaccination levels under new arrangements.
Housebound Seasonal Flu Vaccination Programme 2019 - 2020	• To deliver a programme of activity of seasonal flu and pneumonoccal vaccination to housebound patients aged 18 and over registered with a Glasgow City HSCP GP • To deliver the above to Glasgow City HSCP residential Care Homes • To deliver the above to residential care homes with no registered nursing staff excluding residential care homes on a shared campus where registered nursing staff are employed. • To plan and deliver the 2019 Programme with a timeframe for delivery of vaccinations of 1st October 2019 to 31st December 2019. • To initiate an HSCP Planning Group and Locality Delivery Groups • To identify the potential Nursing and Business Support Resource required to support the programme in 2019. • To share feedback and learning as part of the ongoing vaccination transformation programme	2019/20	• Delivery of seasonal flu vaccination programme for housebound patients aged 18 and over 19/20

PCIP Urgent Care	Know Who To Turn To banners in GP practices	Autumn 2019	Raise patient awareness of alternatives to GP visit

PRIMARY CARE			
Providing greater determination and choice			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
PCIP – Community Care & Treatment; Phlebotomy	Continued roll out of phlebotomy service to areas of the City/ Locality not served by Health Centres providing patients with more choice about where they attend to have their bloods taken	Autumn 2019 and ongoing	Provision of service to increased number of practices with an initial emphasis on those practices who do not have access to existing Treatment Rooms
PCIP Community Care and Treatment/Phlebotomy/Premises Work stream	Support sourcing of suitable accommodation for Phlebotomy service	Autumn 2019	Provision of service to increased number of practices with an initial emphasis on those practices who do not have access to existing Treatment Rooms

PRIMARY CARE			
Shifting the Balance of Care			
City-wide Areas of Activity	**Priority Actions**	**Timescale**	**Outcomes Sought**
PCIP - Primary Care Sustainability	• Test more systematic and proactive approach to the identification of sustainability challenges e.g. combining our current intelligence with the offer of a proactive survey of all practices in one Locality. • Strengthening support to practices could primarily take the form of ensuring that the wider supports are available to the practices in greatest need, examples of these include; Multi-Disciplinary Team (MDT), workflow, administration support, training and other ways of meeting practice specific needs. • Quantify GP time freed up and time spent with those with more complex needs	April 2020	Ensuring continuity of care as implementation of PCIP
PCIP – Urgent Care	• Support the roll out of the Advanced Nurse Practitioner (ANP) model into HSCP care homes. • Develop and provide ANP to new residential units opening in the North West in late summer 2019	Autumn 2019 and ongoing	Enhanced support for care home residents and reduced workload including house calls for GPs
PCIP – Urgent Care	Support new ANPs working in current and new residential units	Autumn 2019	Enhanced support for care home residents and reduced workload including house calls for GPs

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

HEALTH IMPROVEMENT

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

			tier 0-2 mental health and well being support
Community Link Worker programme (Primary Care Improvement Plan)	Support the phased rollout of the community link worker programme; working closely with primary care Refine current operational model and data collection Delivery of the procurement processes to determine allocation of additional link workers	Phased 2019-20	Improved collaboration with GP practices and the Alliance Increased uptake of social prescribing in areas of deprivation Improved connectivity into relevant services and local community supports
Community based mental health and well being services (adult and children)	Deliver preparatory work and commissioning process to determine a service provider for community based adult mental health and well being support from April 2020 Delivery of community based stress service for adults Undertake scoping to inform the development of service model options to address mental health and well being in children Continued delivery of commissioned service to Improve the Mental Health and Wellbeing of Young People	By March 2020 March 2020	Adults experiencing poor mental health and well being can access community based support service Delivery of counselling and groupwork services to over 5000 adults citywide Development of recommendations to discuss with partners to support mental well being of children Delivery of counselling & groupwork programmes in schools and Youth Health Service to over 930 young people
Tackling Poverty and Inequalities	Delivery of financial inclusion & employability services including income maximisation, debt management and		Work to increase referrals across service areas.

	building financial capability.		
Creating a culture for health – reducing alcohol , drugs and tobacco use and obesity	Delivery of multiple risk contract to young people, comprising curricular programme and 1:1 service Delivery of programme of activities to support the Prevention and Education component of ADP strategy		Support young people and build their resilience Increased capacity building and provision of targeted early intervention programmes around drug and alcohol issues
Locality Specific Areas of Activity	Priority Actions	Timescale	Outcomes Sought
Placed based work	Contribute to the development of Thriving Places action plans in Gorbals, Govanhill, Govan and Priesthill & Househillwood with community planning partners Utilise and share the data from the 2018/19 adult Health survey to support place based work	September 2019 Ongoing	Neighbourhoods inform priorities for local development NHS data is utilised by partners and forms part of the basis for planning along with qualitative data gathered locally
Financial inclusion	Deliver financial inclusion embedded within Pollokshaws Medical Practice	April 2019-March 2020	Maximise income and address debt to support health and well being
Programme for Government-Breastfeeding Support to Mothers with additional (cultural) needs	Scottish Government: Programme for Government (PfG) – targeted work with the South Asian community in Pollokshields Scoping and identification of Breastfeeding support needs of women from South Asian community	April 2019-March 2020	Develop models of breastfeeding support for South Asian community Findings to be shared locally, citywide and to

	(Pollokshields) with the aim of reducing breastfeeding attrition rates Working with the community using co-production methods to map and identify support needs and shaping ideas for future supports via 1-1 focus groups and interviews Liaison with Health Visiting and Midwifery team and partner organisations Report on findings with the aim of identifying a way forward of breastfeeding support for the South Asian community		Scottish Government
Faith Works	Liaison with the various Black and Minority Ethnic (BME) communities within South and partner BME organisations Develop short videos aimed at providing information on treatment & recovery service provision Provide initial drug and alcohol awareness training to identified BME groups. E.g. South Asian Muslim community	April 2019-March 2020	Increased awareness about drugs & alcohol within the South BME communities Improved connectivity and access to alcohol and drugs services for South BME communities.

CARERS

City Wide Areas of Activity	Priority Actions	Timescale	Outcomes Sought
Implement the Carers (Scotland) Act 2016	Workforce learning and Development Plan to be made available to all Health and Social Care Partnership staff to ensure Carers are support is embedded within practice.	Initially role out for Older People and Primary Care Services. Followed by Adult Services and then Children's	Carer's (Scotland) Act 2016 training to be available August 2019 onwards.

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

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

6. PROMOTING EQUALITY

The South locality will continue to deliver the actions and priorities set out within Glasgow City HSCP's Equality Plan.

Key actions and priorities for the South Locality include:

- Maintaining accessibility audits of new buildings
- Participation in Equality Impact Assessments of cost savings, service redesigns, service developments and policies
- Hate crime awareness and reporting
- Promote multi-agency working to address violence against women through the Glasgow Violence Against Women Partnership and the locality implementation group, helping to deliver the City-wide strategic delivery plan and the national Equally Safe Strategy.

- Routine enquiry money worries, gender based violence (GBV), employability and appropriate onward referral
- Participation in age discrimination audits as required
- Responding to findings of the Fairer NHS staff survey alongside staff training priorities (Asylum seekers & Refugees, Poverty e-learning module, Key care groups, GBV)
- Meeting the requirements of the HSCP's participation and engagement strategy including equalities monitoring of community engagement
- Analysing performance monitoring and patient experience by protected characteristics as required
- Provision of a programme of equality and diversity training for HSCP staff and local organisations

7. RESOURCES

7.1 Accommodation

New Health and Care Centre

The new £17 million New Gorbals Health and Care Centre opened on Monday 21st January 2019. This new facility replaced the original Gorbals Health Centre, Twomax building and Southbank Centre for Specialist Children's Services. A broad range of services are now provided from the new facility, 4 GP practices, Physiotherapy, Podiatry, General dental services and public dental services, Specialist Children's Services, Child and Adolescent Mental Health services (CAMHs), Alcohol and drug recovery services and Social work services. As well as transforming the standard of accommodation, this new facility will deliver more integrated health and social care services for the benefit of patients and service users. In 2019/20 there will be ongoing evaluation and a post occupancy review.

Reviewing Accommodation Requirements and Promoting Co-location

Services are delivered across a wide range of locations in the South locality. Our vision is that we will focus our health and social care services around our four main centres in Gorbals, Castlemilk, Govan and Pollok supported by other smaller centres across the south. In late 2018 moves took place to support the co-location of Children's Services including relocation of a team into Pollok Health Centre and further work will take place across 2019/2020 in Castlemilk Social Work office and the Castlemilk neighbourhood to make better use of our non-clinical areas through the introduction of agile working, and improving facilities for staff and patients.

A programme to improve our accommodation and support the delivery of integrated health and social care services to the people of South Glasgow is underway. We have begun to assess the scope for increasing clinical space for Primary Care Improvement Plan work-streams including Treatment Room and Care Services as well as Children's Immunisation Programmes. Following a review of sites in South, the Head Quarters offices will relocate in November 2019 into Rowanpark.

7.2 Human Resources

The South Locality directly manages a staffing compliment of approximately 2800 people across a range of services and disciplines (2300 Whole Time Equivalent). This includes services hosted as a management responsibility on behalf of HSCPs across Greater Glasgow and Clyde.

7.3 Finance

South Locality has a total net recurring budget for service provision of approximately £261m. The budget for South Locality in 2018/19 is set out below.

	South Locality		
Strategic care Groups Grouped	**Health Annual Budget £'000**	**SW Annual Budget £'000**	**Total Annual Budget £'000s**
Children & Families	6,969.8	9,961.6	16,931.4
Prison Services & Criminal Justice		2,643.1	2,643.1
Carers		862.0	862.0
Older people		27,878.0	27,878.0
Elderly Mental Health	8,322.6	0.1	8,322.7
Learning Disability	1,708.3	21,565.9	23,274.2
Physical Disability		5,504.5	5,504.5
Mental Health	25,208.9	3,469.4	28,678.3
Alcohol + Drugs	1,952.7	2,022.2	3,974.9
Homelessness		1,144.6	1,144.6
GP Prescribing	46,181.7		46,181.7
Family Health Services	68,060.1		68,060.1
Hosted Services	4,059.5		4,059.5
Other Services	20,557.8	3,179.9	23,737.7
Expenditure	**183,021.4**	**78,231.3**	**261,252.7**