Item No: 13

Meeting Date: **Wednesday 29 June 2022**

Glasgow City Integration Joint Board

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

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Annual Performance Report 2021/22

Purpose of Report:	To present and seek approval of the Annual Performance Report for the Health and Social Care Partnership for the year 2021/22.
Background/Engagement:	The IJB have previously agreed that an Annual Performance Report would be produced and presented to them each year. There have been five previous Annual Performance Reports, covering the financial years 2016/17 to 2020/21.
Governance Route:	The matters contained within this paper have been previously considered by the following group(s) as part of its development. HSCP Senior Management Team ☒ Council Corporate Management Team ☐ Health Board Corporate Management Team ☐ Council Committee ☐ Update requested by IJB ☐ Other ☐ Not Applicable ☐
Recommendations:	The Integration Joint Board is asked to: a) approve the attached Annual Performance Report for 2021/22;

	b) note that some final year-end figures will be included once available; c) approve that responsibility for any final amendments to the report to incorporate these year-end figures will be delegated to the Chief Officer; and d) note that a glossy version and summary version will also be produced and published, as has been done previously.

Relevance to Integration Joint Board Strategic Plan:

The report contributes to the ongoing requirement for the Integration Joint Board to provide scrutiny over HSCP operational performance, as outlined within the Strategic Plan and reviews performance against agreed local and national performance indicators.

Implications for Health and Social Care Partnership:

Reference to National Health & Wellbeing Outcome(s):	HSCP activity and performance within the report is mapped against the Partnership's strategic priorities and the 9 National Health and Wellbeing Outcomes ensuring that performance management activity within the Partnership is outcomes focused.
Personnel:	Activity and Performance in relation to Human Resources is included in the report.
Carers:	Activity and Performance in relation to Carers is included in the report.
Provider Organisations:	None
Equalities:	An Equalities section is is included in the report.
Fairer Scotland Compliance:	Not applicable
Financial:	None
Legal:	This Annual Performance Report is normally required to be published within 4 months of the end of each reporting year although the Coronavirus Scotland Act (2020), Schedule 6, Part 3 enables IJBs to extend the date of publication of APRs until the end of November if required. The Public Bodies (Joint Working) (Scotland) Act 2014 Act and accompanying guidance outlined core contents expected within these Annual Performance Reports. The guidance indicates that APRs are for HSCPs to provide an assessment of performance in planning and carrying out

	the integrated functions for which they are responsible. It also states that they are to be produced for the consideration of the Partnerships themselves and it is primarily their responsibility to act upon the information and recommendations within them.

Economic Impact:	None

Sustainability:	None

Sustainable Procurement and Article 19:	None

Risk Implications:	None

Implications for Glasgow City Council:	The Integration Joint Board's performance framework includes social work performance indicators.

Implications for NHS Greater Glasgow & Clyde:	The Integration Joint Board's performance framework includes health performance indicators.

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 The purpose of this report is to present and seek approval of the Annual Performance Report for the Health and Social Care Partnership for 2021/22.

2. Background - Scottish Government Performance Guidance

2.1 The Public Bodies (Joint Working) (Scotland) Act 2014 requires the Integration Joint Board to publish an Annual Performance Report, setting out an assessment of performance in planning and carrying out those functions for which they are responsible. This Annual Performance Report is normally required to be published within 4 months of the end of each reporting year although the Coronavirus Scotland Act (2020), Schedule 6, Part 3 enables IJBs to extend the date of publication of APRs until the end of November if required.

2.2 Guidance on these Annual Performance reports was produced by the Scottish Government in March 2016. This indicates that APRs are for HSCPs to provide an assessment of performance in planning and carrying out the integrated functions for which they are responsible. It also states that they are to be produced for the consideration of the Partnerships themselves and it is primarily their responsibility to act upon the information and recommendations within them. It also indicates that the reports should be made available online with consideration given to making them accessible to the public.

3. Recommendations

3.1 The Integration Joint Board is asked to:

a) approve the attached Annual Performance Report for 2021/22;
b) note that some final year-end figures will be included once available;
c) approve that responsibility for any final amendments to the report to incorporate these year-end figures will be delegated to the Chief Officer; and
d) note that a glossy version and summary version will also be produced and published, as has been done previously.

DRAFT ANNUAL PERFORMANCE REPORT 2021/22

Version 2

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1. INTRODUCTION

1.1 PURPOSE OF REPORT

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

This is the sixth report for the Glasgow City Integration Joint Board (IJB) and within it we look back upon the last year (2021/22). We consider progress in delivering the priorities set out in our second Strategic Plan (2019-22), with key service developments and achievements from the last twelve months highlighted.

Within this report, we also review our performance against agreed local Key Performance Indicators, as well as in relation to the Core Suite of National Integration Indicators (Appendix C) which have been published by the Scottish Government to measure progress in relation to the National Health and Wellbeing Outcomes (Appendix B).

1.2 PARTNERSHIP OVERVIEW

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

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

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

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

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

Across all services, as at April 2022, the Health and Social Care Partnership has a workforce of 11,120 Whole Time Equivalent (WTE) staff, made up of 4818 WTE employed by Glasgow City Council and 6302 by NHS Greater Glasgow and Clyde.

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

Within the Partnership's area, there are 144 GP practices providing general medical services to their practice populations. There are also 163 community pharmacies, 110 optometry practices and 163 dental practices which include 6 orthodontic practices.

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1.3 AREA PROFILE

Key demographic characteristics of the city are summarised below. A more comprehensive Demographics Profile is available, containing demographic data and indicators at Scotland, Glasgow City and HSCP locality level. The profile relates to the health and social care of the population and includes further data on population and households, health, lifestyles, poverty and deprivation in addition to the high level information shown here. The profile also covers topics not included below, such as social care, social health/capital, education or participation in learning/employment and crime/criminal justice. Additional information sources where further information can be found are listed in Appendix A.

Population

Glasgow has a population of 635,640. It is densely populated with 3,638 people per km2 and most people living in flats (67.8%). This is very different from the Scottish average of 70 people per km2 with most people living in houses (65.8%). (NRS Small Area Population Estimates (SAPE) 2020; Scottish Household Survey 2019).

Glasgow is a diverse city. 77.5% of people living in Glasgow were born in the UK with the remaining 22.5% born outside the UK. This compares with 88.9% and 11.1% respectively for Scotland, less than half the Glasgow rate of those born outside the UK (NRS SAPE 2020 and Scottish Survey Core Questions (SSCQ) 2019).

88.5% of Glasgow's total population has a White ethnic background and 11.5% has a Black or Minority Ethnic (BME) background. The proportion of Glasgow local authority school pupils with a non-White ethnic background is 25.5% - more than double the BME percentage of the total population. By comparison, Scotland's overall population is 96.0% White and 4.0% BME, with 9.2% of local authority school pupils having a

non-White ethnic background. (NRS SAPE 2020; Scotland's Census 2011; Scottish Government Pupil Census Supplementary Statistics 2021)

Projected Population

The overall population of Glasgow is expected to grow by 1.2% between 2022 and 2027, 2.4% between 2022 and 2032 and 4.3% between 2022 and 2043.

Within the overall increase between 2022 and 2032, the child population (0-17 years) of Glasgow is forecast to decrease by 4.9%, the adult (16-64 years) population is expected to increase by only 0.2% and the older people (65+) population is expected to increase by a far greater proportion of 22.3%.

Scotland's population is also expected to grow overall, by 0.8% between 2022 and 2027, by 1.3% between 2022 and 2032 and by 1.6% between 2022 and 2043. Within this small overall increase are expected decreases in both the child and adult populations of 6.9% and 2.2% respectively and a large increase of 20.1% in the older people population. (NRS Population Projections 2018).

Life Expectancy

The Life Expectancy (LE) and Healthy Life Expectancy (HLE) indicators shown below illustrate that on average, Glasgow people live fewer years in good health from birth and die younger than Scotland's people. In addition, the Life Expectancy and Healthy Life Expectancy of Glasgow males are shown to be lower than those of Glasgow females.

- A Glasgow male is expected to live to 56.0 years of age in good health (HLE) from birth compared to a Scottish male who is expected to live a further 4.9 years in good health, to 60.9 years of age
- A Glasgow female is expected to live to 57.4 years of age in good health (HLE) from birth compared to a Scottish female who is expected to live a further 4.4 years in good health, to 61.8 years of age
- A Glasgow male is expected to live to 73.1 years of age (LE) compared to a Scottish male who is expected to live a further 3.7 years, to 76.8 years of age
- A Glasgow female is expected to live to 78.3 years of age (LE) compared to a Scottish female who is expected to live a further 2.7 years, to 81.0 years of age

Glasgow has higher than average death rates for deaths attributable to many causes. This is demonstrated by the premature mortality rate of deaths from all causes for people under 75, which is 678 per 100,000 population for Glasgow, almost 1.5 times the Scottish average rate of 457 per 100,000 population (Sources: Public Health Scotland 2021/NRS 2020)

Key Health and Wellbeing Indicators

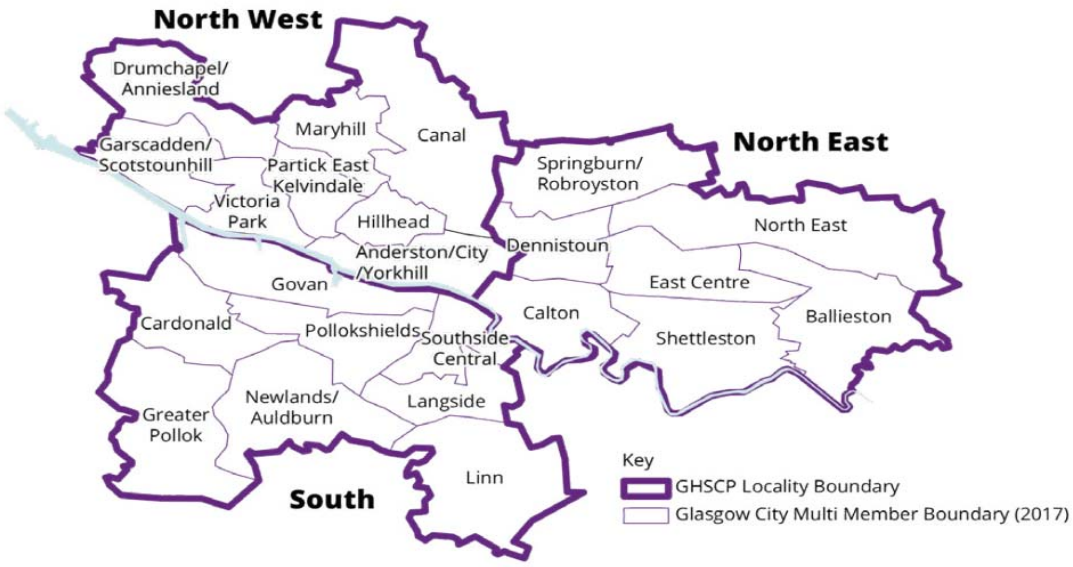
The following high level indicators illustrate some key aspects of the health of, or factors that may impact on the health of, Glasgow's people. More detailed information on these and other related indicators can be found in the Demographics Profile:

- 73.0% of Glasgow adults rated their health positively (NHSGGC Adult Health and Wellbeing Survey – Glasgow City 2017/18)
- 59.4% of Glasgow secondary school pupils rated their health positively (NHSGGC Schools Health and Wellbeing Survey – Glasgow City 2019/20)

- 10.5% of Glasgow adults said their health was bad/very bad, compared to 8.1% of Scottish adults (Scottish Survey Core Questions (SSCQ) 2019)
- 28.6% of Glasgow adults have a limiting condition or illness (NHSGGC Adult Health and Well-being Survey – Glasgow City 2017/18)
- 9.0% of Glasgow secondary school pupils have a limiting illness or disability (NHSGGC Schools Health and Well-being Survey – Glasgow City 2019/20)
- 23.0% of Glasgow adults have common mental health problems, scoring 4+ on GHQ12a, compared to 17.0% of Scottish adults (Scottish Health Survey (SHeS) 2016 to 2019)
- 30.0% of Glasgow secondary school pupils have a WEMWBS well-being score indicating probable depression (NHSGGC Schools Health and Well-being Survey – Glasgow City 2019/20)
- 8117 people or 2.1% of the Glasgow adult population aged 30+ are estimated to have dementia (Alzheimer's Scotland 2017)
- 61.0% of Glasgow adults are overweight (inc. obese) (BMI of 25 or higher) whilst 27.0% are obese (BMI of 30 or higher) compared to the respective figures for Scotland of 65.0% overweight and 29.0% obese adults (SHeS 2016 to 2019)
- 30.0% of Glasgow adult males and 19.0% of Glasgow adult females are current smokers (NHSGGC Adult Health and Well-being Survey – Glasgow City 2017/18)
- 3.1% of Glasgow secondary school pupils are current smokers (NHSGGC Schools Health and Well-being Survey – Glasgow City 2019/20)
- 30.0% of Glasgow adult males and 14.0% of Glasgow adult females have hazardous/harmful levels of alcohol consumption. Both percentages are lower than for Scotland overall (33.0% males; 16.0% females) (SHeS 2016 to 2019)
- There are an estimated 11,869 to 18,060 problem drug users in Glasgow (Public Health Scotland (PHS) – Prevalence of Problem Drug Use in Scotland 2015/16)
- 14.4% of Glasgow adults provide unpaid care to others (NHSGGC Adult Health and Well-being Survey – Glasgow City 2017/18)
- 87.0% of Glasgow households have home internet access – similar to the national average of 88.0% (Scottish Household Survey (SHS) 2019)
- 98.5% of Glasgow secondary school pupils have home internet access (NHSGGC Schools Health and Well-being Survey – Glasgow City 2019/20)
- 19.3% of all Glasgow people are classed as income deprived compared to 12.1% of all Scots (Scottish Index of Multiple Deprivation (SIMD) 2020)
- 24.6% of Glasgow children aged 0-15 are living in relative low income families

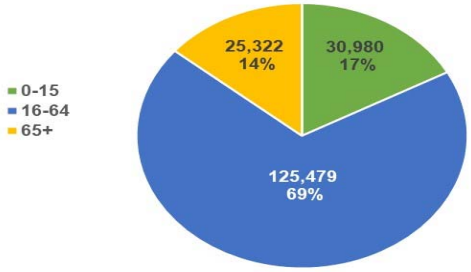
1.4 LOCALITIES

Glasgow is divided into three areas, known as localities, to support operational service delivery and to enable planning to be responsive to local needs. To ensure consistency in local service delivery with key partners, the Glasgow City Health and Social Care Partnership has adopted the same strategic areas as the Glasgow Community Planning Partnership. Services are managed and delivered within three local areas, known as localities. These localities – North West, North East and South – are shown on the city map and described in more detail below.



North East Locality
North East Locality covers the following wards:

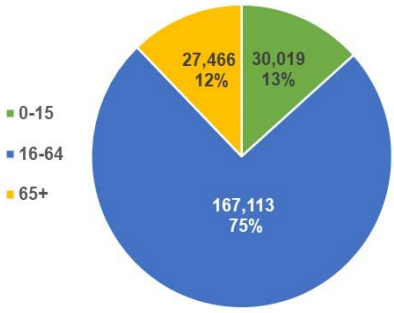
- Calton
- Dennistoun
- Springburn/Robroyston
- East Centre
- North East
- Shettleston
- Baillieston



The total population of North East
Glasgow is 181,781 people and a breakdown by age is shown on the pie chart above.

North West Locality
North West Locality covers the following wards:

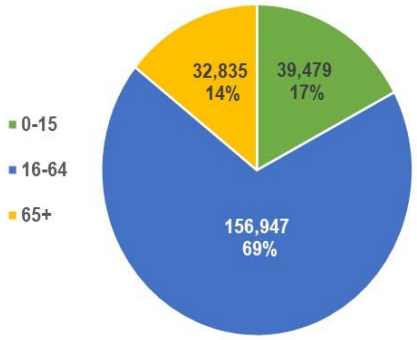
- Anderston/City/Yorkhill
- Hillhead
- Canal
- Maryhill
- Partick East/Kelvindale
- Victoria Park
- Garscadden/Scotstounhill
- Drumchapel/Anniesland



The total population of North West Glasgow
is 224,598 people and a breakdown by age is shown on the pie chart above.

South Locality
The South Locality covers the following wards:

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



The total population of South Glasgow is 229,261 people and a breakdown by age is shown on the pie chart above.

Locality Management Arrangements

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

Community Planning

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

Primary Care Implementation Groups

Each locality has a Primary Care Implementation Group engaging with primary care contractors, which link to the overall city-wide Primary Care Steering Group. The 144 General Practices within Glasgow have been divided into 'clusters' to take forward the quality agenda in primary care. There are 21 GP clusters, 7 in each locality, with an average patient population of 34,000. Each of the clusters has identified a Cluster Quality Lead and a development programme has been implemented to support their learning needs, with a specific focus on using quality improvement methodology.

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

Locality Engagement Forums

Across the City, we have established Locality Engagement Forums (LEFs) in each of the Partnership's localities, which feed into local management arrangements and city-wide networks. LEFs are made up of a range of stakeholders, mainly patients, service users and carers from local communities. They have an important role to play in linking to the governance, decision-making and planning structures of the locality and HSCP, ensuring that feedback and the opinions of patients, service users and carers are heard. These form a key role in our local participation and engagement arrangements, in line with the HSCP's current Participation and Engagement Strategy. These have continued to meet online over the course of the last year with an annual questionnaire to members used to decide upon topics for city wide sessions which included one on Primary Care Services. Localities have also held their own online meetings focusing on local topics and interests.

Locality Plans

Each locality has developed a Locality Plan, which details how they are taking forward the IJB's Strategic Plan (2019-22) and responding to locally identified needs and priorities. To better align locality plans with this overarching 3-year Strategic Plan, current locality plans also cover the 3-year period from 2019-22. Locality plans describe:

- Health and social care needs/demands including changes from the previous plan
- Key service priorities, informed by the IJB Strategic Plan 2019-22
- Current performance against key targets, identifying good performance and areas for improvement
- Resources available including staffing, accommodation, and locality budgets
- Community engagement mechanisms and development
- Equalities activity and priorities

Implementation of locality plans is monitored on an ongoing basis and reported to locality and citywide management teams, as well as to the Integration Joint Board.

1.5 STRATEGIC VISION AND PRIORITIES

Strategic Plan

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

Our IJB's current Strategic Plan was initially agreed to cover the 2019 – 22 period, but due to the factors that have recently impacted the health and social care sector, the IJB decided at its May 2021 meeting to extend it for a further year but begin work over a longer period to review it and develop a new one for the 2023 – 26 period.

The current Strategic Plan sets out the following vision and priorities for health and social care services in Glasgow. Within this report, we capture some of our key achievements in relation to delivering these priorities and the nine National Health and Wellbeing outcomes (See Appendix B).

Our Vision

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

- being responsive to Glasgow's population focussing on reducing health inequalities
- supporting and protecting vulnerable people and promoting their independence and social wellbeing
- working with others to improve physical, mental and social health and wellbeing, and treating people fairly
- designing and delivering services around the needs, talents, aspirations and contributions of individuals, carers and communities using evidence from what we know works
- showing transparency, equity and fairness in the allocation of resources and taking a balanced approach by positively allocating resources where health and social care needs are greatest, with decisions based on evidence of what works and innovative approaches, focussed on outcomes for individuals and risk accepted and managed rather than avoided, where this is in the best interests of the individual
- developing a competent, confident and valued workforce
- striving for innovation and trying new things, even if they are difficult and untested, including making the most of technology evaluating new and existing systems and services to ensure they are delivering the vision and priorities and meeting the needs of communities
- evaluating new and existing systems and services to ensure they are delivering the vision and priorities and meeting the needs of communities
- developing a strong identity
- focussing on continuous improvement, within a culture of performance management, openness and transparency

Our Priorities

The highest priority for the Glasgow City Health and Social Care Partnership is delivering transformational change in the way health and social care services are planned, delivered, received and experienced in the city. We believe that more of the same is not the answer to the challenges facing Glasgow, and we will strive to deliver on our vision through the following strategic priorities:

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

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1.6 PERFORMANCE MANAGEMENT ARRANGEMENTS

A comprehensive Performance Framework is in place and routine performance management arrangements established within the Partnership, which facilitate scrutiny of performance in relation to delivery of our Strategic Plan and against a range of local and national Key Performance Indicators (KPIs).

A detailed Quarterly Performance Report is produced which includes a wide variety of Health and Social Work KPIs and provides information on how services are responding to areas of under-performance. All KPIs have been aligned to the HSCP's Strategic Priorities as set out in our Strategic Plan and to the National Health and Wellbeing Outcomes specified by the Scottish Government.

This Performance report is shared with and scrutinised by HSCP Senior Management Team and is presented to the Integration Joint Board's Finance, Audit and Scrutiny Committee. At each of these meetings, specific service areas are focused upon and relevant strategic leads are invited to discuss performance and demonstrate how they are impacting upon the HSCP's Strategic Priorities.

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

In addition to service performance, the health improvement team, in partnership with the wider public health intelligence community, also undertakes periodic population surveys, analyses and tailored needs assessments, in order to compare population health and well-being trends and inform future planning. These include the Adults and Schools Health and Wellbeing Surveys which are featured within the HSCP's Demographics Profile.

There are, therefore, a range of mechanisms in place within the Partnership in order to monitor and scrutinise performance on an ongoing basis and to consider longer term demographic and health and wellbeing trends.

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1.7 STRUCTURE OF THE REPORT

In chapter 2, we reflect upon the Covid19 pandemic, describing how the HSCP has responded and the impact on service delivery.

Chapters 3 to 9 are structured around the HSCP's strategic priorities and within it we highlight some of the key achievements and developments over the last 12 months and consider our performance in relation to Key Performance Indicators associated with each priority. Drawing on this information, key achievements in relation to our performance over the last 12 months are highlighted and areas for improvement going forward identified. Consideration is also given to the HSCP's performance in relation to the Core Suite of National Integration Indicators as well as other local information sources and surveys (See Appendix C).

Chapter 10 provides information on inspections undertaken over the last twelve months by the Care Inspectorate and Mental Welfare Commission. It also describes the internal audit and evaluation activity undertaken within the HSCP.

In chapter 11, we provide a summary of our financial performance for 2021/22. We also describe some of the key transformation programmes and resultant savings that have been achieved as a consequence. Key capital investments are also summarised and the financial outlook for 2022/23 considered.

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2. COVID-19 AND THE HSCP RESPONSE

Within this chapter, we reflect upon the impact of the Covid-19 pandemic which the HSCP has been actively responding to since early 2020.

2.1 GOVERNANCE ARRANGEMENTS

Throughout this period, we have had business continuity and planning structures in place to respond to the initial impact of COVID-19 and to plan for the recovery and renewal of community-based services. These have been overseen by the HSCP's Executive Group, which was extended to include all of the HSCP's most senior managers.

This has been supported at various times by a number of other groups which have been established in response to the evolving situation. These have included Locality Accommodation Groups and the HSCP wide Accommodation, Social Distancing and Recovery Group which has been responsible for providing final approval to any plans for building use and the restarting/recovery of services. They have ensured this has been done in a co-ordinated way and complies with all Government and Public Health COVID-19 guidelines, with services required to submit detailed floor plans and risk assessments and demonstrate engagement with staff representatives and key stakeholders.

National guidance has also been implemented in respect to the management and governance of residential and care home settings, with a range of multi-disciplinary strategic and operational groups established at city and Health Board levels to oversee this. These groups have introduced new care home monitoring and reporting arrangements and have had responsibility for ensuring that all necessary processes have been in place to ensure the safety of residents and staff during the pandemic.

In managing its response to the pandemic, the HSCP has worked closely with local authority and NHS staff side representatives and has supported and contributed to Glasgow City Council and NHSGGC wide pandemic planning structures, including the Health Board's Strategic Executive and Tactical Groups and the Council's Renewal Board.

2.2 CHALLENGES

The pandemic has presented a number of challenges to the HSCP with the following being experienced at varying times since it began:

- Limited ability to see service users/patients face-to-face
- A lack of IT equipment to facilitate home working
- Digital exclusion impacting efforts to maintain contact with service users
- Staff absences for COVID-19 related reasons, particularly impacting services continuing to deliver face-to-face care
- Rapidly emerging and changing guidance and public health measures such as social distancing
- The requirement to introduce new services while maintaining existing ones e.g., testing, the vaccination programme, community COVID-19 assessment centres etc as described below

2.3 SERVICE REPONSES TO THE PANDEMIC

As reported in last year's APR, service delivery arrangements have adapted over time in response to the above challenges and to the dynamic nature of the pandemic. Initially, face-to-face provision of many community-based services was reduced and alternative models of delivery were adopted which included telephone and online based service provision. To support these developments, work was undertaken to expand staff access to mobile technology, including telephones and laptops with access to a range of digital platforms, including Attend Anywhere, Near Me and Microsoft Teams. Work was also undertaken with the support of initiatives such as Connecting Scotland to provide support in the form of digital devices, connectivity and lessons in their use for vulnerable service users and carers, enabling them to access online services, as well as connect with friends and family. Examples of service responses during the last year include the following:

Breastfeeding Support

In response to COVID-19 restrictions, face-to-face Breastfeeding Support Groups across Glasgow were put on hold and the HSCP and third sector partners - National Childbirth Trust (NCT) and Breastfeeding Network (BfN) - adapted their services to offer a range of support to mothers. This included online groups, text support and Attend Anywhere video calling. In order to enhance these services a telephone support Pilot has been established for women giving birth at the Queen Elizabeth Maternity Hospital (QEUH) in the last year.

Online Gender Friendly Nursery Training

Health Improvement staff have developed an online training programme supporting Early Learning Establishments (ELCs) in Glasgow to work towards Gender Friendly Nurseries Accreditation. Nursery staff are provided with two pre-recorded sessions to watch at their convenience and then invited to take part in two live interactive virtual training sessions.

Carers Support

Local Carer Centres have increased their social media presence while the Carers Advice and Information Team was established to maintain contact with all unpaid carers and disseminate key information such as PPE and COVID-19 restrictions. Throughout the pandemic, the HSCP's Your Support Your Way Glasgow website has also been kept up to date and an online carer self-referral form was launched to facilitate faster and more streamlined referrals.

Covid-19 Vaccinations

The Complex Needs Service - previously known as Homeless Health Service - has ran weekly Covid-19 Vaccination Clinics at the Lodging House mission, as well as visiting around 50 locations across the city. Over 1000 people have been vaccinated, many of whom have underlying health issues that put them at higher risk. A vaccination clinic was also set up to provide COVID vaccinations for newly arrived Asylum Seekers as part of the HSCP Asylum Health Bridging Team, which provides a range of health services to one of Scotland's most vulnerable communities.

Childhood Flu Immunisation

Glasgow HSCP hosts the Childhood Immunisation Team on behalf of NHS Greater Glasgow and Clyde. The Team normally deliver the flu vaccination to all primary schools across NHSGGC and this was extended this year to include all high school pupils, teachers and front-facing pupil support staff. This was part of the Scottish Government's extension of the flu vaccination campaign to help prevent flu co-circulating with Coronavirus.

Bereavement Support

A Webpage dedicated to bereavement information and support services was launched in May 2021 by the Bereavement Subgroup of the Glasgow City Suicide Prevention Partnership, as a response to the importance of grief and bereavement support during the Coronavirus (COVID-19) pandemic. The resource provides information on the subjects of death, grief and bereavement and links users directly to organisations and servicers where they can find further information and support.

Community Assessment Centre

The Barr Street Covid-19 Community Assessment Centre has played an instrumental role in the response to COVID, providing the first point of contact for many patients with suspected Covid-19. It has enabled patients to be assessed and directed either home with a care plan, or moved into acute care and. By the end of 2021, over 37,000 patients had been seen.

Care Homes

In addition to ensuring relevant guidance was followed in respect to the management of Care Homes during the pandemic, the HSCP has also invested in the development of large garden pavilions in each of the 5 HSCP Care Homes which provide a further shared safe space for families to meet outside of the main care home building irrespective of the weather.

2.5 Recovery Planning

It has been recognised that online provision is not appropriate for all service users and face-to-face contact has been maintained across the majority of services throughout the pandemic. RAG risk ratings and triage arrangements were introduced, in order to ensure those with the highest levels of need were prioritised and seen face-to-face. Steps were also taken through the above HSCP wide Accommodation, Social Distancing and Recovery Group to ensure that all buildings from which face-to-face services were being delivered had been risk assessed, and complied with public health control measures around hygiene, infection control, PPE, and physical distancing.

Over time, as the HSCP's Recovery Strategy has been implemented, further services have been reinstated to varying degrees and face-to-face contacts have increased, although there have been recurring challenges experienced such as staff absences, which have affected the nature and speed of service responses and the degree to which service recovery plans have been able to be implemented.

These recovery plans have been progressed within the context of the changing restriction levels and national guidance introduced in response to the different 'waves'

of the pandemic, including the emergence of the new Omicron variant. For example, HSCP managed Care Homes have adhered closely to the guidance entitled *'Open with Care'* issued by the Scottish Government and Health Protection Scotland to minimise the risk of residents contracting COVID-19. This covers a range of areas including infection control and cleaning, testing regimes for staff and residents, vaccinations, managing positive cases and outbreak management.

Detailed and up to date information on recovery responses and progress for all HSCP service areas, can be found in the COVID-19 updates which have been regularly published on a dedicated Covid-19 section of the HSCP website over the last 2 years. This website also includes video messages from the Chief Officer and Senior Management Team members which have been recorded throughout the pandemic. It also contains a range of locally produced information and advice to support homeworking, enable a safe return to work and promote staff health and wellbeing as well as link to other related Council, Health Board and nationally produced resources.

As part of the recovery process, services across the HSCP are continuing to identify where there may be opportunities to consolidate some of the most effective practices adopted during the pandemic and incorporate these going forward within mainstream service delivery in order to offer greater flexibility for service users and improve service efficiency.

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DELIVERING OUR KEY PRIORITIES

Chapters 3 to 9 are structured around the HSCP's Strategic Priorities:

- Prevention, early intervention and harm reduction
- Providing greater self-determination and choice
- Shifting the balance of care
- Enabling independent living for longer
- Public Protection
- Staff Development and Engagement
- Equalities

For each Priority, we profile some of the key developments/achievements in the last 12 months. We then consider performance in relation to some of our Key Performance Indicators (KPIs) which are associated with each Strategic Priority.

Indicators where performance has shown the greatest improvement over the past 12 months are highlighted, along with areas where we would like to see improvements over the next year. Key actions which we will progress to achieve these improvements are also summarised and progress going forward will be monitored through the range of performance management mechanisms in place to scrutinise performance at city wide and locality levels described in Chapter 1.

Under each priority where relevant, we also include other information such as local service surveys as well as our performance in relation to the National Integration Indicators. These are produced by the Scottish Government to provide the basis against which Health and Social Care Partnerships can measure their progress in relation to the National Health and Wellbeing Outcomes and as they are derived from national data sources, allow comparisons to be made with the Scottish average. (See also Appendix C).

Key

Within Chapters 3 to 9, Performance Status has been classified as Red, Amber or Green (RAG) and the key below explains these categories. The **Status** is provided for the end of 2021/22, the previous 2 years and the baseline of 2015/16. The **Direction of Travel** details whether the current figure (2021/22) is better or worse in comparison with i) the Baseline (2015/16) and ii) the previous year 2020/21.

KEY TO PERFORMANCE STATUS		
	RED	Performance misses target by 5% or more
	AMBER	Performance misses target by between 2.5% and 4.99%
	GREEN	Performance is within 2.49% of target
	GREY	No current target and/or performance information to classify performance against.
DIRECTION OF TRAVEL		
▲		Improving
▶		Maintaining
▼		Worsening

3.1 PREVENTION, EARLY INTERVENTION AND HARM REDUCTION

In tackling this Strategic Priority, we have continued to work with a wide range of partners across the City to improve overall health and wellbeing, prevent ill-health and increase healthy life expectancy. This work is underpinned by agreed priorities for Health Improvement which focuses on reducing health inequalities and changing the culture in relation to health behaviours in the city.

The activities described in this section have contributed to a range of the 9 national Health and Wellbeing Outcomes, most notably those shown below. Other related activities including those addressing poverty, are described in later sections of this report in relation to other Strategic Priorities.

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

3.1 KEY DEVELOPMENTS/ACHIEVEMENTS

3.1.1 EARLY YEARS AND CHILDREN

Youth Health Services Expansion

Glasgow City Youth Health Service (YHS) offers confidential, personalised support to young people aged 12 to 19 years. The service was rebranded and officially launched in September 2021 to mark its expansion to three venues in each of the North East, North West and South localities (9 in total). Most consultations are now face to face at the request of young people although online support remains available The service offers advice and support with all aspects of health and wellbeing, including sexual health, alcohol and drugs and mental health which has become an increasing priority as a result of the pandemic. Support is also available for a range of other issues including relationships, housing, and employability with young people being signposted as required.

User/Carer Feedback

A digital satisfaction survey was undertaken last year as part of a wider Communications Plan and feedback included the following:

'With other services, it feels very formal, whereas when you walk into the Youth Health Service it feels fun and there's signs on the wall to show you're accepting of everyone. The LGBT+ sign, it just feels very welcoming' (Young Person)

'The nurse took on board everything we were saying and communicated with us. If she said she would call us back, we knew she would call us back.' (Parent)

'Easy to access, simple referral process and friendly helpful staff.' (Social Worker)

Case Study

Martin was 16 when he was referred by his GP to the YHS for anxiety and low mood, while he was awaiting support from Specialist Mental Health Services. The Nurse discovered that he had experienced significant verbal and physical homophobic bullying and referred him to an Advocacy Service and to YHS Counselling for further support. Despite being sceptical, he went on to engage well and completed therapeutic sessions which he felt benefitted him. He has opted to continue to receive support from the YHS in addition to the Specialist Mental Health Service, given the positive outcomes he felt were achieved with their input.

Thrive Under Five and the Glasgow Food Plan

The Thrive Under 5 Project aims to help children under five years of age and their families to eat more healthily and maintain a healthy weight. It is operating in a number of areas and adopts a child poverty lens, seeking to involve local families and organisations in addressing and overcoming barriers to healthier eating including low family income, limited access to affordable fresh foods, a lack of cooking knowledge/skills and a lack of access to wider healthy lifestyle supports. To support these aims, Thrive Under 5 Networks have been established in each area which seek to ensure that local needs are understood and shape local solutions. This project is underpinned by similar principles to that of the Glasgow Food Plan, which was formally launched in June 2021.

Multiple Risk 1:1 Service

A new Multiple Risk Service for young people commenced on the 1 July 2021 and is being provided within Youth Health Service venues across the city. This provides one to one support for young people engaging in, or at risk of engaging in, multiple risk activities such as antisocial/offending behaviour, alcohol and/or drugs, non-engagement in education/employment, risky sexual behaviour, gambling, and self-harm/suicidal ideation. Staff within the service work with young people to identify underlying issues which may be contributing to these behaviours and then support them through a programme which comprises of 13 specialist modules and seeks to maximise health and wellbeing outcomes for each young person involved.

User/Carer Feedback

'My anger has improved – I can control it more and I've stopped drinking since June'

'I've gone to school for the first time since pre-Covid'

'My mental health has got better. I'm more positive'

How Nurturing is our Children's House? Programme

Colleagues from children's residential services and psychological services teams have been working together on the '*How Nurturing is our Children's House?'* project. This was successfully piloted in one residential house and is now being rolled out across the city. As a result of the approach, young people and their carers both reported better relationships between them. There was also a decrease in the number of incidences of reported violent behaviour, a reduction in the number of

times physical intervention was considered to be required and a reduction in staff absence due to work-related stress.

3.1.2 MENTAL HEALTH

Flourish Glasgow

Studies have suggested that Covid-19 has impacted negatively upon mental health in Scotland and the UK. The Flourish Glasgow Partnership has been established by the HSCP along with a range of statutory and voluntary sector partners and aims to 'act together to promote the mental well-being of everyone in Glasgow, mitigate the emotional challenges of the pandemic and reduce the toll of distress and mental illness'. Key activities have included the sharing of knowledge and good practices; capacity building in areas such as such as suicide prevention (for example a Suicide Contagion event); and support for staff mental health and wellbeing.

Let's Introduce Anxiety Management (LIAM)

A number of initiatives have been taken forward to support young people's mental health recognising the impact of the pandemic. These include the delivery of the 'Let's Introduce Anxiety Management (LIAM)' package by School nurses which is based on Cognitive Behavioural Therapy (CBT) principles and is aimed at children and young people experiencing mild anxiety. It enables participants to learn more about the causes of anxiety, its symptoms and how to manage it and involves children and young people (and parents/carers, where appropriate) meeting with a LIAM worker for around 8 sessions to work through the resources together.

User/Carer Feedback

Feedback from virtual evaluation sessions with parents have highlighted the following

- *'The session was really informative with lots of examples. Also, it really helps to know that those tantrums are normal and that as a parent I need some strategies to deal with them, rather than getting frustrated myself'*

- *'Very helpful and made me feel at ease. The information shared has helped me gain more confidence in how I can approach a No Listening scenario with my son. So glad I was given the opportunity to attend the session. Thank you'*

Mental Health Support for Deaf People

The prevalence of mental health issues is four times higher for people in the deaf community due to issues like isolation, social exclusion, discrimination and stigma caused by deafness and communication barriers. Evidence has also shown that accessing services can be difficult for deaf people who often present to services during a mental health crisis rather than at an earlier stage when this could have been avoided. In response, a Deaf Mental Health Peer Support Worker has been appointed in the last year who has lived experience of these issues and as a result, is able to help others to manage their own mental health recovery. If successful, it is hoped that this will lead to the recruitment and training of other Peer Support workers across the Health Board area and Scotland as a whole.

3.1.3 HARD TO REACH GROUPS

Cervical Screening for Women with Learning Disabilities

Staff from Glasgow City Health and Social Care Partnership's (HSCP) Health Improvement Team have been working with Jo's Cervical Cancer Trust to produce cervical cancer screening awareness videos to encourage women with learning disabilities to be tested. This is being done in response to data from the NHSGGC Public Health Screening Report which highlights much lower rates of attendance for cervical screening for women with a learning disability compared to the rest of the population. Enable Scotland assisted in the production of these videos, working in co-production with women with learning disabilities to inform them.

Supporting the Roma Community

An Outreach Support Service has been introduced for the Roma Community in Glasgow which is being delivered by two integrated Health Care Support Workers, supported by peer mentors from the Roma community. This aims to increase the accessibility and uptake of services and improve the health and wellbeing of children and families within the Roma population. Peer mentors have been helping the Outreach Support Service to build relationships with families with a range of complex needs and have been supporting them to register and attend appointments with local services including health, housing, and employment support. Work has also been undertaken to connect and refer members of the Roma community to local charities and community groups where required.

3.1.4 SEXUAL HEALTH

Sexual Health and HIV Prevention Outreach service

The expanded Sexual Health and HIV Prevention Outreach service began in May 2020 and has continued providing services to the most vulnerable including those who are homeless or people who inject drugs (PWID). In the last year, following a positive evaluation, the programme to distribute and prescribe Pre-Exposure Prophylaxis (PrEP) - a medication that can be taken to lower the risk of acquiring HIV infection - to people who inject drugs was featured as an example of good practice in integrated working in the national HIV Journal '*HIV Medicine.'* Uptake amongst PWID has historically been negligible and Sandyford staff worked with the HSCP's Homelessness and Addictions Services to provide a tailored outreach PrEP service based in Glasgow's Homeless Health Centre, which provides information about HIV prevention and access to PrEP medication.

Abortion

The introduction of telemedicine consultations for Early Medical Abortion at Home (EMAH) by the Sandyford Termination of Pregnancy and Referral service (TOPAR), has seen a significant change in the percentage of women completing medical abortion at home (up from 30% of medical abortions in 2018 to over 80% in 2021). This service has also reduced the waiting time for abortion assessment and resulted in abortions now being carried out at an earlier gestation than previously which is regarded as safer (8.2 weeks average in 2018 compared to 6.3 weeks currently).

3.2 KPI PERFORMANCE

INDICATOR (Health & Wellbeing Outcome)	2021/22 TARGET	2015/16 BASELINE	2019/20 YEAR END	2020/21 YEAR END	2021/22 YEAR END	Direction of Travel since 2015/16	Direction of Travel since 2020/21
Percentage of HPIs (Health Plan Indicators) allocated by Health Visitors by 24 weeks. (Outcome 4)	95%	NE 95% ✓ NW **93%** ✓ **South 96%** ✓	NE 98% ✓ NW 95% ✓ South 96% ✓	NE 96% ✓ NW 96% ✓ South 99% ✓	NE 95% ✓ NW **98%** ✓ **South 95%** ✓ (Jan 2022)	NE ▶ NW ▲ S ▼	NE ▼ NW ▲ S ▼
Access to specialist Child and Adolescent Mental Health Services (CAMHS): % seen within 18 weeks (Outcome 9)	100%	100% ✓	51.9% ●	60.8% ●	**59.4%** ●	▼	▼
Mumps, Measles and Rubella (MMR) Vaccinations: (% uptake at 24 months) (Outcome 1)	95%	**94.6%** ✓	93.2% ✓	94.2% ✓	**93.7%** ✓ (Q3)	▼	▼
Mumps, Measles and Rubella (MMR) Vaccinations: (% Uptake at 5 years) (Outcome 1)	95%	**95.9%** ✓	96.5% ✓	96.3% ✓	**96.2%** ✓ (Q3)	▲	▼
Psychological Therapies: % of people who started treatment within 18 weeks of referral. (Outcome 9)	90%	N/A	NE 69.9% ● NW 90.3% ✓ S 80.3% ●	NE 56.6% ● NW 93.6% ✓ S 91.4% ✓	NE **46.3%** ● NW **92.4%** ✓ S **81.2%** ●	**N/A**	NE ▼ NW ▼ S ▼
% of service users commencing alcohol or drug treatment within 3 weeks of referral (Outcome 7)	90%	**97%** ✓	98% ✓	99% ✓	**94%** ✓ (Q3)	▼	▼

INDICATOR (Health & Wellbeing Outcome)	2021/22 TARGET	2015/16 BASELINE	2019/20 YEAR END	2020/21 YEAR END	2021/22 YEAR END	Direction of Travel since 2015/16	Direction of Travel since 2020/21
Alcohol Brief Intervention Delivery (Outcome 4)	5,066 per annum	5,643	4,394	4,269	7,749	▲	▲
Smoking Quit Rates at 3 months from the 40% most deprived areas. (Outcome 5)	Year End Target 1,217	1,229	1,389	1,280	921 (Total Qs1-3)	▲	▼
Women smoking in pregnancy (general population) (Outcome 1)	<12%	n/a	9.8%	8.2%	9.5%	**N/A**	▼
Women smoking in pregnancy (most deprived quintile) (Outcome 5)	<17% from 19/20	n/a	14.6%	12.4%	16.7%	**N/A**	▼
Exclusive Breastfeeding at 6-8 weeks (general population) (Outcome 1)	Target to achieve by Year End 31.4% (19/20) 32.2% (20/21) 33% (21/22)	n/a	31.8%	29.6%	28.3% Q3	**N/A**	▼
Exclusive Breastfeeding at 6-8 weeks (15% most deprived data zones). (Outcome 5)	Target to achieve by Year End 22.4% (19/20) 23.4% (20/21) 24.4% (21/22)	n/a	24.9%	21.9%	20.1% Q3	**N/A**	▼

Key Achievements

Indicators where performance has shown the greatest improvement over the past 12 months.

INDICATOR	YEAR END 20/21	YEAR END 21/22
Alcohol Brief Intervention Delivery	4,269	7,749

Areas for Improvement

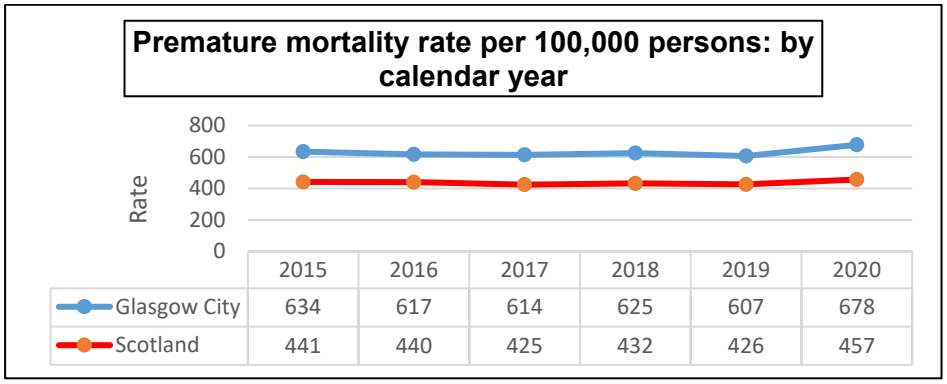
INDICATOR	Performance Issues and Actions to Improve Performance
Access to specialist Child and Adolescent Mental Health Services (CAMHS) **Target** 100% **Actual** 59.4%	**Performance Issues** COVID-related restrictions reduced the number of face-to-face appointments offered with Near Me/Attend Anywhere and telephone contact offered for all other children and young people. The waiting list was impacted by a significant number of missed appointments (DNAs) at the end of last year which had to be rescheduled. Challenges also remain with recruitment and resourcing of teams to meet current demands.

	Actions to Improve Performance include: • Continue work on the Waiting List Initiative. • Review the current waiting list to ensure that the information is up to date. • Improve the quality of information contained in referral forms. • Learning gained from the analysis of the service response during the pandemic will feed into sustainable improvements to service delivery. • Continue to implement actions to address missed appointments (DNAs). • Work to ensure that CAMHS teams are embedded within Children's Services in localities. • Building on the successful pilot of a digital group for parents of young children with anxiety, new guidance has been produced meaning that all parts of the service can now proceed to deliver group work remotely.
Exclusive Breastfeeding at 6-8 weeks (general population) **Target** 33% **Actual** 28.3% (Q3) AND Exclusive Breastfeeding at 6-8 weeks (15% most deprived data zones) **Target** 24.4% **Actual** 20.1% (Q3)	**Performance Issues** Continuing COVID restrictions has impacted performance - breast feeding groups and antenatal classes have been suspended and the remobilisation of the Health Visitor (HV) led groups has been delayed. The capacity of the Midwifery, Health Visiting and Infant Feeding teams continues to be impacted by vacancies and absence. **Actions to Improve Performance include:** • Re-establish HV led groups as soon as possible within current safety considerations. • Breastfeeding Problem-Solving Clinics continue to offer a blended approach to support, with a planned increase in face-to-face appointments once restrictions ease. • Continue to signpost mothers to the online pre-recorded classes and online local Peer Support antenatal sessions while Midwifery Services remain unavailable. • Continue to implement action plans within localities to maintain UNICEF Gold Accreditation. • Continue the telephone breastfeeding peer support pilot until March 2023 and target the recruitment of peer volunteers and mums from our diverse communities, implementing Quality Improvement approaches to support this. • Continue to develop the Family Nurse Partnership at the Young Parents' Support Base at Smithycroft High School.

3.3 NATIONAL INTEGRATION INDICATORS

*National Integration Indicator 11**

- Glasgow higher than the Scottish average in 2020



	2015	2016	2017	2018	2019	2020
Glasgow City	634	617	614	625	607	678
Scotland	441	440	425	432	426	457

*Information for 2021 is due to be published by National Records of Scotland (NRS) in late June

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4. PROVIDING GREATER SELF-DETERMINATION AND CHOICE

We are committed to ensuring that service users and their carers are supported and empowered to make their own choices about how they will live their lives and what outcomes they want to achieve. Within this section, we profile some of the key developments progressed in relation to our strategic priority of Providing Greater Self-Determination and Choice and consider performance in relation to KPIs associated with this theme. Activities undertaken have contributed to a range of the national Health and Wellbeing Outcomes, most notably the following:

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

4.1 KEY DEVELOPMENTS/ACHIEVEMENTS

4.1.1 PERSONALISATION

Personalisation, as outlined in the Social Care (Self-directed Support, SDS) (Scotland) Act 2013, aims to provide people with greater choice and control over the support they receive. At the end of March 2022, a total of 3,244 adult service users were in receipt of a personalised social care service - an increase of just under **6%** since March 2021 (3,063). Children with disabilities in receipt of personalised services rose by **31%** over the same period (from 291 to 382). The overall proportion of service users who chose to receive their personalised budget as a direct payment remained at just over **19%**. This varied between client groups with **64%** of children with disabilities receiving a direct payment compared to **14%** of adults. Trends over time in respect to these indicators are provided below:

% service users in receipt of a personalised service (end of March each year)						
Client Group	**2016**	**2018**	**2019**	**2020**	**2021**	**2022**
Adults	2735	2994	3208	3163	3063	3244
Children	117	184	266	272	291	382
% receiving Direct Payments (end of March each year)						
All Users	14%	15%	15%	17%	19%	19%

4.1.2 LISTENING TO OUR SERVICE USERS

Family Connections Assessment and Plan

The HSCP has developed the Family Connections Assessment and Plan – a tool to assist practitioners to understand the important relationships for children and young people with care experience. The aim of this tool is to keep them connected to people they identify as important to them and children, their siblings, family members, foster families and social workers all have a role in contributing to the plan. This approach is currently being evaluated and the work will be reported to the national '*Staying Together and Connected'* implementation group. Work undertaken by this national group includes the *'Staying Together and Connected: Getting it Right for Sisters and*

Brothers: National Practice Guidance', which includes good practice examples from Glasgow.

Viewpoint

Social Workers use several tools to help children and young people to express their views and encourage participation. One such tool is Viewpoint which has been used in the past to allow a child or young person to complete a questionnaire prior to a meeting on their care. A working group has involved care experienced children and young people in the development of new shorter and more strengths-based questionnaires (for under and over 15s) which could be completed through the Viewpoint MyView app on personal phones or other devices. The new questionnaires are being piloted before being made more widely available and once finalised will be promoted and the findings used to inform future practice and service development.

Children's Rights Service

The Children's Rights Service provides advocacy and information on rights for children and young people who live with foster or residential carers and those in continuing care and aftercare. They also have a role in informing service development and in enabling care experienced children and young people to have their voices heard and influence HSCP policy and practice.

The service has had a key role in supporting PAC (People Achieving Change), a Young People's Champions' Group in Glasgow who, along with Who Cares? Scotland and Glasgow HSCP, commissioned research into the experiences and opinions of Glasgow's care experienced young people on mental health services. PAC members were offered a range of opportunities to get involved in the research including designing and promoting the surveys being used and acting as peer facilitators in discussion groups. 143 young people took part in the research that was completed in February 2022 and young people worked with the Steering group to ensure the research was effectively disseminated. PAC met for the final time in February where they received copies of the completed research and thank you letters for their commitment, work, effort and ideas during the lifespan of the group.

Building on the work of PAC, Promise Participation Workers are now being recruited who will be responsible for ensuring that the stories and voices of children, young people and families are at the very heart of service design and that corporate parents are held to account in respect to their responsibilities in relation to the Promise.

Children's Services Plan

Glasgow's Integrated Children's Services Plan (CSP) was published in 2021 and in line with the HSCP Participation and Engagement Strategy, UNCRC Article 12 and the Promise, we decided to fully co-produce the child-friendly version with children and young people. In Summer 2021 we held discussions with groups of children about what this should look like and they recommended using social media-friendly videos explaining the CSP and its priorities. Since then, we have been supporting groups of children to produce their own video segments, which will then be linked together to communicate the CSP to children and young people. As part of this, we have recruited third sector partners to support diverse groups of children to contribute including those from pre-school, asylum seekers, LGBTQ+ and disabled young people. This Child-Friendly version will be available later this year.

Understanding Mental Health Needs

A scoping exercise has been undertaken to identify mental health issues amongst Black and Minority Ethnic children and young people, as part of a Scottish Government funded work stream. This involved a literature search and discussions with a wide range of organisations working with ethnically diverse communities in Glasgow and beyond. A report was completed in January 2022 which highlighted specific issues for certain groups including refugees and asylum seekers and made a number of recommendations including: training and development on the impact of racism on mental health; the role of faith and culture in recovery; anti-racist practices; creating opportunities for knowledge exchange; and practical issues like interpreting.

ASD Test of Change Engagement

The North East Glasgow Under-5 Autistic Spectrum Disorder test of change was established in March 2021. It aimed to improve the assessment process and offer better community supports to families of children with suspected ASD. In an attempt to co-produce appropriate services, new flexible ways to offer feedback were offered. These included providing feedback in person, in writing or online enabling respondents to respond in a manner that was convenient to them, at a time of their choice.

Learning Disability Short Breaks

Since 2015, Glasgow City Health and Social Care Partnership (HSCP) has been organising short breaks for adults with learning disabilities. These enable people with learning disability to get away for a few days on their own, while giving their families some respite from their caring role. Service users influence the range of breaks offered and select the break they wish to go on. The Covid-19 pandemic meant that these short breaks had to be paused, but they recommenced during the last year. Over 100 adults have been able to enjoy a break and feedback from service users and carers has been very positive.

4.1.3 EMPLOYABILITY

Community Investment Project

Students at St. Andrew's School in Glasgow's East End recently worked on a Community Investment Project tied to the development of the planned Parkhead Health and Care Centre. Local partners worked to design and deliver a course as part of the SCQF Level 4 Foundation Apprenticeship Course at Glasgow Kelvin College, which aimed to provide young people interested in careers in construction with hands-on experience in the design and construction of a building for outdoor learning activities at Parkhill Secondary School. All four of the pupils involved have been offered a modern apprenticeship when work begins onsite to construct the new Parkhead Health and Care Centre and another cohort is planned for next year.

Supported Employment Service - Modern Apprenticeships

Glasgow City Health and Social Care Partnership's (HSCP) Supported Employment Service recently secured additional funding from the Scottish Government to develop and deliver a new supported work experience programme called the 'Improving Modern Apprenticeships Programme' (IMAP), in partnership with other Glasgow City Council services. The programme is aimed at young people with autistic spectrum conditions and involves matching young people to a work experience placement

which corresponds with their aspirations and allows them to build their skills and experience before applying for a relevant Modern Apprenticeship.

Young Persons Guarantee Programme

In the last year, Health Improvement in partnership with other HSCP service areas, were successful in a bid to Glasgow's Young Persons Guarantee Fund, which was created with the support of a national initiative to support recovery from Covid-19. This has enabled the establishment of the pilot HSCP Young Person's Guarantee Programme, with Employability coaches now located within 5 HSCP services including the Youth Health Service. These coaches work with young people to ensure they reach and sustain a positive destination such as employment, training or a modern apprenticeship.

Case Study

A aged 17, was referred to the Young Person's Guarantee Programme as she was at risk of leaving school without a positive destination. A had experienced the domestic abuse of her Mum within her childhood into early adolescence and they had been supported to leave the family home and resettle. A's school attendance was declining, she was fearful of meeting new people and she was feeling very anxious about new places (specifically attending college). A's peers had started attending college, leaving her feeling left behind and she had not developed any positive relationships with new peer groups in school.

It was identified at initial assessment by the Youth Employability Coach that there was a need for soft skills and personal development to build her confidence, re-establish positive lines of communication and create a better vision for the future. The Coach explored A's preferred learning styles, coping strategies and positive personal interests. She received coaching in job searching which increased her confidence to pursue and obtain part-time work, while keeping her positively engaged in education. Plans are now in place within the Youth Health Service team for longer term options related to mental health and employability, which aim to support A's ongoing positive engagement and outcomes.

4.2 KPI PERFORMANCE

INDICATOR (Health & Wellbeing Outcome)	2021/22 TARGET	2015/16 BASELINE	2019/20 YEAR END	2020/21 YEAR END	2021/22 YEAR END	Direction of Travel since 2015/16	Direction of Travel since 2020/21
Number of Anticipatory Care Plan (ACP) conversations and summaries completed and shared with the patient's GP (Outcome 2)	ACP conversations held 800	N/A	530	264	208	**N/A**	▼
	Summaries completed and shared with GPs 200	N/A	130	69	50	**N/A**	▼
% of young people currently receiving an aftercare service who are known to be in employment, education or training. (Outcome 4)	75%	67%	68%	80%	80%	▲	▶

Key Achievements

INDICATOR	YEAR END 20/21	YEAR END 21/22
Adult service users in receipt of a personalised social care service	3063	3244
Children with disabilities in receipt of a personalised social care service	291	382

Areas for Improvement

INDICATOR	Performance Issues and Actions to Improve Performance
Number of Anticipatory Care Plan (ACP) conversations and summaries completed and shared with the patient's GP **Target** 800 conversations 200 summaries **Actual** 208 conversations 50 summaries	**Performance Issues** Continued pressures on services due to the COVID-19 pandemic have limited staff capacity to engage with people on the topic of ACPs and future care planning. Current activity may also be under reported as the processes for capturing conversations and recording progress has not yet been fully embedded. **Actions to Improve Performance include:** • Establishment of an HSCP implementation group to review the plan to embed ACPs. The plan includes a focus on staff training and the development of ACP Champions to provide support to colleagues. • Staff training will continue to be offered to all key staffing groups identified in the plan. • Ensure that the ACP Standing Operating Procedures (published Feb 22) are implemented by all staff. • The HSCP has committed two additional years of funding for the Anticipatory Care Programme.

4.3 NATIONAL INTEGRATION INDICATORS

National Integration Indicator	2021/22 Survey Results (19/20 results shown in brackets)				Direction of Travel Since Last Survey (19/20)
	Outcome	Glasgow	Scotland	Compared to Scottish average Above Below	
3. % adults supported at home who agreed that they had a say in how their help, care or support was provided	3	**71.1%** (75.5%)	**70.6%** (75.4%)		▼

4.4 LOCAL EVIDENCE

User Feedback - Home Care

Home Care and Reablement Services provide care and support to enable people to live as independently as possible in their own home. The annual service user consultation on the Home Care service was carried out at the end of 2021. Some of the headline figures for the 2021 survey in relation to our Strategic Priority of Self Determination and Choice are presented below.

Question	% who responded Yes	National Health & Wellbeing Outcome
Does having a home care service allow you to get up and go to bed at times that suit you?	87%	Outcome 3
Do you feel that you are listened to and your wishes respected?	93%	Outcome 3
Do your home carers treat you with dignity and respect?	98%	Outcome 3
Do you feel your home carers respect your right to confidentiality?	99%	Outcome 3
Do home care staff/managers always respond to any concerns you have?	86%	Outcome 8

Carer Feedback

The Carers Centres provide an Evaluation form to Carers who have been in recent contact with the service which asks a number of questions, one of which also relates to this Strategic Priority of Self Determination and Choice. Feedback in the last year is included below:

Question	% Carers Responding Positively
Did you feel valued and respected by the worker?	99%

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5. SHIFTING THE BALANCE OF CARE

Transformation Programmes have been delivered across HSCP services in recent years, with the balance of care shifting away from institutional, hospital-led services, towards those that support people more in the community and which promote recovery and greater independence wherever possible. Progress in delivering these Programmes is overseen by the Integration Transformation Board, chaired by the Chief Officer and within this section, we profile some of the key developments which have been able to be progressed over the last year and consider performance in relation to KPIs associated with this theme. Within this section, we consider the range of Transformation Programmes delivered across Children's, Adult, Older People and Primary Care. Activities undertaken have contributed to a range of the national Health and Wellbeing Outcomes, most notably the following:

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

5.1 TRANSFORMATION PROGRAMMES

5.1.1 CHILDREN'S SERVICES

Glasgow's Transformation Programme for children's services aims to deliver a sustainable shift in the balance of care for Glasgow's children. Key aims are to enable children looked after within other local authorities to return and be supported within their local communities; and to reduce the number of families accessing statutory services. This is allowing savings to be generated which are being reinvested in prevention and earlier intervention work in our most disadvantaged communities and in increasing the availability, accessibility and quality of family support services. Through expanding these services, the aim is to support children and their families to stay together within their local communities and connected to school, peers and their existing networks. Some of the key developments progressed in the last 12 months include:

Glasgow's Family Support Tender and Services

Glasgow City's first integrated Family Support Strategy was revised and updated last year. A Family Support Tender to deliver the Strategy had been postponed due to the pandemic but was awarded in June 2021 and newly commissioned family support services were established in October. Through this, Glasgow is investing £5.2 million citywide over 2020/23 and a joint commissioning and outcomes evaluation framework has been developed that will ensure regular and consistent monitoring and reporting from all funded organisations. The Glasgow Intensive Family Support Service (GIFSS) delivers a strengths-based approach to working with families with children aged 12 years and over at risk of accommodation, in order to support them to remain within their families and local communities. Building on this approach, the Early Intervention and Prevention Family Support (EIP) was launched in October 2021

aimed at families with children under 12 years requiring support as early as possible in order to divert them away from statutory Social Work Services and prevent escalation of need.

User/Carer Feedback

Positive feedback has been received by families and practitioners outlining the benefits of the range of practical, emotional and parenting support offered by these services:

'Would just like to say that GIFSS have been amazing for my son and cannot thank them enough'

'Knowing that they are available whenever is very reassuring and calms anxieties of ever feeling there is no one to help or listen'.

'GIFSS have followed through with everything they said they would and built good relationships with our family'

Of those responding to a survey of GIFFS users:

- *70% reported improvements in family relationships;*
- *70% reported that GIFSS helped the family identify their strengths;*
- *60% reported being happier and having improved confidence in life;*
- *80% reported less worries.*

Glasgow's Promise

In February 2020, the Scottish Government produced a report called 'The Promise,' which set out what needs to change in the care system to ensure children and young people grow up loved, safe and respected. This has informed the HSCP's Transformational Programme for children's services and 'Glasgow's Promise (2021-24)' has been produced in the last year which sets out how we will implement The Promise locally. This sets out 100 actions that we will take forward with partners and a Care Experienced Board has been established to oversee progress with 44 named 'Promise Keepers' identified for each action. The Board have secured the website name www.glasgowspromise.org.uk and work is currently underway to build this website with the help of children and young people and discussions are underway to progress a #Glasgowspromise twitter account.

Practice Feedback Group

In taking forward the Transformation Programme, Children's Services have established a Practice Feedback Group (PFG) in the last year, which has been developed to strengthen the feedback loop between leadership and frontline teams responsible for implementing the Programme. This PFG has worked with the Children's Services Core Leadership Team to review the vision, principles and aims of the Transformational Programme, developing a shared narrative around its aims and strengthening understanding of the system 'as is' and the vision for how we want it 'to be'. This group has overseen a series of development sessions on a range of issues including new Family Support services and Child Protection, which were attended by over 900 staff.

5.1.2 PRIMARY CARE

The third iteration of Glasgow's Primary Care Improvement Plan has recently been published covering the period from April 2021. A key aim of the plan, in line with the new GP contract, is to enable GPs to operate as 'expert medical generalists', by diverting work that can best be done by others, leaving GPs with more capacity to care for people with complex needs and to operate as senior clinical leaders of extended multi-disciplinary teams. Updates on progress in implementing this Plan are available through the Regular Bulletins available on the HSCP website and are reported to the IJB. Achievements over the last year have included the following:

North East Health and Care Centre

The plans for the new £67m North East Health and Care Centre which will be built on the site of the former Parkhead Hospital, have been given final approval by the Scottish Government and work will commence in March 2022 with the aim of being operational in 2025. Once complete, the hub will be home to three GP practices, as well as to a range of community services delivered by the HCSP and other public and third sector organisations. The hub will be the largest primary care development in the history of NHSGGC and will become the Health Board's first zero carbon facility through a range of measures including air source heat pumps and solar panels.

Pharmacy Led Pain Clinic

The Pharmacy Led Pain Clinic in Govanhill Health Centre takes a more holistic approach than the traditional medical management of pain, with the pharmacist linking in with other members of the primary care team such as community links workers and an advanced physiotherapist. This service won a national award for the 'Addressing Overprescribing' category and an overall Silver Award, at the PrescQIPP Annual Awards in October 2021.

GP Feedback

Feedback from GPs and patients has been very positive and evaluation of the clinic has shown at least a 40% reduction in GP appointments for patients attending the clinic and less medication prescribed or chronic pain, with the emphasis switching to self-management. Patients have also reported how there had been a reduction in the impact pain was having on their lives.

5.1.3 OLDER PEOPLE'S AND CARE SERVICES

Through the Transformation Programme for Older People, the HSCP is aiming to support a shift in the balance of care away from institutional care (hospital and care homes) towards supporting people more in the community. The HSCP has also been working with all five HSCPs in NHS Greater Glasgow and Clyde (GGC), along with the Acute Services Division and the NHS Board, to develop and then implement a system wide Unscheduled Care Commissioning Plan and Delivery Plan as part of the Moving Forward Together programme. Some of the key developments progressed in the last 12 months include:

Discharge to Assess Pathway

During the course of the last year, it was evident that normal admission pathways had been disrupted by the pandemic for internally provided care homes, resulting in significantly reduced occupancy. In response, HSCP Care Homes worked closely with Public Health and colleagues in Hospital Assessment Teams to develop a pathway which allowed for more effective and timely planning of admissions to care homes and which avoided unnecessary delays in discharge from hospital. This included a pathway for admission even if the care home was in a managed outbreak position. This approach has promoted safe and timely discharge, while facilitating more positive outcomes for residents and their families and has led to the occupancy of the HSCP Care Homes rising to 97%, above even pre-pandemic occupancy rates.

Improving Community Infrastructure

Efforts have also been progressed to enhance the community infrastructure in place to support safe discharge. For example, Care Services have worked to provide access to home care support within 4 hours, 7 days a week. The number of service users in receipt of mainstream care at home has also increased from 4025 at the start of 21/22 to over 4200 at the end of the year, despite at times experiencing the highest levels of staff absence since the start of the pandemic. Work has also been undertaken in the last year to invest in IT equipment, software and systems in Care Services. Developments have included the introduction of a new overtime app and Care Safe in order to support more effective mobile working and enable better workload planning and management amongst homecare staff.

Day Care

The HSCP operates 10 day centres for older people across the city, all of which had to close in March 2020 in line with Scottish Government guidance. In August 2021, plans were progressed which enables service users to return to day care. This was done with social distancing measures being maintained within the centres and on transport to them. Existing service users were provided with the opportunity to return to the same level of service they received pre-pandemic, with some steps being made to address waiting lists for new service users to attend.

5.1.4 ADULT SERVICES

The Adult Services Transformation Programme sets out the aim of shifting the balance of care away from high cost inpatient, residential and 'buildings' based services and delivering more effective community based alternatives. The Recovery Model of Care has been introduced across a number of services which seeks to support greater self-determination and choice and shift the focus to enabling and supporting those that require assistance to enjoy the best quality of life possible, informed by choices they make for themselves. A number of strategies have been developed underpinned by these principles across the various Adult Service Areas including the 5 year Strategy for Mental Health (2018-23) and associated financial framework; the Sexual Health Transformation Programme and Implementation Plan; and the Homelessness Rapid Rehousing Transition Plan. Key achievements over the last year across these areas have included:

Compassionate Distress Response Service Extension

The Compassionate Distress Response Service (CDRS) offers an immediate response to people experiencing emotional distress and was established to provide a more suitable alternative to Emergency Departments for patients in mental distress out of hours. In September 2021 it was expanded to include 16/17-year-olds, along with a pilot pathway offering support for parents and carers of the young people referred. This pathway has been established in response to an identified need for family members to receive emotional and practical support. Since opening, almost 200 young people have engaged with the service.

User/Carer Feedback

'It feels so good to be able to know I can handle situations and pull myself back now, thank you'

'I was so surprised at the response time, it's so good how quick you get in contact'

'I enjoyed chatting and I felt I was able to open up'

Rapid Rehousing Transition Plan

Glasgow's Homelessness Rapid Rehousing Transition Plan was developed in response to the Homelessness Rough Sleeping Action Group recommendations (HARSAG) which had been established by the Scottish Government. An update on this was reported to the IJB in September and key achievements over the last year include the following:

- Closed the Bellgrove Hotel and secured positive destinations for the residents
- Reduced rough sleeping in the City Centre to single figures
- Increased the number of settled lets secured from housing associations to resettle homeless households (see below).
- Increased the supply of emergency accommodation to ensure that all homeless households had access to accommodation at the point of need
- Continued to deliver improvements to service user experience & embed a rapid re-housing approach to service provision
- Part-funded the Private Rented Sector (PRS) Hub aimed at supporting tenants at risk of homelessness as a consequence of welfare reform
- Increased tenancies within the Housing First Service from 195 to 250 during the course of 2021/22.

Case Study

Adam has been known to Homelessness Services for most of his adult life with his involvement with the service punctuated by multiple emergency accommodation placements. He has a complex case history with poly-drug use, alcohol addiction & mental health issues. Following the tragic loss of his partner Adam has been engaging positively with his allocated Social Care Worker at the Complex Needs Team, The Simon Community Scotland, and other partner agencies.

Adam moved into his own temporary furnished flat in the summer of 2021. He has been very focussed on his recovery and trying to establish contact with his children. He has managed his flat particularly well despite being on his own for the first time in years. He has really tried to make his flat a home and has requested that this be

made permanent as he has settled into the local community. He has also found a support network through engagement with his local Recovery Hub. During a recent relapse, support agencies were able to work well with Adam to identify supports and an alternative emergency placement was facilitated to allow him to stabilise his substance misuse. The work with Adam during this phase has been marked by a strong commitment, by all those involved, including Adam, to addressing the challenges in his life.

The successful work with Adam evidences the value in having a community based Complex Needs Team which is able to carry out crisis response outreach work and build positive relationships with clients. It also highlights the positive partnerships that the HSCP have built with other agencies to enable a multi-agency response to complex service users.

5.2 KPI PERFORMANCE

Children's Balance of Care/Performance Indicators

INDICATOR (Health & Wellbeing Outcome)	2021/22 TARGET	2015/16 BASELINE	2019/20 YEAR END	2020/21 YEAR END	2021/22 YEAR END	Direction of Travel since 2015/16	Direction of Travel since 2020/21
Number of out of authority placements (Outcome 4)	40 (year end 20/21) 30 (year end 21/22)	126	46	34	31	▲	▼

Looked After and Accommodated Children (LAAC)									
Year End	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	Direction of Travel since 2016	Direction of Travel since 2021
Total LAAC	**1352**	**1203**	**1078**	**960**	**899**	**801**	**733**	▼	▼
Children Looked After at Home (LAC)									
Looked After at Home	545	496	469	443	539	436	365	▼	▼
Kinship Placements	1191	1144	1125	1100	1064	1087	1044	▼	▼
Total LAC	**1736**	**1640**	**1594**	**1543**	**1603**	**1523**	**1409**	▼	▼
Overall Total (LAAC/LAC)									
LAAC/LAC Total	**3088**	**2843**	**2672**	**2503**	**2502**	**2324**	**2158**	▼	▼
Unaccompanied Asylum Seekers									
Unaccompanied Asylum Seekers	18	17	23	52	87	33	16	▼	▼

The totals shown above for LACC include foster placements as well as Out of Authority Placements, with trends in relation to these components shown below:

Foster Care									
Year End	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	Direction of Travel since 2016	Direction of Travel since 2021
Purchased	283	262	232	206	182	168	144	▼	▼
Provided	766	666	608	550	511	487	444	▼	▼
Total	**1049**	**928**	**840**	**756**	**693**	**655**	**588**	▼	▼

Out of Authority Placements (end of March each year)									
Year End	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	Direction of Travel since 2016	Direction of Travel since 2021
Out of Authority Placements	**126**	**111**	**67**	**51**	**46**	**34**	**31**	▼	▲

Adults and Older People Balance of Care/Performance Indicators

INDICATOR (Health & Wellbeing Outcome)	2021/22 TARGET	2015/16 BASELINE	2019/20 YEAR END	2020/21 YEAR END	2021/22 YEAR END	Direction of Travel since 2015/16	Direction of Travel since 2020/21
A&E Attendances							
New Accident and Emergency attendances (18+). MSG 3 (Outcome 9)	153,791	153,791	159,916	113,513	117,569* (Apr 21 – Jan 22)	▲	▼
Emergency Admissions and Bed Days							
Number of Emergency Admissions (18+) MSG 1 (Outcome 9)	66,624	70,133	63,324	54,947	50,020* (Apr 21 – Jan 22)	▲	▼
Number of Unscheduled Hospital Bed Days - Acute (18+) MSG 2 (Outcome 9)	453,866	493,371	497,641	438,871	402,178* (Apr 21 – Jan 22)	▲	▼
Number of Unscheduled Hospital Bed Days- Mental Health (18+) MSG 2 (Outcome 9)	181,371	190,791	189,139	170,093	107,860* (Apr–Dec 21)	▲	▲
Delayed Discharges							
Total number of Acute Delays (Outcome 9)	0	N/A	77	103	136	**N/A**	▼
Total number of Bed Days Lost to Delays (All delays and all reasons 18+). MSG 4 (Outcome 9)	39,919	41,582	45,318	49,902	52,669* (Apr 21 – Jan 22)	▼	▼
Total number of Acute Bed Days lost to delayed discharge for Adults with Incapacity (AWI) (65+). (Outcome 9)	1,910	10,715	6,571	11,163	16,209	▼	▼
Total number of Adult Mental Health delays (Outcome 9)	0	17	19	25	26	▼	▼

INDICATOR (Health & Wellbeing Outcome)	2021/22 TARGET	2015/16 BASELINE	2019/20 YEAR END	2020/21 YEAR END	2021/22 YEAR END	Direction of Travel since 2015/16	Direction of Travel since 2020/21
Total number of Older People Mental Health patients delayed (Excluding AWI) (Outcome 9)	0	11	15	9	19	▼	▼
Intermediate Care							
Intermediate Care: % users transferred home. (Outcome 2)	>30%	25%	19%	25%	15%	▼	▼

*Provisional

Key Achievements

Indicators where performance has shown the greatest improvement over the past 12 months.

INDICATOR	YEAR END 20/21	YEAR END 21/22
Number of Unscheduled Hospital Bed Days – Mental Health (18+)	170,093	107,860* (Apr–Dec 21)

*Provisional

Areas for Improvement

INDICATOR	Performance Issues and Actions to Improve Performance
Total number of Older People Mental Health (OPMH) patients delayed (Excluding AWI) **Target** 0 **Actual** 19	**Performance Issues** We continue to experience challenges in discharging patients with complex needs. COVID also continues to have an impact on our ability to discharge to other providers. **Actions to Improve Performance include:** • Continue to robustly monitor all OPMH delays. • Continue to implement the new discharge pathway which supports 72-hour discharge and includes dedicated Social Work resource, improved MDT (Multi-disciplinary Team) working and early referral to Social Work. • Continue to develop new ways to support timely discharge through MS Teams and remote working.
Number of Unscheduled Hospital Bed Days - Acute (18+) **Target** 453,866 **Actual** 402,178* (Apr 21 – Jan 22) *Provisional	**Performance Issues** There was a significant reduction in unscheduled care during the peak of the pandemic in 2020/21, however in 21/22 as activity returned to normal, we have seen an increase in the number of unscheduled care bed days. **Actions to Improve Performance include:** The Unscheduled Care Commissioning Plan details a range of programmes which aim to reduce both the number of patients attending acute care settings and the bed days occupied. These include: • Hospital at Home • Programmes to support care homes • Provision of community respiratory service, home antibiotic and heart failure programmes

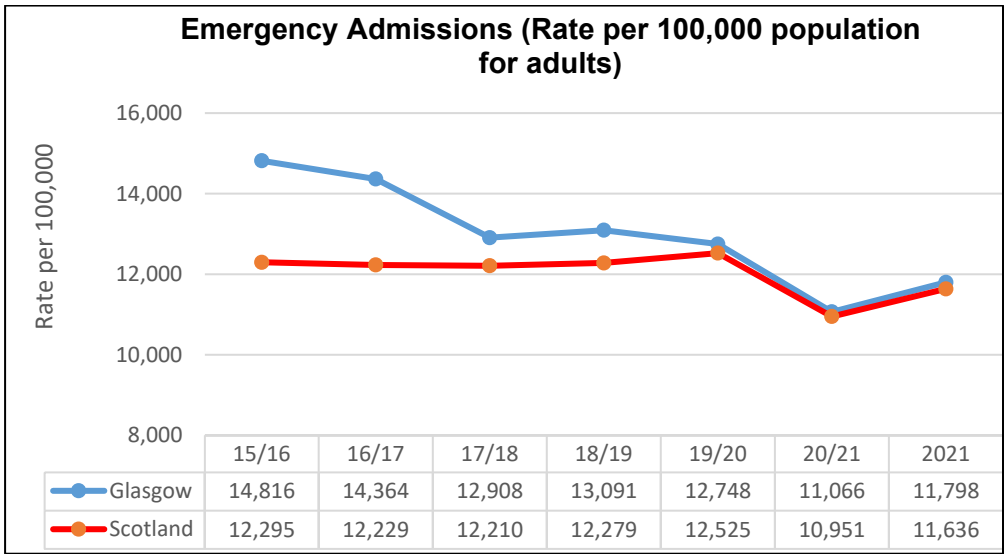
INDICATOR	Performance Issues and Actions to Improve Performance
	• Flow Hub Navigation Centre • Alternatives to admission through primary care • Mental Health Assessment Units • Management of Delayed Discharge • Management of Frailty to avoid attendance or prevent admission / reduce length of stay • Targeting of frequent attenders / high volume conditions Several of these programmes have already been established and it is our intention during 22/23 to increase their capacity.
Total number of Acute Delays and Bed Days Lost to Delays (All delays and all reasons 18+). **Target** **Delays** 0 **Bed days** 39,919 **Actual** **Delays** 136 **Bed days** 52,669* (Apr 21 – Jan 22) *provisional	**Performance Issues** The number of Acute delays has remained above target for several reasons including: • Closure of wards due to COVID • Significant closures of care homes to admissions by public health due to COVID outbreaks. • Care Homes staggering admissions due to staffing pressures and the current cohort of patients within the care home being frail / complex. • Staffing pressures in Social Work due to COVID absences. • Access to legal aid has slowed in-line with the impact of Omicron. **Actions to Improve Performance include:** • Continue the daily focus on both AWI and non-AWI patients including daily senior management "huddles" to focus on delays. • Continue to implement a high level of scrutiny to identify opportunities to prevent delays or mitigate their impact. • Development of a real time tracker to provide improved information in respect of specific delays. • Continue to implement the discharge to assess pathway. This has improved outcomes for patients as they are assessed within a care home environment rather than a hospital bed. • A strategic commissioning group has been established to review pathways into care homes. Please see below for the actions being taken to address AWI delays.

INDICATOR	Performance Issues and Actions to Improve Performance
Total number of Acute Bed Days lost to delayed discharge for Adults with Incapacity (AWI) (Older People 65+). **Target** 1,910 **Actual** 16,209	**Performance Issues** In addition to the issues highlighted above (*Total number of Acute Delays and Bed Days Lost to Delays*) which affect all patients, the legal process with AWI delays means that each contributes significantly to bed days lost each month. Non AWI delays are less likely to individually impact on bed days lost. **Actions to Improve Performance** In addition to the actions detailed above for patients in general, for AWI patients we will: • Continue to implement agreed improvement actions. • Continue the significant focus on current AWI activity with the development of a tracker process to monitor individual patient progress against agreed milestones. It is envisaged that this will mitigate delays across the AWI journey and identify when escalation is required. • Additional investment has been planned to support the GCC legal team where capacity to process Local Authority applications has been recognised as a current issue in the journey.
Total number of Adult Mental Health delays **Target** 0 **Actual** 26	**Performance Issues** Admission routes and discharge relationships continued to be disrupted by the pandemic including COVID-positive patients, staff redeployment to ward areas, wards closed to admissions and patient movement as a result of infection prevention and control measures. There also continues to be pressure on delays because of the complexity of patient need and availability of commissioned packages of care and accommodation. **Actions to Improve Performance include:** • Increase staffing of the integrated discharge teams to address the delays in social work assessments and accessing care home placements. These teams include representation across the service with links to housing providers and commissioners. • Ensure plans are in place which allow people to return to their own home where appropriate. • Increase funding for the adult mental health social care contract to increase the number of providers and the types of care available. • Increase the number of Mental Health Officers (MHO) across the city to address delays in relation to guardianship applications.
Intermediate Care: Percentage of users transferred home **Target** >30% **Actual** 15%	**Performance Issues** COVID-19 restrictions continued to have an impact on the percentage of individuals returning home. Factors that affect the numbers discharged home include COVID infection control requirements, the frailty of individual service users, and the impact of COVID on other services involved in discharge processes. **Actions to Improve Performance include:** • A recovery plan for intermediate care is in the process of being implemented with a focus on further increasing home discharge options. • Introduction of an Intermediate Care daily Huddle which adopts a Multi-Disciplinary team approach and involves HSCP staff and intermediate care providers. The group discusses appropriateness of referrals and it has a strong focus on rehabilitation potential, making quicker decisions and setting admission dates.

5.3 NATIONAL INTEGRATION INDICATORS

National Integration Indicator 12

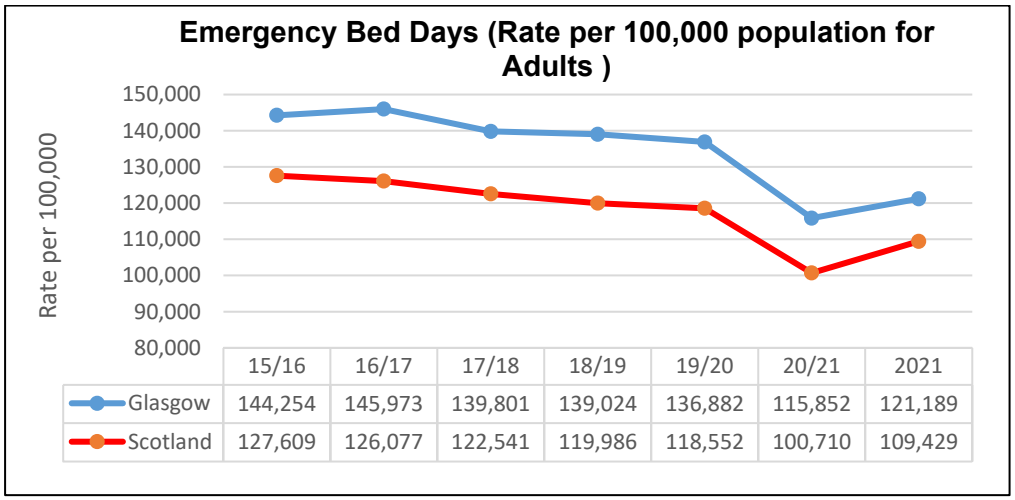
- Glasgow similar to the Scottish average in 2021



	15/16	16/17	17/18	18/19	19/20	20/21	2021
Glasgow	14,816	14,364	12,908	13,091	12,748	11,066	11,798
Scotland	12,295	12,229	12,210	12,279	12,525	10,951	11,636

National Integration Indicator 13

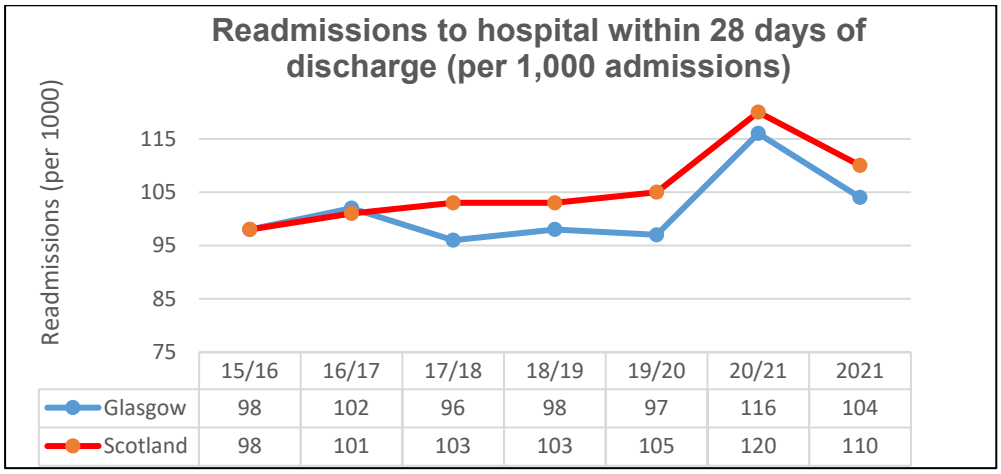
- Glasgow higher than the Scottish average in 2021



	15/16	16/17	17/18	18/19	19/20	20/21	2021
Glasgow	144,254	145,973	139,801	139,024	136,882	115,852	121,189
Scotland	127,609	126,077	122,541	119,986	118,552	100,710	109,429

National Integration Indicator 14

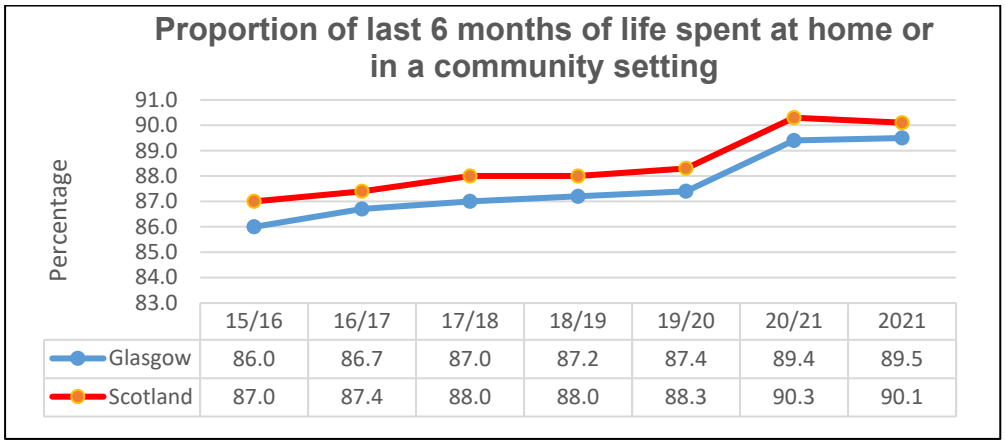
- Glasgow lower than the Scottish average in 2021



	15/16	16/17	17/18	18/19	19/20	20/21	2021
Glasgow	98	102	96	98	97	116	104
Scotland	98	101	103	103	105	120	110

National Integration Indicator 15

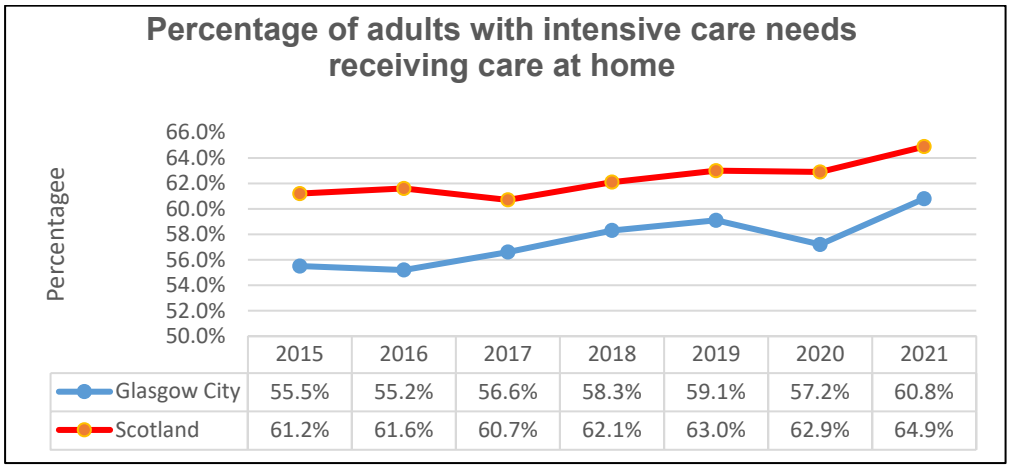
- Glasgow lower than the Scottish average in 2021



	15/16	16/17	17/18	18/19	19/20	20/21	2021
Glasgow	86.0	86.7	87.0	87.2	87.4	89.4	89.5
Scotland	87.0	87.4	88.0	88.0	88.3	90.3	90.1

National Integration Indicator 18

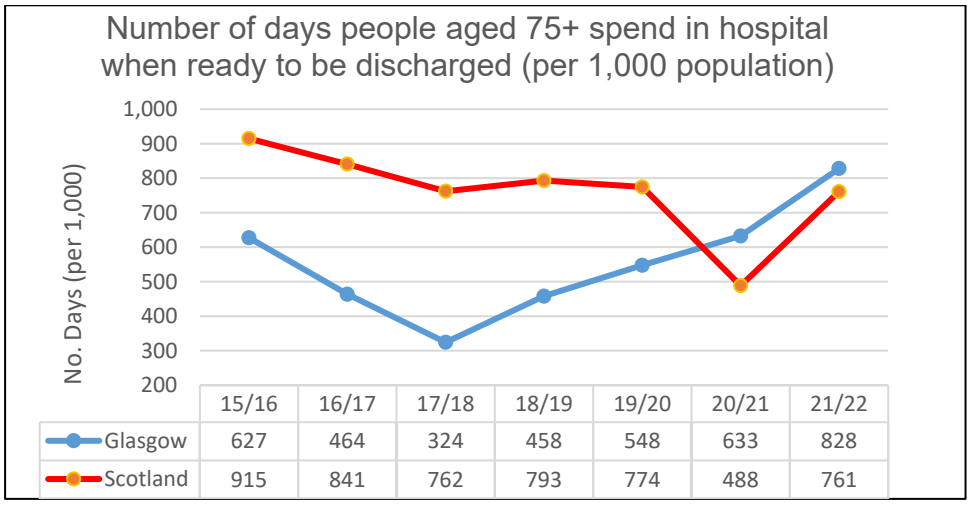
- Glasgow lower than the Scottish average in 2021



	2015	2016	2017	2018	2019	2020	2021
Glasgow City	55.5%	55.2%	56.6%	58.3%	59.1%	57.2%	60.8%
Scotland	61.2%	61.6%	60.7%	62.1%	63.0%	62.9%	64.9%

National Integration Indicator 19

- Glasgow higher than the Scottish average in 2021/22



Please note that calendar year 2021 is used for indicators 12-15 above as a proxy for 2021/22 due to the national data for 2021/22 being incomplete. We have done this following guidance issued by Public Health Scotland to all Health and Social Care Partnerships. Figures presented may not fully reflect activity during 2021/22 due to the varying impact of COVID-19 at different points of the pandemic.

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6. ENABLING INDEPENDENT LIVING FOR LONGER

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

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

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

6.1 KEY DEVELOPMENTS/ACHIEVEMENTS

6.1.1 Maximising Independence

Over recent years, Glasgow City HSCP has begun a programme of work called Maximising Independence which aims to ensure that people can live independently, safely and in good health for as long as possible. Key principles of this approach are putting people at the centre of care processes and working with them to find solutions; focusing on existing assets and strengths of individuals and communities; taking early action to prevent problems developing into a crisis further down the line; ensuring the right support is available and easy to find in the right place and at the right time; embracing new technology; and working closely with partners in community and voluntary sectors to provide a range of supports and services.

Going forward, adopting this approach, where we've previously asked 'what's the matter with you and how can our services fix it?' we'll be asking 'what matters to you, and how can we best support you to achieve your goals', recognising that a statutory social work service or intervention isn't always the answer. An example would be linking someone who loves the outdoors but is socially isolated into a local walking group where they can build relationships and their confidence, instead of a more traditional approach such as collecting them in a bus to go to a day centre each week.

6.1.2 Reablement

Reablement helps people learn or re-learn the skills necessary for daily living, which have been lost through deterioration in health and/or increased support needs. Its key aim is to support people to regain their physical capabilities and enable them to sustain independent living. Maintaining the reablement service has been a key priority for Care Services over the pandemic and over the last year, a total of **2573** service users fully or partially completed the reablement process. A total of **1282** service users (50%) required further support from Care Services after the initial period of reablement. There were, however, **1291** service users (50%) who did not need ongoing support from Care Services, equating to a saving of approximately **£6.8m** annually.

Case Study

In early Sept 2021, I contacted Glasgow Social Work regarding my mother's failing health and her continuing desire to stay at home. Over winter 20/21 she had mentioned going into a home, much to our surprise as it was not an environment that we think she would enjoy. Her health had been worsening and she recently had another fall and had been referred to the community falls team.

The person on the first call took all the required details and a home assessment appointment was made. I was at that meeting and my sister 'joined' via a Facebook linkup from Ireland. We were both happy at their empathy and couldn't believe that a decision was made that day for a care package to start the following week which involved somebody coming in 4 times a day for a 6 week period of 'reablement'. Quite correctly after 6 weeks, the package stopped but we were reassured that if need be, a care package would be reactivated if required.

Within this period, the social work Local Area Co-ordinator was involved and opened up a whole new world for us as a family. This led to i-care meals, a library service, a fire service home visit, expedited access to nurses, care and repair services etc. All these services have been provided and without exception all been so friendly and helpful to my mother. Her quality of life has improved and now she is happy again in her home.

6.1.3 Community Alarms

The Community Alarms & Telecare service currently supports over **8000** people to live as independently as possible and has a role in helping service users to stay in their own home for as long as possible, as well as facilitating hospital discharge. Over the course of the last 12 months, work has been undertaken to upgrade the ICT systems and infrastructure. In November 2021 the service was also independently audited by TEC Quality association and re-accredited with their Quality Standard Framework, with the resilience of the service and the effectiveness of the Business Continuity arrangements recognised.

6.1.4 Community Link Workers Expansion

The Community Link Workers (CLW) programme has been expanded to an additional 40 practices across Glasgow, taking the total to 81 practices. CLWs are embedded in GP practices in areas of deprivation and take a person-centred approach, working with patients to find out what is important to them and what issues they may need support with. The CLWs support and where required, signpost patients to other

services, in response to a range of issues which may be affecting their health and wellbeing such as money worries, housing issues, mental health and wellbeing, and loneliness and isolation. During 2021/22, 8,188 first appointments were held with patients using the service.

Case Study

B was referred to the links worker after struggling with a period of chronic depression. After more than 40 years in the same company their employment was coming to an early end due to a significant physical health issue, which hit them hard. In addition, they had been personally affected by Covid-19 including a family bereavement and felt that as well as grieving themselves, they also needed to support their partner in coping with the bereavement.

B needed a lot of emotional support at first. They talked about how they were feeling, and we discussed ways in which I could help. They agreed to being referred to a local mental health organisation which they had used in the past, in relation to their low mood. They also spoke about how their partner was feeling and I passed on details for CRUSE counselling and their partner has since been in contact with them.

B was also unsure about aspects of the termination of their employment so I suggested calling ACAS to ensure the correct procedures were followed. They were also unaware that they may be entitled to Personal Independence Payment so we started the process of applying and I referred them to the local welfare advice service.

B started to come along to the weekly walking group CLWs help run. At first, they were worried they would be slow and hold everyone else back, but they were quickly reassured by the group who are supportive of each other. They haven't missed a week since starting and have benefitted from the peer support of the group, especially from speaking to a fellow participant who had recently been through a similar employment experience. With an increase in their self-confidence in relation to their physical ability, they recently agreed to a referral to Live Active. **(CLW Worker)**

6.1.5 Supporting Carers

Carers Strategies

During the course of the last year, Glasgow's current carers strategies (Carers Strategy 2019 - 22 and Young Carer Strategy 2019 - 22), have been reviewed and consulted on widely. An update on this work was provided to the IJB in March and the revised strategies will be finalised and reported in June 2022.

New Carer Pathways

Glasgow Carer Partnership have also led on a Health Board wide initiative to develop the current acute carer support pathway to include all of the stages of a carers journey through acute services, including pre-admission, the hospital stay itself and discharge planning. Work has also been progressed during the pandemic to create two additional support pathways with Parkinson's Scotland and Improving the Cancer Journey, which will be launched alongside the new carers strategies in June 2022.

Training and Peer Support

HSCP Carer Services have also been involved in reviewing and updating the range of training and peer support available to help carers with their caring role and their own personal development. A wide range of areas are covered including mindfulness and dementia. Work has also been undertaken to expand the methods of delivery to include digital and online options.

6.1.6 Income Maximisation

The HSCP is a key funding partner, with Glasgow City Council, of Financial Inclusion Partnership services, which support community-based NHS staff to refer patients to a range of dedicated Money Advice providers.

For several years, the HSCP has also supported the delivery of an embedded money advice service in 30 General Practices across the City, via the Deep End Money Advice Project. From February 2022, Scottish Government investment in the Welfare Advice & Health Partnerships (WAHPs) programme enabled this model of service delivery to be rolled out to an additional 54 GP Practices for a two-year period.

On the Social work side, the HSCP hosts a Welfare Rights service visit people in receipt of a range of chargeable social work services to ensure that they are receiving all relevant benefits to which they are entitled. Performance in respect to these services in the last year is summarised below:

Financial Inclusion Partnership

During 2021/22, there was a **10%** increase in referrals from NHS staff to the service, in comparison with 2020/21 (5,074 vs 4,621 referrals). The financial gain achieved in 2021/22 was £5,264,800, a **19%** decrease compared to 2020/21 (£6,465,275). The total debt managed in 2021/22 (£574,181) was **24%** less than in 2020/21 (£759,735).

Deep End Money Advice Project/Welfare Advice & Health Partnerships (WAHPs) programme

The provision of welfare advice in GP practices has been found to be linked to a reduction in patient anxiety and stress, as well as in the number of prescriptions for antidepressants and hypnotics/anxiolytics and GP consultations. Building on the success of the Deep End Money Advice project, the Welfare Advice Health Partnerships (WAHP) programme has been established to address growing mental health concerns caused by money and housing insecurity. Each participating practice receives the equivalent of one day per week advisor time for the next 2 years who will provide advice on income maximisation, debt resolution, housing, employability issues, as well as provide representation at tribunals.

From April to December 2021, GP Practice staff made 566 referrals to the Deep End service, a **42%** increase compared to the same period in 2020/21 (398 referrals). The total financial gain generated for patients in Q1-3 of 2021/22 was £1,663k (**13%** more than £1,468k realised in Q1-3 of 2020/21). The total debt managed in Q1-3 of 2021/22 (£254k) was almost **five times higher** than in the same period in 2020/21 (£51k) and the majority of this related to non-housing debt; this may, in part, reflect people taking on debt to meet every day living costs.

Welfare Rights Social Work Service

During 2021/22 our service represented **298** clients at social security appeal tribunals compared to **462** the previous year. The number of appeal sessions for the year was down to **210** compared to **295** the previous year. In 2021/22 **£1.99m** (£1.26m in ongoing benefits and £727K in backdated benefits) has been generated in successful claims for benefit for service users who receive a chargeable non-residential care service. This compares to **£1.98m** in 2020/21 and £5.09m in 2019/20.

Case Study

Ms X made a claim for Personal Independence Payment (PIP) but was refused and was given advice by another organisation not to appeal but to claim again. This led to a second refusal of PIP. She was referred to Welfare Rights by the HSCP Mental Health Team who decided to appeal the 1st decision as well as an additional decision which it was felt should be challenged. Both appeals were successful resulting in an award of Standard Daily Living and Standard Mobility backdated from February 2019 up until the date of the decision in February 2022, which was worth £13k to Ms X. She was also assisted to make a claim for Severe Disability Premium which was also backdated, resulting in an additional £10k. A referral was also made to the area team to initiate a Disability Living Allowance claim for her son who has suspected autism and allergies and she was signposted to make a self-referral to the North West Carers team for additional support.

Winter Social Protection Payments

In December 2020, Glasgow received a grant from the Scottish Government of £4.2m from the Winter Plan Social Protection Fund. The grant was awarded to address the disproportionate impact of the pandemic on the most disadvantaged. Social workers, health visitors and family nurses identified those who would most benefit from a small grant, with £3.3M being distributed directly to families over the period since.

User Feedback

A survey was issued to evaluate the impact of the above grants and feedback included the following:

- '*Made us all not worry about where our next healthy meal was coming from'*
- *'It was unexpected and being a single mum it helped out a lot especially as my son had just taken another stretch in size so I was very grateful for it, we both were'*
- *'I have 5 children, my partner lost his job during Covid, the funding we received helped to get my kids what they needed.'*

Free Personal Care

Following an amendment to the Community Care (Personal Care and Nursing Care)(Scotland) Act free personal care (FPC) for under 65's was introduced in April 2019 bringing parity with older people who have been entitled to free personal care since 2002. This means that people whether over or under 65, who have been assessed as requiring personal care, no longer have to make a financial contribution towards the costs of that care. The HSCP's Social Care Charging Policy has been updated to reflect this major change in legislation. At the end of March 2022 there were 2,257 service users under 65 in receipt of free personal care (FPC); an increase of just over 9% in comparison with March 2020 figure (2,066). **94%** of current service users under 65 in receipt of FPC have either a Learning Disability (42%), a Physical Disability (36%) or a Mental Health issue (16%).

6.2 KPI PERFORMANCE

INDICATOR (Health & Wellbeing Outcome)	2021/22 TARGET	2015/16 BASELINE	2019/20 YEAR END	2020/21 YEAR END	2021/22 YEAR END	Direction of Travel since 2015/16	Direction of Travel since 2020/21
Number of Clustered Supported Living tenancies offered to Older People (Outcome 2)	75 per annum	N/A	N/A	N/A	84 New KPI from 21/22	N/A	N/A
Percentage of service users who receive a reablement service following referral for a home care service. (Outcome 2)	**Hospital discharges** 70%	83%	68.9%	70.9%	71.7%	▼	▲
	Community referrals 70%	79%	75.5%	81.5%	72.5%	▼	▼
Has the Carer's Service improved your ability to support the person that you care for? (Outcome 6)	70%	N/A	87%	90%	97%	N/A	▲
Number of New Carers identified during the year that have gone on to receive Carers Support Plan or Young Carer Statement (Outcome 6)	1,900 per annum	N/A	1,932	1,928	2,391	N/A	▲
Telecare: Standard (Outcome 2)	2,750 (19/20 & 20/21) 2,000 (21/22)	N/A	2,723	2,326	2,771	N/A	▲
Telecare: Enhanced (Outcome 2)	1,500 (19/20 & 20/21) 500 (21/22)	N/A	1,565	444	672	N/A	▲

Key Achievements

Indicators where performance has shown the greatest improvement over the past 12 months.

INDICATOR	YEAR END 20/21	YEAR END 21/22
Percentage of service users who receive a reablement service following referral for a home care service: Hospital discharges	70.9%	71.7%
Number New Carers identified during the year that have gone on to receive Carers Support Plan or Young Carer Statement	1,928	2,391
Has the Carer's Service improved your ability to support the person that you care for?	90%	97%
Telecare: Standard	2,326	2,771
Telecare: Enhanced	444	672

Areas for Improvement

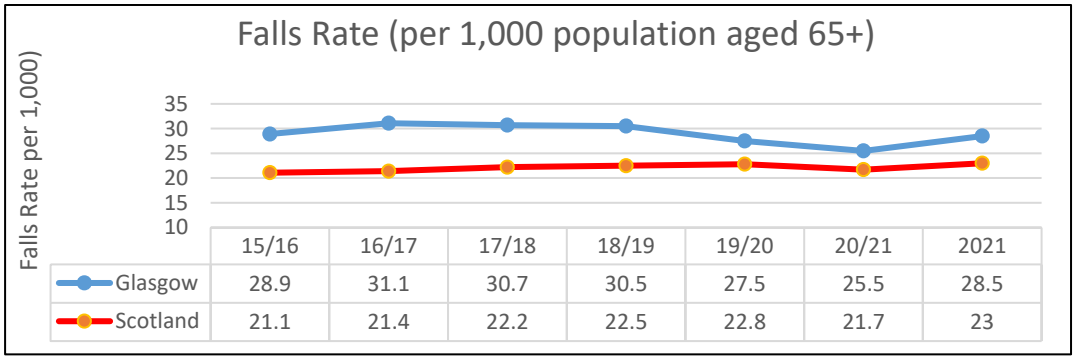
No areas for improvement have been identified for this Priority in relation to our KPIs.

6.3 NATIONAL INTEGRATION INDICATORS

National Integration Indicator	2021/22 Survey Results (19/20 results shown in brackets)				Direction of Travel Since Last Survey (19/20)
	Outcome	Glasgow	Scotland	Compared to Scottish average Above / Below	
1. % adults able to look after their health very well or quite well	1	**88.1%** (89.7%)	**90.9%** (92.9%)	Below	▼
2. % adults supported at home who agreed that they are supported to live as independently as possible	2	**80.3%** (81.5%)	**78.8%** (80.8%)	Above	▼
4. % adults supported at home who agree that their health and social care services seemed to be well co-ordinated	3	**70.1%** (74.8%)	**66.4%** (73.5%)	Above	▼
5. % adults receiving any care or support who rate it as excellent or good	3	**74.9%** (78.9%)	**75.3%** (80.2%)	Below	▼
6. % people with positive experience of the care provided by their GP practice	3	**71.4%** (83.1%)	**66.5%** (78.7%)	Above	▼
7. % adults supported at home who agree that their services/support had impact on improving /maintaining their quality of life.	4	**79.6%** (79.2%)	**78.1%** (80.0%)	Above	▲
8. % carers who feel supported to continue in their caring role	6	**33.7%** (35.8%)	**29.7%** (34.3%)	Above	▼
9. % adults supported at home who agreed they felt safe	7	**81%** (81.6%)	**79.7%** (82.8%)	Above	▼

National Integration Indicator 16

- Glasgow higher than the Scottish average in 2021



Please note that calendar year 2021 is used above as a proxy for 2021/22 due to the national data for 2021/22 being incomplete. We have done this following guidance issued by Public Health Scotland to all Health and Social Care Partnerships. Figures presented may not fully reflect activity during 2021/22 due to the varying impact of COVID-19 at different points of the pandemic.

6.4 LOCAL EVIDENCE

User Feedback - Home Care

Home Care and Reablement Services provide care and support to enable people to live as independently as possible in their own home. The annual service user consultation on the Home Care service was carried out at the end of 2021. Some of the headline figures for the 2021 survey in relation to our Strategic Priority of Enabling Independent Living for Longer are presented below.

Question	% who responded Yes	National Health & Wellbeing Outcome
Does having a home care service make you feel safe at home?	96%	Outcome 7
Do you feel the contact you have with home carers improves your quality of life?	96%	Outcome 4
Do you feel the service enables you to maintain the standard of personal care that you want?	94%	Outcome 4
Are your home carers helpful and friendly?	97%	Outcome 3
Are your home carers thorough at what they do?	94%	Outcome 4
Are you confident that your home carers have the right skills/training to support you?	94%	Outcome 8
Are your telephone calls to the office are always answered promptly?	89%	Outcome 3
Are the home care office staff always polite and helpful?	94%	Outcome 3

Carer Feedback

The Carers Centres provide an Evaluation form to Carers who have been in recent contact with the service. The Evaluation form asks Carers to rate the Carers Service in relation to a number of questions including those which relate to this Strategic Priority of Enabling Independent Living for Longer.

Question		% Carers Responding Positively
Has the Carers Service…	improved the quality of life for the person you look after?	86%
	improved your quality of life?	87%

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7. PUBLIC PROTECTION

A continued emphasis has been placed on promoting health and well-being, as part of our focus on safeguarding and protecting our most vulnerable children, adults and older people and helping to ensure that they are kept safe from harm. This work has continued to be prioritised in the context of the worldwide Covid-19 pandemic and related challenges. Within this section, we profile some of the key developments progressed in relation to our strategic priority of Public Protection and consider performance in relation to KPIs associated with this theme.

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

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

7.1 KEY DEVELOPMENTS/ACHIEVEMENTS

7.1.1 ADULT SUPPORT AND PROTECTION

The Adult Support and Protection (ASP) Committee and its sub-groups are the primary strategic planning mechanisms for over-seeing multi-agency support in Glasgow in relation to vulnerable adults. They have expanded their membership over the last year to help promote a wider focus on support alongside protection, allowing fuller consideration to be given to areas of growing concern such as the impact of the COVID-19 pandemic, poverty, homelessness, substance misuse and mental illness. The HSCP has also developed an Adult Support and Protection Team, consisting of a Service Manager and two ASP Senior Officers, to help link with operational services and promote a robust approach to governance, service delivery and practice improvement.

Data reporting and analysis has also been strengthened during the last year, partly linked to the “real time” data that has been required to meet national reporting requirements linked to the pandemic. This has helped to inform ASP related activity and establish increased reporting around wider aspects of Public Protection including homelessness, addiction and justice matters. Glasgow HSCP is aware that work in ongoing in a national context to improve the collation of ASP data, which it is anticipated will lead to a new national data set that will strengthen consistency of recording/reporting at a local and national level.

The commitment to Self Evaluation is also reflected in the development of a new Learning Review Protocol and publication of two Significant Case Reviews (Adult A and Adult B) over the last year. Similarly, a multi-agency approach has been adopted to disseminate the learning from both reviews and to implement related action plans, to drive practice improvements. A new Learning Review Protocol has also been launched to help promote more consistent approaches in this complex area of practice,and help respond to national drivers for change.

During 2021/22, a total **8431** Adult Support and Protection referrals and **506** formal investigations were reported to the Scottish Government as commencing between 1st April 2021 to 31st March 2022 as part of the Annual Data return for Glasgow HSCP, compared to **5826** and **302** the previous year (20/21).

7.1.2 CHILD PROTECTION

In tandem with the transformational agenda, the HSCP is endeavouring to adopt a strengths based approach to all intervention ensuring that the use of the Child Protection (CP) register is thoughtful, measured and robust. While practice remains consistent in the overall trend, the additional investment in Health Visiting and indeed introduction of the universal pathway (aligned to Getting It Right For Every Child) allows the HSCP to adopt and develop a more considered and preventative approach rather than simply surveillance, as does the introduction of our comprehensive Family Support Strategy. Trends over time are shown as follows:

Year	March 18	March 19	March 20	March 21	March 22	Direction of Travel since 2018	Direction of Travel since 2021
No. on CP Register	314	388	401	342	303	▼	▼
	17/18	**18/19**	**19/20**	**20/21**	**21/22**	**Direction of Travel since 17/18**	**Direction of Travel since 20/21**
New Registrations	415	517	495	423	366	▼	▼
De-Registrations	587	443	482	482	405	▼	▼
Average Time on Register before De-Registration (Days)	315	285	255	333	306	▼	▼

At year-end 2022 **46%** of the children on the CP register were aged 0-4; **38%** (5 to 11); **16%** (12 to 15); and **<1%** (16+), similar proportions to last year.

7.1.3 JUSTICE SOCIAL WORK

The Justice Social Work transformational agenda has aspirations to improve long term outcomes for service users, creating opportunities for reintegration and rehabilitation while working to reduce the prison population and improving engagement and compliance with community orders. Early and effective intervention remains at the heart of this agenda with the ongoing development and enhancement of services in pursuit of these ambitions.

Domestic Abuse Strategy

The HSCP's response to the pandemic has sharpened the focus on domestic abuse which emerged as a key priority and risk factor for individuals and families in Glasgow City. In response, the HSCP is now working to produce the first comprehensive Domestic Abuse Strategy for Glasgow, which will seek to improve our responses to those affected by domestic abuse, as well as those who perpetrate it. An extensive engagement process on the strategy was undertaken in the last year involving staff, service users, people with lived experience and key partners across the Glasgow Domestic Abuse system including the third sector, Police and Education.

PHHaB Project

In April 2021, a pilot partnership project (PHHaB, Pathfinder to Housing, Health and Benefits) was launched in Barlinnie to help prepare people for release and support them when they return to the community. This was set up by the Scottish Prison Service (SPS) in partnership with Glasgow City Council and the HSCP and it aims to develop a solution to break the 'cycle of reoffending' by targeting three main challenges identified by people released from prison: accessing tenancies/suitable accommodation, health services and universal credit/benefits.

Problem Solving Youth Court

In July 2021, Glasgow City Council HSCP introduced a Youth Court in an effort to improve sentencing and outcomes for young people. It aims to improve rehabilitation and enhance the effectiveness of community sentences by combining the provision of multi-disciplinary intervention and support in the community, with regular court reviews to monitor and encourage young people's progress. Since its inception over 50 young people have been diverted through the Court. 9 have been subsequently admonished with 3 receiving a further community disposal and only one placed in custody. The remainder continue to engage with the Youth Court process.

Case Study

Case B was made subject to a Youth Court Structured Deferred Sentence (SDS) at Glasgow Sheriff Court having pled guilty to multiple offences. B is a care experienced young person and their involvement in offending behaviour occurred over a short period of time. Since engaging with the Youth Court, B has been able to develop an insight into his offending and to understand and address the root causes of his behaviour. B is now attending college on a full-time basis and has been successful in achieving greater stability in his relationships and home environment and has ceased the use of alcohol and other substances. After a short period of SDS, the Court admonished him and there has been no further offending.

Bail Supervision

Bail Supervision is a Glasgow HSCP service that is intended to provide a robust and credible alternative to remand in custody. Individuals who would otherwise be held on remand pending trial, or for reports after conviction, can if assessed as suitable, be released on bail on the condition they meet with a bail supervisor a specified number of times per week, who will oversee a package of supervision and support and report upon progress to the court. The overarching aim of Bail Supervision is, therefore to reduce the use of remand by giving confidence to the court that individuals bailed in

the community will be supported to comply with the conditions of bail, and that any non-compliance will be robustly managed.

Case Study

Case A was made subject to a Bail Supervision Order between September 2020 and August 2021. At this time, he was subject to a Community Payback Order (CPO) and had been homeless for approximately 2 years. He had a long-standing addiction issues with alcohol and drugs, as well as a brain disorder and severe health complications, resulting in memory loss and cognitive issues, which meant he was struggling to comply with the conditions of his CPO. Mr A engaged well with his supervising officer and had weekly contact with them and with their help, completed his CPO successfully. SACRO and Housing First also worked with him and he was eventually offered his own tenancy. SACRO also supported Mr A and his mother to apply for benefits, council tax, furniture for his new home and a blue badge. To date, Mr A still remains in his own tenancy, supported by Addiction Services and Housing First.

7.1.4 ALCOHOL AND DRUG SERVICES

Reducing Drug Deaths

A new pilot **project** has been introduced this year which involves offering prisoners set to be released from Barlinnie Prison with a Nyoxoid nasal inhaler and training on how to use it. The spray temporarily reverses the effects of opioids and when administered, provides time for emergency services to deliver appropriate treatment for someone who has overdosed. This initiative follows on from an existing programme that has seen 11 prisoners trained as peer mentors, who have been involved in explaining the benefits of naloxone to other prisoners, with the aim of reducing Glasgow's drug deaths. This peer support training is also now being rolled out to other prisons in the Health Board area, including HMP Low Moss and HMP Greenock

The WAND Initiative

The pilot WAND Initiative (Wound Care, Assessment of Injection Risk, Naloxone provision and Dry Blood Spot Testing) in Glasgow city centre involves the targeting of individuals who inject. It seeks to engage them by providing safe injection equipment and encouraging them on a regular basis to have injection areas on their body examined, test for blood borne viruses and accept life-saving Naloxone. This service has improved engagement with some of the most vulnerable members of the community who traditionally may have shied away from primary healthcare services. A formal evaluation of this pilot is underway and Glasgow ADP hopes to roll out this initiative across the city during 2022/23.

Glasgow City ADP Crisis Outreach Team

Following an increase in the number of drug related deaths, new monies were made available via the Scottish Government's Drug Death Task Force to establish a Crisis Outreach service to tackle drug related deaths (DRD's) and non-fatal overdoses (NFOD). This service was introduced in April 2021 and they are now working alongside partners to reduce the number of DRD's and NFODs through early intervention with drug users (known and unknown to services). The service has a strengths-based focus with harm reduction at the heart of care and treatment.

The team operate seven days a week and out of hours and anyone who has a NFOD in the city will be referred to them by Accident & Emergency Departments, Scottish Ambulance Service, Police Scotland and other relevant agencies. In the first full year of operation, the Team has received over 1000 referrals and has engaged with over 800 individuals, approximately 20% of whom were previously unknown to Alcohol and Drug Recovery Services in Glasgow.

Primary Care Alcohol Nurse Outreach Service

The Primary Care Alcohol Nurse Outreach Service (PCANOS) involves embedding specialist addiction nurses into General Practice (GP) surgeries. It started in 2015 as a pilot project to reduce alcohol related harm in response to the evidence that deaths in the most disadvantaged areas of Scotland were more than four times higher than the average. The nurse specialists employed by the service increase engagement with vulnerable individuals and deliver broad ranging supports for them. A recent academic study published in March 2022 by the Universities of Stirling and Dundee has identified that the PCANOS model has been effective in reducing alcohol related harms in the community and has made a recommendation that the service be rolled out across all areas of high deprivation in Scotland to support individuals most at risk from alcohol harms.

7.1.5 HOMELESSNESS SERVICES

Increasing Settled Accommodation

Through 2021/22, the public health emergency continued to be a significant backdrop to the delivery of homelessness services within the City. The rapid expansion of emergency accommodation seen during the initial phases of the pandemic ensured that anyone requiring emergency assistance could access temporary accommodation and support. Partnership working between the City's Housing Associations and the HSCP's Homelessness Services to ensure that homeless households are able to access settled accommodation has, however continued, with the aim of reducing reliance on temporary and hotel/bed and breakfast accommodation. The out-turn figure of **3305** settled lets for 2021/22 represents an increase of **405 (14%)** on the total for 2020/21.

Despite this increase in the number of settled lets, the number of people requiring hotel and bed and breakfast type accommodation has risen over the course of 21/22 - from **286** (Q1) to **414** (Q4) - after reductions were achieved from the previous year when they were at 573 (Q2 of 20/21). This has arisen due to increasing requests for homelessness assistance which led Homelessness Services to review its approach to Housing Options and homelessness prevention activity, a key priority for the service. In response to this rise in demand, a number of actions were identified and progressed in order to further develop and enhance our work, including the following:

- Continued to re-design front-line Homelessness Services systems and processes to focus on prevention activity
- Worked with colleagues across the Council to deliver the £1.54m Tenant (Covid19) Hardship Fund. So far, the fund has supported 600 tenants to avoid eviction through rent arrears accrued due to financial hardship during the public health emergency
- Invested in additional posts within the Prison Casework Service to enhance prevention pathways for people involved in the criminal justice system

- Increased access to money and debt advice service within our Community Homelessness Services
- Developed a Housing Options Practice Forum
- Invested staffing resource into the development of the Housing Options Toolkit
- Continued to provide funding for the Private Rented Sector Prevention Hub which works with households who are at risk of homelessness.

Whilst the HSCP continues to use bed and breakfast type accommodation, we are committed to ending the use of bed and breakfast type accommodation and will publish a Temporary Accommodation Strategy that will set out how this ambition will be achieved.

Complex Needs Service

The HSCP has continued to develop its approach to supporting vulnerable households with complex case histories and a new Complex Needs Service has been recently established to replace the previous Homeless Health Service. The service has a strong focus on multi-agency and partnership working and is focused on delivering an assertive outreach model, increasing contact with those at highest risk and who are historically 'hard to reach'. It came about as a result of the need to quickly adapt to the challenges of the Covid-19 pandemic and move away from a clinic based model. It is providing a range of medical, health and social care interventions for individuals with multiple and complex health and social care needs who are not engaging with mainstream services and is acting as an interface between homelessness, alcohol and drug recovery services, mental health and justice services in the city.

Housing First

Housing First is a rapid rehousing approach to tackling homelessness amongst people with complex needs such as mental health or addiction issues. Previously people were supported to tackle complex needs in a bid to become 'tenancy ready', but the Housing First model is based on the assumption that housing should be provided rapidly and be supplemented by intensive support to address any health issues and factors which threaten the person's ability to sustain that tenancy. During the last year, the Housing First Service have continued to provide an outreach approach to ensure face to face contact and support to our most vulnerable service users, with over **51** households securing settled tenancies in 2021, meaning it has achieved **250** settled tenancies for people with complex case histories over the duration of the service. The service also expanded to undertake a Mental Health Test of Change, working to secure tenancies with the Mental Health Unit at Stobhill Hospital, an approach which will now be rolled out to the Leverndale unit.

7.2 KPI PERFORMANCE

INDICATOR (Health & Wellbeing Outcome)	2021/22 TARGET	2015/16 BASELINE	2019/20 YEAR END	2020/21 YEAR END	2021/22 YEAR END	Direction of Travel since 2015/16	Direction of Travel since 2020/21
Number of households reassessed as homeless/ potentially homeless within 12 months. (Outcome 4)	<480 per annum	395	437	420	526	▼	▼
Percentage of Community Payback Order (CPO) unpaid work placements commenced within 7 days of sentence (Outcome 9)	80%	64%	76%	76%	87%	▲	▲
Percentage of Community Payback Orders (CPO) with a Case Management Plan within 20 days (Outcome 9)	85%	94%	85%	85%	93%	▼	▲

Key Achievements

Indicators where performance has shown the greatest improvement over the past 12 months.

INDICATOR	YEAR END 20/21	YEAR END 21/22
Percentage of Community Payback Order (CPO) unpaid work placements commenced within 7 days of sentence	76%	87%
Percentage of Community Payback Orders (CPO) with a Case Management Plan within 20 days	85%	93%

Areas for Improvement

INDICATOR	Performance Issues and Actions to Improve Performance
Number of households reassessed as homeless/ potentially homeless within 12 months **Target** <480 per annum **Actual** 526	**Performance Issues** Analysis of the increase in the number of households re-presenting as homeless has shown that repeat presentations are, generally, driven by households with complex case histories. **Actions to Improve Performance include:** • As a result of analysis, the service has developed a number of actions to address the underlying causes of the increase. • Continued implementation of the action plan to support continued improvement.

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8. STAFF DEVELOPMENT AND ENGAGEMENT

8.1 KEY DEVELOPMENTS/ACHIEVEMENTS

8.1.1 SUPPORTING OUR STAFF

iMatter

iMatter is a national staff engagement questionnaire which measures staff engagement within teams and supports the production of action plans to improve this. After being paused due to Covid, it was reintroduced in 2021 and had a 53% response rate. An overall HSCP Employee Engagement Index of 77 was recorded which is classified by iMatter as being 'Strive and Celebrate' and the overall experience of working for the HSCP has gone up from a score of 6.9 to 7 out of 10. In terms of actions arising from the survey, 29% of teams completed an action plan to follow up the reports.

Virtual Coaching Service

GCHSCP are committed to offering a range of support for staff and feedback from them has shown the value they put on conversations. In response, we launched the Virtual Coaching service in 2020 and it was relaunched for a third time in September 2021, with the invite extended to other HPSCPs in NHSGGC. The service provides an opportunity to explore solutions in a one to one confidential conversation with a qualified coach and during 2021/2022, 115 members of staff received coaching. Themes covered included confidence and resilience, leading teams, relationships, team dynamics and communication, wellbeing and working remotely.

Staff Feedback

- *'It has been helpful to reflect and work through challenges'.*
- *'It has given me the confidence to act and try new approaches'.*
- *'It provides a safe space to be vulnerable'.*
- *Has been great for thinking about practical management approaches and having more effective conversations to enable collaboration.*
- *'I have taken away actions to improve team communication and connections.*

Mental Health and Wellbeing

Responding to the pandemic and the impact this has had on staff has highlighted the importance of supporting staff mental health and wellbeing. A Staff Mental Health and Wellbeing Group was established in the last year with the aim of developing our approaches to improving staff mental health and wellbeing and 4 key themes have been identified within which action is being taken forward; culture/ways of working, communication, activity and environment.

Activity has also been progressed across individual care groups. For example, within Children's Services, a new staff group called the People's Group was established which has been looking at learning and development needs, innovations in practice and how to support staff wellbeing. Similarly, within Care Services, a 20 Minute Care Space was introduced which provides staff with a structured reflective space during working hours, enabling them to connect with colleagues, reflect on their present circumstances and identify areas for self-care. These were supplemented with a

range of other support including well-being webinars (e.g. on breathing exercises, yoga and mindfulness) and wellbeing days for building team morale and resilience.

GREATix

Under the NHS GG&C Healthcare Quality strategy, GREATix has been introduced as a way to recognise and celebrate high quality practice. The NHS has a culture of identifying errors and learning from mistakes which – while valuable – can impact morale and overlook positive contributions. GREATix is a system for recognising colleagues' good practice and highlighting where things have worked well. Within the GREATix process, staff are invited to scan a QR code with their phone and complete a simple online form to report examples of good practice. Evidence from the Scottish Ambulance Service indicates that GREATix has had a positive impact, with staff commenting on an improved culture and how they find it easier to provide positive feedback to colleagues.

Recruitment and Training

A key challenge facing the HSCP is ensuring the right numbers and levels of staff are in place. This has been particularly challenging for Care Services over the course of the pandemic due to a shrinking employment pool as a result of rising industry wide need and competitive recruitment campaigns across other providers. In response, Care Services have commissioned targeted recruitment campaigns which reach across multiple mediums, including television, radio and online advertising including events encouraging young people to pursue a career in care. This has led to a total of 357 staff being recruited to date in 21/22. In addition to recruitment, Care Services have reviewed and updated training arrangements and made courses more accessible by offering refresher courses for longer serving members of staff. This has ensured there has been a skilled workforce across the teams and localities within Glasgow, whilst dealing with the challenges of recruitment and Covid -19 related absences.

8.1.2 AWARDS

While internal awards have been suspended due to the pandemic, submissions have continued to be made for a number of external awards, with the following winners/recognitions in the last year:

- Craig Davidson, Senior Health Nurse with Clare Manley, Mental Health Nurse (Pennine Care NHS Foundation Trust), Finalists, Innovations in Your Speciality, Royal College of Nursing Awards 2021
- Homeless Health and Asylum Service (now called Complex Needs and Asylum Health Services) Winner, People's Choice Award, Scottish Health Awards 2021
- Leverndale Therapeutic Staff, Finalist, Care for Mental Health, Scottish Health Awards 2021
- Quit Your Way Service, Winner, Uniformed Services Award, Glasgow Times Community Champions Awards 2021
- Chara Centre, Finalist, North West Public Service Award, Glasgow Times Community Champions Awards 2021
- Julie Campbell, Mental Health Officer, Finalist, Mental Health Officer Practice Award 2022, Scottish Association of Social Work
- Pharmacy Led Pain Clinic in Govanhill Health Centre won a national award for the 'Addressing Overprescribing' category and an overall Silver Award, at the PrescQIPP Annual Awards in October 2021.

8.1.3 COMMUNICATIONS

Effective communications enable the HSCP to engage with staff and other key stakeholders to increase awareness of its priorities for health and social care and to engage them in the planning and delivery of services. This past year, Glasgow City HSCP's Communications Team has continued to provide support to the HSCP's business continuity and recovery planning arrangements and responses to COVID-19. Activities have included regular Covid-19 Briefings; personal video messages from SMT members; the maintenance of dedicated Covid-19 Web Pages on the HSCP website; and the production of posters for HSCP buildings on physical distancing, hygiene and other controls.

Staff Feedback

In the last year, a survey has been undertaken with HSCP staff, IJB Members and Council Elected Members to share their views on the above HSCP COVID-19 communications. 930 people responded and some of the key findings are noted below:

- *89% of respondents found HSCP email communications useful/very useful*
- *87.6% of respondents found the HSCP's COVID-19 briefing useful/very useful*
- *69.5% of respondents found the SMT videos published alongside the COVID-19 briefing useful/very useful*

In addition to the work on Covid-19, communications activities have included:

- Continued improvement of the content and accessibility of a variety of HSCP and Council websites
- Development of the HSCP's Partnership Matters Briefing to keep internal and external audiences up to date on work across the HSCP
- Development of guidance on accessible written communications for HSCP to support more consistent best practice
- Supported recruitment campaigns to attract people to work for the HSCP across a number of roles
- Provided communications support to a number of programmes/projects including the Strategic Plan Review, Maximising Independence, and the Primary Care Improvement Plan
- Further development of the HSCP's Team Meeting Communications Briefing Framework
- Continued to innovate how the HSCP communicates through the use of videos, graphic design and motion graphics and through social media channels such as the HSCP website and Twitter, Facebook and YouTube profiles

Activity

- *During 1 April 2021-31 March 2022, there were 382,437 visitors to the HSCP's website, with 693,048 page views*
- *As at 31 March 2021, the HSCP's Facebook profile had 1,189 followers, and 438 posts were made during 1 April 2021-31 March 2022*
- *As at 31 March 2021, the HSCP's Twitter profile had 4,789 followers, and 919 Tweets were made during 1 April 2021-31 March 2022.*

8.2 KPI PERFORMANCE

INDICATOR (Health & Wellbeing Outcome)	2021/22 TARGET	2015/16 BASELINE	2019/20 YEAR END	2020/21 YEAR END	2021/22 YEAR END	Direction of Travel since 2015/16	Direction of Travel since 2020/21
NHS Sickness Absence rate (%) (Outcome 1)	<4%	6.3%	6.37%	5.1%	6.39%	▼	▼
Social Work Sickness Absence Rate (Average Days Lost) (Outcome 1)	ADL per employee per annum <10.2 ADL	9.9 ADL	15.7 ADL	15.9 ADL	19.7 ADL	▼	▼

Areas for Improvement

INDICATOR	Performance Issues and Actions to Improve Performance
Sickness absence rates **NHS** **Target** <4% **Actual** 6.39% **Social Work** **Target** <10.2ADL **Actual** 19.7 ADL	**Performance Issues** During 21/22 COVID-19 continued to cause high levels of sickness absence across both Health and Social Work staff groups. The impact of the pandemic on the workforce has been particularly significant in its effect on staff mental health and wellbeing **Actions to Improve Performance include:** • The HSCP HR Team have updated the Wellbeing and Attendance Action Plan to co-ordinate and implement a consistent, effective approach to Attendance Management and support the wellbeing of staff (NHS). • HR continue to work with managers to develop Wellbeing and Attendance Action Plans for each staff group, and to implement a quarterly operational plan. This includes a refresh of processes, manager training and incorporating staff mental health and wellbeing promotions / activities into daily working lives (Social Work). • Ensure assistance and guidance is available to HSCP staff and managers. • Support management teams to access and analyse available attendance data and identify trends and areas of concern. • The HR Team will identify areas where additional input is required to ensure long term sickness absence is supported by line managers with support from HR where required.

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9. EQUALITIES

9.1 PROGRESS UPDATE

The Equality Act 2010 (Specific Duties) (Scotland) Regulations 2012, list the following specific duties which the IJB is required to undertake:

- Report progress on mainstreaming equality
- Publish equality outcomes and report on progress in relation to them
- Assess and review policies and practices in respect to equality
- Consider award criteria and conditions in relation to public procurement
- Publish equality information in an accessible manner

Glasgow City HSCP Equalities Working Group oversees the programmes of work related to the Equalities and Fairer Scotland Duties. During 2021/22 activity undertaken to further advance equalities practice across all our business areas included:

- Participation for the first time in the Employers Network for Equalities and Inclusion (enei) Talent Inclusion and Diversity Evaluation (TIDE). The TIDE mark allows organisations to assess their status in equalities and inclusion across eight mainstreaming domains. Glasgow City HSCP was awarded a Bronze TIDE award.
- Equality Impact Assessments (EQIAs) – undertaking EQIAs are a key way for us to design and deliver services that are responsive and appropriate to protected characteristic groups and intersectionality. During the reporting period, a total of 18 EQIAs were undertaken and published.
- Achieving a good practice charter marker. Child and Adolescent Mental Health Services (CAMHS) have joined the Youth Health Service and Sandyford Sexual Health Services in achieving the LGBT Youth Charter Mark award, demonstrating and reassuring our young LGBT community members that services are sensitive to their needs.
- Delivered an Equalities Progress Report to the IJB on progress made in delivering against our agreed Equality Outcomes as set out within our second Equalities Mainstream Report (2020-24). This Progress Report indicates substantial progress has been made and provides full details of the actions and progress to date in relation to these Outcomes. It includes actions and our impact to reduce inequalities of outcome caused by socio-economic disadvantage, known as our Fairer Scotland Duties, which have been taken forward in a number of ways including income maximisation, our EQIA processes and our contribution to community planning activity in Glasgow to prevent poverty, as discussed in more detail below.

9.2 THRIVING PLACES

A key part of the Community Empowerment (Scotland) Act 2015 is that local people have the right to be involved in local decision making. Councils and other public sector organisations also have a duty to improve outcomes in areas disadvantaged by inequalities. HSCP staff, in particular Health Improvement staff, continue to take a focused neighbourhood approach in recognition of persistent inequalities which exist within and between communities and they support over 300 partnerships in the city. Much of this work is aligned with the Community Planning Thriving Places approach,

which aims to find a better way of working between organisations and communities, to make better use of existing resources and assets and improve outcomes.

Thriving Places activity is taken forward in 10 neighbourhoods across Glasgow, which are particularly affected by poverty. Each developed a 10-year Locality Plan in 2017 which includes a history of the area; a profile of the local population; details of local amenities and community groups; local priorities; and an action plan. Links to these plans are provided below:

North East

Easterhouse
Parkhead, Dalmarnock and Camlachie
Springboig and Barlanark

North West

Drumchapel
Ruchill and Possilpark
Lambhill and Milton

South

Gorbals
Govan
Govanhill
Priesthill and Househillwood

The Thriving Places programme (GCC and GCHSCP) currently funds a Community Connector in each of the 10 neighbourhoods who are employed by a local organisation and bring stakeholders together to address local priorities. HSCP Health Improvement staff play a key role in Thriving Places activity by supporting and facilitating local partnerships, providing guidance and support around monitoring and evaluation, and enabling access to funding streams.

Thriving Places activity has continued to be severely impacted by the COVID-19 pandemic with activity focussed on connecting people with services and support. Social media has been used extensively to interact with members of the local community and share information and about a range of support available including:

- Food, mental health, addiction, finance, and energy efficiency
- Employability support and job vacancies
- Funding support
- Online activities and events

An example of activity undertaken within each of the localities in the past year is described below.

North East - Parkhead, Dalmarnock and Camlachie (PDC) Thriving Place – Urban Fox Bike Project

Following a successful summer programme, Thriving Places PDC decided to continue working in partnership with Urban Fox to deliver free weekly bike repair sessions. The Urban Fox initiative is a voluntary managed project providing young people in the East End of Glasgow with a wide range of educational and diversionary activities including supervised sports and leisure programmes, health and social education, IT training, as well as many other structured learning programmes. Urban Fox also provide help with assembling and servicing new bikes, as well as refurbishing donated bikes and redistributing them to local families.

Three new local volunteers have been enrolled to the project to learn how to fix and maintain bikes and they will provide additional community information sessions on bike safety and maintenance. These skills will allow them to gain the industry recognised Velotech Bronze and Silver awards with one of the volunteers also hoping to gain a recognised professional mechanics qualification. Plans are in place to also introduce community cycles in the summer.

Case study

A was referred to the Thriving Places Team on his discharge from a rehabilitation centre. He was keen to establish positive supportive links within the community as part of his rehabilitation journey. One of his main barriers was lack of transport to attend meetings, join activities or take up employment again. A was referred to the Urban Fox Bike Project where he secured a refurbished second-hand bike free of change. Getting a bike enabled him to engage and continue his recovery journey. He said, "Thank-you so much… a bike will make getting about so much easier."

North West - Drumchapel Thriving Place - Keep Drumchapel Tidy

The Community Connector for Drumchapel Thriving Places held sessions with children and young people from the G15 Youth Project, and a local primary school. These conversations highlighted that 'feeling safe', and having access to nature or green spaces, were key priorities for both groups and that a major concern was the increasing amount of litter particularly in spaces children and young people would ideally choose to spend their time. In response, the Community Connector sought out local volunteers already looking to tackle the issue and 'Keep Drumchapel Tidy' was born. Among the team, a local artist designed the visual identity for the group and colouring-in posters were given to every school child in Drumchapel, informing them about the initiative and how they could participate. During the June Clean Up, 123 volunteers donated over 314 volunteer hours over 33 litter picks, with 350 bags of litter being collected. The initiative is going from strength to strength, with monthly litter picks now taking place which are promoted on social media (Facebook and Twitter #keepdrumchapeltidy).

South - Govan Thriving Place - Food for Good Group

The South Locality Health Improvement Team has been leading the co-ordination of food work in the Govan area through the Food for Good Group, which brings local organisations and community members together to seek better access to food. At the beginning of the pandemic, Food for Good developed a specific COVID-19 action plan, with the aim of ensuring those who were most vulnerable would have access to food and hot meals during lockdown. More recently, they also received funding to support organisations transitioning from COVID into the recovery phase and in the

last year work has been undertaken with the Kinning Park Complex, a community-owned space who applied for help from the Food for Good Group to relaunch their Community Cafe. This has helped them ensure that it met COVID-19 protocols and allowed local people to access a healthy meal and gain the social and mental benefits of being able to meet in a supportive environment.

10. INSPECTION AND PRACTICE AUDIT

10.1 HSCP REGISTERED SERVICES – CARE INSPECTORATE

Inspections during 2021/2 have been targeted at areas of higher risk in order to assess care and support during the ongoing COVID-19 pandemic. In 2020 the Care Inspectorate introduced an additional new Standard for Older People Care Homes in addition to the 5 existing ones: *How good is our care and support during the COVID-19 pandemic?* This standard was added to robustly assess care home arrangements in response to the COVID-19 pandemic with a focus on infection prevention and control (IPC), personal protective equipment (PPE) and staffing. This was implemented to meet the statutory duties outlined in the Coronavirus (Scotland) (No.2) Act and subsequent guidance.

Between April 2021 and March 2022, the Care Inspectorate undertook 9 unannounced inspections in services provided by Glasgow City HSCP. The following table details the individual services inspected during this period, the care grades achieved across each Standard and the number of requirements made. Full details of these inspections can be accessed from the Care Inspectorate Website and via the individual links provided in the following table.

UNIT (DATE OF INSPECTION)	How well do we support people's wellbeing?	How well is our care and support planned?	How good is our setting?	How good is our Staffing?	How good is our leadership?	How good is our Care and Support during the COVID-19 pandemic?	No. of Requirements
CARE HOMES (OLDER PEOPLE)							
Meadowburn Care Home (29/04/21)	Not Assessed	Not Assessed	Not Assessed	Not Assessed	Not Assessed	3	0
Victoria Gardens (7/10/21)	4	Not Assessed	Not Assessed	Not Assessed	Not Assessed	4	0
Orchard Grove (24/02/22)	4	Not Assessed	Not Assessed	Not Assessed	Not Assessed	4	0
CHILDREN'S RESIDENTIAL HOUSES							
Wellhouse RCU (14/07/21)	2	2	3	2	2	Not Applicable	8
Kempsthorn RCU (27/08/21)	4	4	5	4	2	Not Applicable	4
Hinshaw Street (21/10/21)	3	3	3	3	3	Not Applicable	3
Norse Road (22/02/22)	3	2	3	3	3	Not Applicable	6
Balmore RCU (31/03/22)	*Report has not yet been published.*						
DAY CARE (OLDER PEOPLE)							
Meadowburn Day Care (17/03/22)	4	Not Assessed	Not Assessed	4	Not Assessed	Not Applicable	0

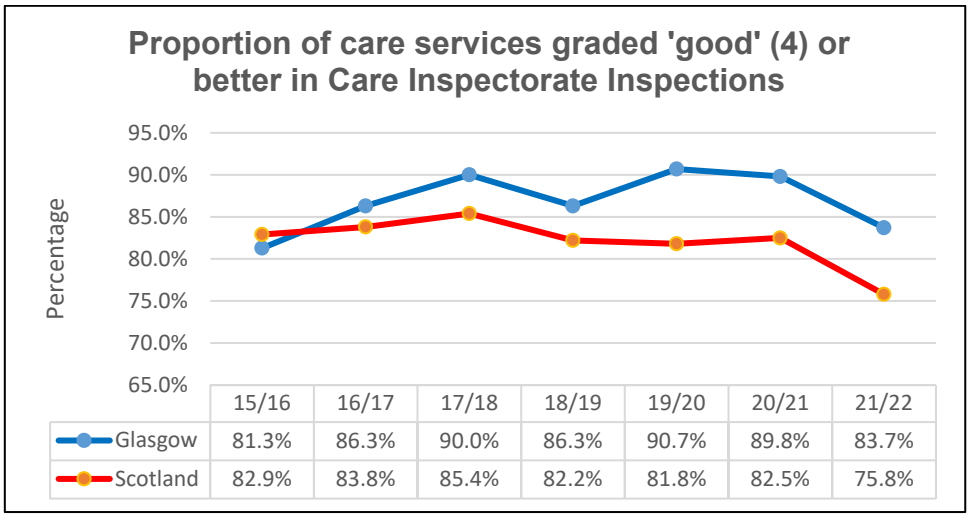
Key to Grading:
1 – Unsatisfactory, **2 –** Weak, **3 –** Adequate, **4 –** Good, **5 –** Very Good, **6 –** Excellent

Care Inspectorate grades are regularly reviewed by the IJB Finance, Audit and Scrutiny Committee. Reports for 2021/22 were presented in April 2022, giving details of inspections by care group and details of Requirements and Areas for Improvement. These can be accessed on the HSCP website via the following links:

Care Inspectorate Activity Within Directly Provided Children's Residential Services (2021)

Care Inspectorate Activity Within Directly Provided Older People's Residential Services (2021)

National Integration Indicator Number 17 (Care Inspectorate Grades) shows Glasgow's performance over time and in comparison to the overall figure for Scotland. Glasgow is higher than the Scottish average in 2021/22.



	15/16	16/17	17/18	18/19	19/20	20/21	21/22
Glasgow	81.3%	86.3%	90.0%	86.3%	90.7%	89.8%	83.7%
Scotland	82.9%	83.8%	85.4%	82.2%	81.8%	82.5%	75.8%

10.2 MENTAL WELFARE COMMISSION LOCAL VISITS

The Mental Welfare Commission (MWC) undertake local visits, either announced or unannounced; these involve visiting a group of people in a hospital, care home or prison service. The local visits identify whether individual care, treatment and support is in line with the law and good practice; challenge service providers to deliver best practice in mental health, dementia and learning disability; follow up on individual cases where the MWC have concerns; and provide information, advice, and guidance to people they meet with. Local Visits are not inspections, however the Commission details findings from the visit and provide recommendations, with the service required to provide an action plan within three months.

The Mental Welfare Commission made Local Visits in Glasgow to a range of adult inpatient wards, older adult inpatient wards, intensive psychiatric care units (IPCU), and rehabilitation wards. 13 reports were published for local visits undertaken in 2021 and the reports from 5 visits during 2021 will be published in due course. Details of the sites visited, and the recommendations and good practice noted during these visits was presented to the IJB in April 2022.

10.3 PRACTICE AUDIT AND EVALUATION ACTIVITY

In addition to external inspections, the Partnership has an ongoing planned programme of audit and self-evaluation to give quality assurance across all service areas. Practice Audit and Evaluation activity carried out by Social Work between April 2021 and March 2022 is listed in the following table.

Practice Audit and Evaluation Activity 2021/22
ASP (Adult Support and Protection) Duty System audit
Occupational Therapy evaluation
Glasgow City Council's Interpreting Service evaluation
Linguistics Service User evaluation
Justice Social Work: Your Voice evaluation
Social Care Direct Audit
Separated and Unaccompanied Child Refugees/Asylum seekers: HSCP Campus evaluation
Older People Care Homes Discharge to Assess (D2A) evaluation/survey
Survey of vulnerable people who received a COVID payment
Kinship BAME (Black, Asian and minority ethnic) audit
Devolved Decision-Making Pilot evaluation (Child Protection - related to young people being trafficked)
Evaluation of the Care Home Review Programme
Abstinence Residential Addiction Service audit
Complex Needs Team audit
Thematic Review: The increase in Mental Health Officer detentions during COVID-19
Case File Review - Participation of children and young people in child protection processes

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11. FINANCIAL PERFORMANCE

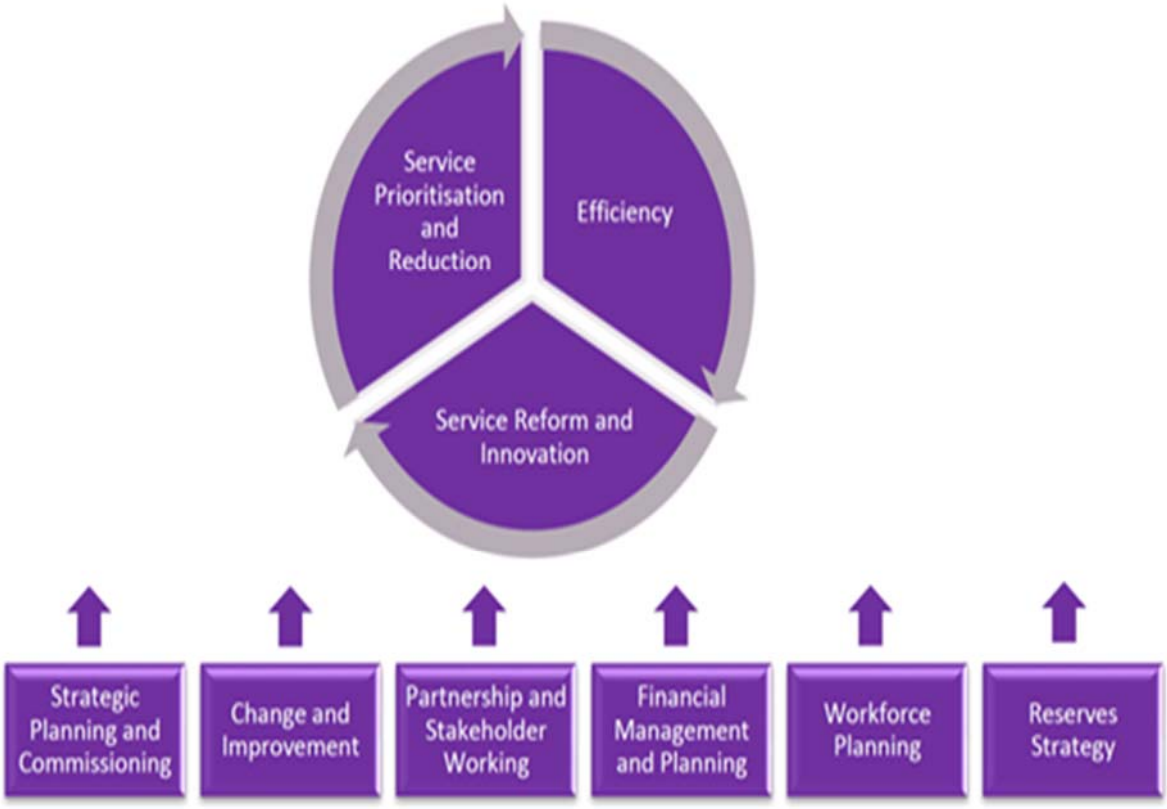
11.1 INTRODUCTION

National Health and Wellbeing Outcome 9 is set out below and within this chapter, we seek to demonstrate how we have achieved this. Firstly, we provide an overview of financial performance during 2021/22. We then describe the transformation programmes we have been taking forward and the key capital investments progressed during the last year, before briefly considering the financial outlook for 2022/23.

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

11.2 BEST VALUE

The IJB has a duty of Best Value, by making arrangements to secure continuous improvements in performance, while maintaining an appropriate balance between quality and cost. In making those arrangements and securing that balance, the IJB has a duty to have regard to economy, efficiency, effectiveness, equal opportunities requirements and to contribute to the achievement of sustainable development. The IJB has in place a clear strategy to support the delivery of best value over the medium term and is this reflected in our medium term financial outlook. This is demonstrated in the diagram below.



11.3 2021/22 FINANCIAL PLANNING

The total financial resources available to the partnership for 2021-22 were around £1.4billion. This can be seen in the table below along with trend information for previous financial years.

Client Group	2019/20 £000's	2020/21 £000's	2021/22 £000's
Children and Families	152,205	160,895	169,654
Adult Services	289,213	311,697	336,393
Older People Services	296,757	309,101	330,485
Resources	50,425	75,477	85,984
Justice Social Work	-397	(740)	(658)
Primary Care	345,268	374,918	377,518
COVID-19	-	46,447	99,449
TOTAL	**1,133,471**	**1,277,795**	**1,398,825**

11.4 2021/22 SET ASIDE BUDGET

In addition to the above, there is a “Set Aside Budget” which is made available by the Health Board to the Integration Joint Board in respect of ‘’those functions delegated by the Health Board which are carried out in a hospital within the Health Board area and provided for two or more Local Authority areas’’. The total set-aside budget for 2021/22 was £235.618m, which excludes the budget value for Adult Mental Health and Elderly Mental Health inpatient services.

11.5 2021/22 FINANCIAL MANAGEMENT

The financial position for public services continues to be challenging. This required the IJB to have robust financial management arrangements in place to deliver services within the funding available in year, as well as plan for 2022-23.

Budget monitoring has reported an underspend throughout 2021-22. The IJB has continued to operate under the powers introduced by the emergency legislation in relation to Covid 19 during 2021-22. As a result, financial performance has continued to change as the IJB has been required to adapt in response to the challenges of the pandemic. The IJB has also experienced increased Scottish Government funding to meet the increased demand being experienced across client groups. This is reflected in the final operational underspend of £18.2m and is shown in the table below.

	Note	£ m
Impact of Pandemic on Service Delivery		
Underspend in personalisation care packages	1	-4.0
Underspend in purchased care home places	2	-5.8
Underspend in spend on supplies and services and transport	3	-2.9
Total Underspend As a Result of the Impact of the Pandemic		**-12.7**
Operational Service Delivery		
Underspends as a result of vacancies and staff turnover	4	-8.5
Underspend as a result of increased income recoveries	5	-4.5
Underspend in prescribing budget	6	-1.8
Total Underspend in Operational Service Delivery		-14.9
Less		
Health visitor regrading currently unfunded	7	1.1
Non delivery of savings	8	2.8
One-off investment in property portfolio and IT infrastructure to support service delivery	9	1.6
Shortfall in funding provided to meet pay settlements for 2021-22	10	2.1
Homelessness - Operational Overspend	11	1.7
Total Pressures/Investments in Operational Service Delivery		9.3
Net Underspend in Operational Service Delivery		**-5.5**
Total Underspend Related to 21/22 Activity		**-18.2**

Notes

Impact of Pandemic on Service Delivery

1. The pandemic has impacted on the ability of our providers to respond to service demand during this period whilst complying with COVID guidance and restrictions such as infection control measures and social distancing. This has resulted in an underspend in personalisation care packages as a result of the Provider's inability to deliver support. In addition, some service users have chosen to temporarily reduce support.

2. The pandemic has continued to have a significant impact on care homes with an 8% decrease in admissions levels, but also a 39% increase in discharge levels being experienced compared to planning assumptions.

3. With services operating at reduced capacity during the pandemic this has resulted in underspends in some direct service budgets such as transport and supplies and services.

Impact of Operational Service Delivery

4. Employee recruitment continues to represent a challenge to the IJB. A range of factors are impacting on this including the scale of new Scottish Government funding to support our health and social care workforce and the associated recruitment, capacity of teams to recruit whilst responding to the pandemic, timescales to recruit and the availability of the skills mix required within the workforce market. We continue to align recruitment timescales with the availability of newly qualified professionals and undertake targeted recruitment and training strategies to develop existing and new staff to meet the skills requirements of our services. This will continue to be a priority in 2022-23.

5. Additional income has been recovered mainly from two sources, firstly through recovery of financially assessed client contributions which generated an additional £2.9m; and £1.7m from additional income linked to Unaccompanied Asylum Seeking Children based on cases accepted to date by the Home Office.

6. The IJB had a budgeted prescribing contingency £1.8m which was not required in 2021-22.

7. There is a funding gap in relation to Health Visitors following a national regrading which took place a number of years ago. This has resulted in an overspend of £1.1m, for which no funding has been made available nationally.

8. These are occurring mainly within the programmes for Maximising Independence and the Transport Review. Delivery of these savings will continue to be monitored though the Transformation Programme Board.

9. Opportunities have been taken to undertake one-off investment across the property portfolio and IT infrastructure as part of our continued commitment to support service delivery.

10. Full funding was not provided to meet the NHS and Council Pay Settlement for 2021-22. This has a resulted in an overspend in year.

11. The homelessness service does not operate in a full cost recovery model primarily due to the level of housing benefit which is recoverable from subsidies. As a result, as the number of units increase the deficit on the service will also increase. This deficit has increased from £1.1m in 2020-21 to £1.6m in 2021-22 and is reflective of the increase in the number of units which has been taken on during 2021-22.

In addition to this there are local and national priorities which will not be completed until future financial years and require funding to be carried forward (£94.2m). The relates to ring-fenced funding which has been received to meet specific commitments and must be carried forward to meet the conditions attached to the receipt of this funding. This is higher than normal and reflects the additional funding which has been secured during the year to implement national policy commitments. It is also reflective of the

timing of when this funding was received and the difficulty in securing full spend before the financial year end.

The IJB elected to transfer £111.6m to earmarked reserves for specific commitments in 2021/22 and £0.8m to general reserves as a contingency. This is in line with the IJB's reserve strategy. Details of this can be found here

11.6 CHANGE AND IMPROVEMENT

Within the Partnership, we have been taking forward a Transformational Change Programme which has been approved by the IJB across the entirety of the HSCP's business over the course of the last year, as described in Chapter 3 of this report. This Programme is being monitored via an Integration Transformation Board, chaired by the Chief Officer, the aims of which are to:

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

Delivery of the Transformation Programme is closely monitored by the Transformation Board and delivery of associated savings is reported regularly to the IJB and the IJB Finance, Audit and Scrutiny Committee through budget monitoring reporting. 97% of budget savings targets in respect of the IJB's Transformation Programme were achieved in 2021/22.

11.7 CAPITAL INVESTMENT AND PRIORITIES

Health and Care Centres

Final sign off on the business case for the North East Health and Care Centre was received from the Scottish Government in January 2022, and financial close achieved February 2022. Work is due to commence on site in March 2022 with the site planned to be operational in 2025.

Tenders were awarded in February 2022 to undertake redesign and upgrading works at 6 of our Health Centre sites to develop the buildings and increase clinical room capacity to address the requirements for services developed as part of the Primary Care Improvement Plan. This work is scheduled to complete by October 2022 and it is planned to undertake a similar exercise during 2022/23 for the remaining Health Centre sites to ensure we are maximising the use of our primary care estate.

Children's Residential Provision

Glasgow City HSCP has a statutory requirement to provide the highest standards of care to vulnerable young people and we are proceeding with a programme of new build developments and refurbishments within children's residential services. During 2021/22 work resumed on Butterbiggins Road and Mosspark Drive, and the refurbishment of the Airth Drive property was completed. This investment will help to support high standards of care for children and young people and help facilitate their successful integration into the wider community.

Homelessness Services

Work relating to the Rodney Street extension progressed during 2021/22 and is due to be complete in April 2022 providing a permanent location for accommodation that currently resides within a temporary building following the closure of Clyde Place. Scoping work has begun on developing the property at Brighton Place to provide accommodation for young homelessness service users, with work anticipated to commence during 2023/24 and a site search is underway in relation to the provision of a new Women's Assessment Centre in the South of the City.

Sandyford

Work was completed during 2021/22 to enable relocation of the Sexual Assault Recovery Service (SARC) to the refurbished William Street Clinic from the previous location within Sandyford Central.

Other Sites

Work was completed at Blair Court to accommodate Out of Hours and Standby Services and work was completed on the relocation of the Homecare Training Centre from Edgefauld Road to a purpose built facility in Albion Street.

11.8 FINANCIAL OUTLOOK FOR 2022/23 AND BEYOND

The financial position for public services continues to be challenging and the IJB must operate within significant budget restraints and pressures. In March 2022, the IJB conditionally approved its budget for 2022/23, subject to receipt of a final funding offer from NHS Greater Glasgow and Clyde in the new financial year. The IJB will be required to further consider its budget later in the financial year once a final funding offer is known.

This draft budget identified a potential funding gap of £6.1m which will be addressed through a wide range of service reforms and efficiencies to address budget pressures in 2022/23 and support achievement of the National Health and Wellbeing Outcomes. Progress on achievement of this programme will be reported during the year to the IJB and the IJB Finance, Audit and Scrutiny Committee and in the 2022/23 Annual Performance Report.

A Medium Term Financial Outlook was also reported to the IJB on the 23 March 2022. This considers a range of pressures and uncertainties to assess the likely impact on the IJB's financial position over the medium term. Examples include:

- National commitments such as uplifts for social care providers and policy commitments in relation to Primary Care, Mental Health, Carers, Alcohol and Drug Partnership
- Inflationary pressures linked to pay and contractual commitments
- Impact of COVID-19 on people's health, wellbeing and the economic impact including income, employment and housing
- Local pressures linked to demand as a result of demographic, deprivation and health
- Financial cost of responding to the pandemic and the impact of delivery on our transformation programme.

This looks forward to 2024-25 and identifies the need for a further £54m of savings to deliver a balanced budget in 2023/24 and 2024/25.

The IJB is operating in an increasingly challenging environment with funding not keeping pace with increasing demand for services and increasing costs linked to delivery. Our response to the pandemic has also brought with it a number of challenges as well as opportunities to deliver services in a different way. The financial impact of implementing the required changes to services and service delivery models e.g. to support social distancing requirements, support staff with the appropriate protective equipment and manage the new and changing levels of need and demand, is significant and likely to be ongoing and evolving.

Delivery of effective and lasting transformation of health and social care services is central to the vision of the IJB. The IJB's Strategic Plan for Health and Social Care 2019 – 2022 outlines its ambitions over the medium term and the transformation programme which supports delivery. Our ability to deliver this during a pandemic has been challenging and will require us to develop a financial strategy which will support phased delivery which reflects system capacity to deliver.

The IJB is clear about its overall commitment to service reform and innovation. This is not just about changing the ways in which services are structured. It is a significant change in how they are planned and delivered. The IJB has approved transformation programmes for Adults, Older People, Children and Families Services and Primary Care. This includes the Maximising Independence Programme which will seek to deliver a sustainable health and social care service for the City, which will focus on prevention and early intervention approaches and will encourage individuals and communities to support each other. This recognises that the best health and care outcomes are associated with the highest possible levels of self-management and independence. We need to change the way we work with people to reflect the way they live now, balancing the need for care and support.

The IJB has a clear strategy to support delivery of the Strategic Plan and also to ensure the IJB remains financially sustainable over the medium term. The IJB also understands the key risks and uncertainties linked to delivery and has clear actions in place to mitigate these. The current pandemic is impacting on the IJB's ability to support full delivery of the Strategic Plan, but it is also providing opportunities for us to consider new ways of working which could influence delivery of the Strategic Plan over the longer term. We will continue to work closely with all our partners and stakeholders to secure a future which is sustainable and meets the needs of our communities and we remain committed to this as we move forward into 2022/23.

APPENDIX A

Glasgow City Profile – Additional Information

Department of Work and Pensions (DWP) Stat-Xplore	Provides data on DWP benefits – regularly updated.
Glasgow City Council Planning and Building - Factsheets and Statistics	Links to further sources of information on the city's population and needs including data by ward.
Glasgow City HSCP Health Improvement Annual Report 2020/21	This report highlights the work that Health Improvement has led on or been involved in supporting in the last year.
Glasgow City HSCP Strategies and Plans	This webpage provides links to the key strategies and plans of the Glasgow City Integration Joint Board and Glasgow City Health and Social Care Partnership.
Glasgow Community Planning Partnership Thriving Places	Further information on locality planning in Glasgow being delivered in 10 of 56 neighbourhoods in the city. These 10 neighbourhoods are particularly deprived in comparison to the rest of the city and are covered by the Thriving Places programme.
Glasgow Health and Care Experience Survey	This is used for measuring perceptions in relation to GP, care and carers services. It also measures progress against the national integration indicators. The latest survey results available are for 2019/20.
HSCP Demographics Profile for Glasgow City	Last updated May 2022, includes general population estimates and projections at HSCP locality, city and national level plus a profile of health in the city.
National Records of Scotland (NRS)	Official statistics on registrations of births, deaths (inc. COVID 19), marriages, adoptions in Scotland. Annual population estimates and bi-annual projected population estimates.
NHS Greater Glasgow and Clyde Health and Well-being Survey - Glasgow City Main Report NHSGG&C Health and Well-being Survey Glasgow City Summary Report 2017/18	Survey information on adult health and behaviours in the city. A suite of full and summary reports for the 2017/18 survey for Glasgow City and each of the 3 localities within the city are available in addition to reports for other local authority and HSCP areas.

NHSGGC Glasgow City Schools Health and Wellbeing Survey 2019-2020	Survey Information on S1-4 secondary school children's health and behaviours in the city. The latest published survey was for 2019/20.
NOMIS	NOMIS is a service provided by the Office for National Statistics, ONS, which provides access to detailed and up-to-date UK labour market statistics from official sources.
Public Health Scotland (formerly ISD Scotland)	Provides robust and extensive health information and health intelligence from data collated mostly from services provided through the NHS in Scotland.
Scotland's Census	Takes place every 10 years with results from the 2011 Census available online. The 2022 Census has taken place, postponed in Scotland from 2021 due to COVID 19. First results for the 2022 Census are likely to be available online from 2023.
Scotland's Labour Market People Places Regions Statistics - Annual Population Survey	Annual household survey providing headline estimates on employment, unemployment and economic inactivity. Latest data from 2020/21.
Scottish Burden of Disease Study	ScotPHO hosted study of health inequalities comparable internationally. Local reports and interactive visual data dashboards available from 2019.
Scottish Government Statistics	Scottish Government statistics website pre-dating the website above that still contains some national statistics publications or data not offered via other platforms e.g. homelessness data.
Scottish Health Survey 2019 (dashboard)	Information in relation to the health and health related behaviours of the population of Scotland. Annual national survey with latest results from the 2019 survey.
Scottish House Condition Survey	Annual national survey looking at the physical condition of homes as well as the experiences of householders. Latest results from 2019.
Scottish Household Survey	Annual national survey providing robust evidence on the composition, characteristics, attitudes and behaviour of private households and individuals as well as evidence on the physical condition of Scotland's homes. Latest results from 2019.

Scottish Index Multiple Deprivation (SIMD) 2020	Uses multiple indicators to provide comparative information on population deprivation at a small area level (data zones) within Scotland.
Scottish Public Health Observatory profiles (ScotPHO)	Presents a range of information from routine health statistics to survey data. Some data is available at small area level (e.g. intermediate zone of HSCP locality). Updated on an ongoing basis.
Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS)	A national survey of secondary school pupils in Scotland covering smoking, drinking, drug use and other lifestyle, health and social factors including mental wellbeing. Latest national results from 2018.
Scottish Surveys Core Questions (SSCQ)	An annual Official Statistics publication. SSCQ is a result of a harmonised design across the three major Scottish Government household surveys - the Scottish Household Survey, the Scottish Health Survey and the Scottish Crime and Justice Survey. Latest data form 2019.
Skills Development Scotland Annual Participation Measure	Provides data on the learning, training and work activity of 16-19 year olds in Scotland. Latest data from 2021.
statistics.gov.scot	Scottish Government statistics website offering a wide range of official statistics from multiple sources including population, government statistics and survey data.
UK Government	Provides access to many statistics at UK and local authority level inc. children in low income families statistics.
Understanding Glasgow Profiles	Health and wellbeing profiles for adults and children.

APPENDIX B

National Health and Wellbeing Outcomes

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

APPENDIX C – NATIONAL INTEGRATION INDICATORS

The Core Suite of 23 National Integration Indicators was published by the Scottish Government in March 2015 to provide the basis against which Health and Social Care Partnerships can measure their progress in relation to the National Health and Wellbeing outcomes. As these are derived from national data sources, the measurement approach is consistent across all Partnerships. The Integration Indicators are grouped into two types of measures. Numbers 1-9 below are Outcome indicators based on feedback from the biennial Scottish Health and Care Experience survey (HACE), which was undertaken using random samples of approximately 15,000 patients identified from GP practice lists in the city. The remaining indicators are derived from partnership operational performance data. Of these Operational indicators, 10 are currently reported upon, with a further 4 indicators currently under development by NHS Scotland Information Services Division (ISD).

Health and Care Experience Survey (HACE) Indicators

1. Percentage of adults able to look after their health very well or quite well.
2. Percentage of adults supported at home who agree that they are supported to live as independently as possible.
3. Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.
4. Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated.
5. Percentage of adults receiving any care or support who rate it as excellent or good
6. Percentage of people with positive experience of care at their GP practice.
7. Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.
8. Percentage of carers who feel supported to continue in their caring role.
9. Percentage of adults supported at home who agree they felt safe.

Operational Indicators

11. Premature mortality rate per 100,000 population.
12. Rate of emergency admissions per 100,000 population for adults.
13. Rate of emergency bed days for adults per 100,000 population.
14. Rate of readmissions to hospital within 28 days of discharge per 1000 admissions.
15. Proportion of last 6 months of life spent at home or in community setting.
16. Falls rate per 1,000 population in over 65s.
17. % of care services graded ‘good’ (4) or better in Care Inspectorate Inspections.
18. % of adults with intensive needs receiving care at home.
19. Number of days people aged 75+ spend in hospital when they are ready to be discharged per 1000 population.
20. % of health and care resource spent on hospital stays where the patient was admitted in an emergency. (Please note that NHS Boards were not able to provide detailed cost information for 2020/21 due to changes in service delivery during the pandemic. As a result, PHS have not provided information for indicator 20 beyond 2019/20 so this Indicator has not been included in this report).

Under Development

10. % staff who say they would recommend their workplace as a good place to work.
21. % of people admitted from home to hospital, who are discharged to a care home.
22. % of people who are discharged from hospital within 72 hours of being ready.
23. Expenditure on end of life care.