Item No: 15

Meeting Date: **Wednesday 20th June 2018**

Glasgow City Integration Joint Board

Report By: **David Williams, Chief Officer**

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ANNUAL PERFORMANCE REPORT

Purpose of Report:	To present the Annual Performance Report for the Health and Social Care Partnership for the year 2017/18.

Background/Engagement:	The IJB have previously agreed that an Annual Performance Report would be produced and presented to them each year. This is in addition to the regular Performance Report which is presented to the IJB on a quarterly basis. The first Annual Report was presented in June 2017 covering 2016/17.

Recommendations:	The Integration Joint Board is asked to: a) approve the attached Annual Performance Report; b) note that some final year-end figures will be included once available; and c) approve that responsibility for any final amendments to the report to incorporate these year-end figures will be delegated to the Chief Officer.

Relevance to Integration Joint Board Strategic Plan:

This report reviews performance against agreed local and national performance indicators and against the commitments within the Glasgow City IJB's first Strategic Plan.

Implications for Health and Social Care Partnership:

Reference to National Health & Wellbeing Outcome:	HSCP activity and performance within the report is mapped against the Partnership's strategic priorities and the 9 national health and wellbeing outcomes.

Personnel:	None

Carers:	The report includes a section relating to carers.

Provider Organisations:	None

Equalities:	None

Financial:	None

Legal:	The Integration Joint Board is required by statute to produce a performance report within four months of the end of each financial year (by 31 July).

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 performance indicators previously reported to the Council.

Implications for NHS Greater Glasgow & Clyde:	The Integration Joint Board's performance framework includes performance indicators previously reported to the Health Board

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 and to the note that year-end figures will be included once available.

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. Guidance on these Annual Performance reports was produced by the Scottish Government in March 2016.

2.2 This Annual Performance Report is required to be published within 4 months of the end of each reporting year. The 2017/18 report requires to be published no later than 31 July 2018.

3. Recommendations

3.1 The Integration Joint Board is asked to:

a) approve the attached Annual Performance Report;
b) note that some final year-end figures will be included once available; and
c) approve that responsibility for any final amendments to the report to incorporate these year-end figures will be delegated to the Chief Officer.

DRAFT ANNUAL PERFORMANCE REPORT 2017/18

Version 4

CONTENTS

FOREWORD

We are pleased to provide this foreword to the second annual report by Glasgow City IJB on the performance on integrated health and social care provision within the city.

The last year has seen some significant strides forward by the IJB and the operational vehicle reflecting the Partnership, the HSCP, in working towards delivering not just the nine National Health and Wellbeing Outcomes, but also the spirit and principles behind the Public Bodies (Joint Working) (Scotland) Act.

In relation to the IJB itself, there has been a significant turnaround in membership through this year following the May 2017 election with six new Councillors. Pleasingly, this has not impacted on the general approach that has been the hallmark of the Glasgow City IJB since it was constituted in February 2016, that is, one of achieving consensus amongst voting and non-voting members, on delivering transformation of health and social care provision.

This approach is exemplified by the fact that in 2017/18 there was not a single vote within any IJB meeting and the Board has agreed significant change by consensus on transformation programmes for Older People's Services; Children's Services; and Adult Services In the past year the IJB has also set out its Commissioning Intentions which committed to, amongst other things, the developing Alliance Commissioning with the voluntary and independent sector in homelessness provision, and the re-tendering for the Framework in adult social care provision both of which will deliver in 2018/19.

The IJB has also taken some notably courageous decisions in respect of investment in forensic medical services and healthcare provision at Low Moss Prison in the face of significant historic underfunding in these two areas. The IJB has agreed to HSCP officers working jointly with Scottish Prison Service on the development of the Maryhill Community Custody Unit, the first in Scotland and anywhere in Europe, to be opened in late 2020, and continued to provide full backing to the development of the UK's first Safe Drug Consumption Facility. In this vein of courageous decision making, the IJB hasn't shied away either from making difficult decisions with regard to long-standing but ineffective service provision. It has approved for instance, the closure of a specialist fostering service following a full review by the HSCP which unequivocally demonstrated that the service was not achieving good outcomes for young people; and agreed the review of how assisted garden maintenance is delivered in the city.

The annual report can only ever provide a snapshot of the overall performance of the IJB in delivering its Strategic Plan and its aspirations to transform how health and social care is planned, delivered, received and experienced. The size, scale, (multi) complexity, history, culture, expectation within and across a city the size of Glasgow necessarily means that it would be impossible to produce an all-encompassing definitive report that establishes unequivocally that the IJB is delivering the nine National Health and Wellbeing Outcomes. We're clear that the IJB has only been functioning for the last two years but what we hope this report is able to convey to the reader is that progress has been made; there is a strong culture of joint working established in some key areas across the Partnership, and that is developing in others. There is much further work still to be done of course but we firmly believe the IJB in Glasgow has demonstrated there is a will to deliver the transformation of health and social care and the hard work that is necessary to deliver on that shared commitment is being applied on a daily basis.

Councillor Mhairi Hunter
Chair, Glasgow City Integration Joint Board

Trisha McAuley OBE
Vice Chair, Glasgow City Integration Joint Board

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 second report for the Glasgow Integration Joint Board (IJB) and within it we look back upon the last year (2017/18). Within it, we review our performance against agreed local and national performance indicators and against the commitments set out in our first Strategic Plan which covered the period 2016-19.

We have commenced the process of reviewing this Strategic Plan and will be producing an updated version for the period 2019-22. Within this report, however, we focus upon how we have been taking forward the priorities and commitments from the first Strategic Plan, which remain relevant.

1.2. Partnership Overview

i. Organisational Profile

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

Across these services, the Health and Social Care Partnership (HSCP) directly employs approximately 7250 staff and has a total budget in the region of £1.1 billion (see chapter 4). Within the Partnership's area, there are 150 GP practices (over 430 GPs) providing general medical services to their practice populations, of whom approximately 100,000 live outside the city boundary. There are also 145 dental practices and five orthodontic practices, 163 community pharmacies and 113 optometry practices.

ii. Locality Management Arrangements

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

iii. Performance Management Arrangements

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

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

There are, therefore, a range of mechanisms in place to scrutinise performance within the Partnership, which enables areas for improvement to be identified and actions taken forward and monitored on an ongoing basis.

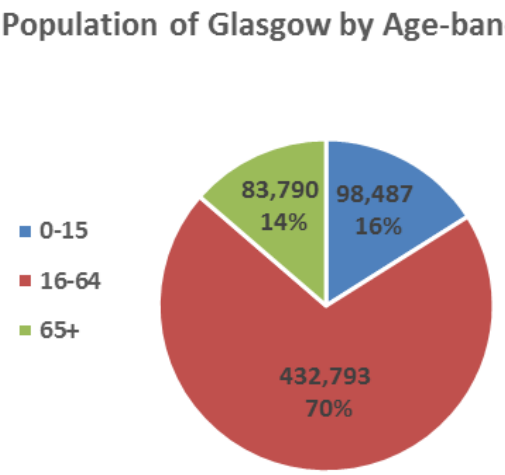
In addition to service performance, the health improvement team, in partnership with the wider public health intelligence community, also undertakes periodic population surveys, analyses and tailored needs assessments, in order to compare population health and well-being trends and inform future planning.

1.3. Area Profile

A full profile of the city was set out in the 2016-19 Strategic Plan. Some of the key characteristics are described below. A list of additional information sources where further information can be found are listed in **Appendix B**.

i. Population

The 2016 population of Glasgow City is 615,070, 11.4% of the total population of Scotland (Source: National Records of Scotland - NRS). The breakdown of population by age-band is shown in the following chart.



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

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

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

Mirroring national trends, the population of Glasgow is ageing. As shown above, it is anticipated that there will be increases in the older people population (65+) of 14.4% between 2016 and 2026; and 43.4% between 2016 and 2041. The increase in the 75+ population is expected to be even higher, at over 54.8% between 2016 and 2041.

A lower increase (1.1%) in the adult population (16-64) is expected between 2016 and 2041, although the number of adults is expected to fluctuate in the intervening years. The child population (0-15) is projected to increase by 6.7% between 2016 and 2026, after which it is likely to decrease steadily giving an expected overall rise between 2016 and 2041 of 2.6%.

ii. Deprivation

Glasgow City contains 4 in 10 of the 15% most deprived data zones in Scotland, the highest proportion for any local authority, according to the 2016 Scottish Index of Multiple Deprivation (SIMD 16). 127 of these most deprived data zones are in the North East of the city, while the North West has 87 and South 106. More than 40% of Glasgow's entire population live in one of these 320 data zones, with 59% of these people living in the North East of the City.

iii. Health and Social Care Needs

- The 2016-17 life expectancy for a Glasgow male is 72.9 years compared to 77.4 years for a Scottish male. For females, it is 78.2 years for Glasgow and 81.3 for Scotland. Life expectancy is forecast to increase steadily for both males and females but the gap between Glasgow and Scotland is likely to remain (National Records Scotland (NRS) 2016 population projections).

- Healthy Life Expectancy (HLE) at birth for males in Glasgow is currently 58.7 years and for females 59.2 years, both far lower than the Scottish averages of 62.2 years for males and 63.4 years for females (Office for National Statistics (ONS) 2014-2016 UK HLE comparisons).

- The 2016 Scottish Health Survey (SHeS) estimates that 12% of Glasgow adults (age 16+) have bad/very bad health compared to 8% of Scotland's adults. 33% of Glasgow adults are reported by the SHeS as having a limiting long term illness compared to 32% of Scottish adults.

- More than 50,000 Glasgow people claim incapacity benefit/severe disablement allowance/employment and support allowance representing 9.8% of the 16+ population, compared to a Scottish rate of 6.1% (May 2016 Department of Work and Pensions (DWP)).

- During the 2014-2016 period Glasgow had a far higher rate of people aged 65+ with multiple emergency hospitalisations at almost 7,400 per 100,000 population compared to 5,400 per 1000,000 population for Scotland (Information Services Division (ISD) 2014/16).

- Around 9.3% of people in the city carry out unpaid caring duties – equal to the Scottish average rate (Scotland's Census 2011).

- 21% of Glasgow adults are estimated to suffer from common mental health problems compared to 16% of Scottish adults. Far higher proportions of females (25% for Glasgow and 17% for Scotland) than males (17% for Glasgow and 14% for Scotland) are affected in both Glasgow and Scotland (2016 SHeS GHQ12).

- A higher rate of Glasgow people experience more severe mental illness than nationally. More than 2,000 Glasgow people were hospitalised for psychiatric reasons between 2013 and 2016 equivalent to a rate of 359 per 100,000 population compared to the Scottish rate of 270 per 100,000 population. (ISD 2013/14 – 2015/16 3 year aggregate).

- An estimated 30% of Glasgow males are potential problem drinkers and 18% of Glasgow females, both far higher than the equivalent Scottish averages of 24% for males and 12% for females (2016 SHeS).

- The rate of alcohol related hospital stays for Glasgow is the highest of any local authority in Scotland and more than double the Scottish average. In 2016/17 there were almost

1,340 stays per 100,000 population in Glasgow compared to a rate of 690 per 100,000 population for Scotland (ISD 2017).

- Glasgow has an estimated 13,000 problem drug users, most of whom also consume alcohol on a daily basis. There were almost 2,000 drug related hospital stays in Glasgow during 2016/17 - a rate of 304 per 100,000 population, nearly twice the Scottish rate of 162 per 100,000 population (ISD 2017).

1.4 Strategic Vision and Priorities

i. Strategic Plan

In accordance with the Public Bodies (Joint Working) (Scotland) Act 2014, we prepared a Strategic Plan for the delivery of those functions which have been delegated to the Integration Joint Board by Glasgow City Council and NHS Greater Glasgow and Clyde. This plan, which covers the period from 2016-19, sets out our agreed vision and priorities for health and social care services in Glasgow, as set out below. We have now begun the process of updating this Plan for 2019 - 2022.

Progress in taking forward the current Strategic Plan continues to be monitored through the range of Strategic Planning Groups which have been established in the city. Within this report, we capture some of our key achievements in relation to delivering the vision and priorities set out within the Plan and the nine National Health and Wellbeing outcomes (**Appendix B**).

ii. Our Vision

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

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

iii. Our Priorities

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

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

1.5 Structure of the Report

In chapter 2, we describe progress which we have made over the course of the last 12 months for each of the agreed strategic priorities described in section 1.4 above. Where relevant, performance indicators and trends affected by these developments are highlighted, along with user/carer feedback and case studies which seek to demonstrate our impact on the nine national Health and Wellbeing Outcomes

In chapter 3, we provide an overview of our three localities. We describe their management arrangements, along with the engagement mechanisms they have established and how these have been used. We also describe the locality planning processes and highlight some of the key developments progressed over the last year in each locality.

In chapter 4, we provide a summary of our financial performance for 2017/18. 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 2018/19 considered.

Finally, in chapter 5, we provide a more comprehensive overview of performance, drawing on a range of sources including our agreed local key performance indicators, national integration indicators, national inspections and key survey findings. Where available, performance in relation to our local performance indicators is shown for the end of 2017/18, with comparisons made to the end of 2016/17 and 2015/16.

2. DELIVERING OUR KEY PRIORITIES

2.1 INTRODUCTION

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

- Early intervention, prevention and harm reduction
- Providing greater self-determination and choice
- Shifting the balance of care
- Enabling independent living for longer
- Public Protection

In the following sections we highlight some of the key service developments and improvements undertaken in relation to our Strategic Priorities over the last year. We also describe any associated activity or performance trends and where relevant, draw upon some of the local Key Performance Indicators which are reported quarterly to the Integration Joint Board.

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

In section 2.7 we then focus on our staff and how we have engaged with and supported them over the last 12 months. Finally, in section 8, we consider how we have taken forward our statutory duties and responsibilities in respect to equalities.

2.2 EARLY INTERVENTION, PREVENTION AND HARM REDUCTION

Within this section, we profile some of the key developments progressed in relation to our strategic priority of Early Intervention and Prevention. These activities have contributed to a range of the 9 national Health and Wellbeing Outcomes, most notably those shown below. Other examples, particular to each locality within the context of the Thriving Places approach, are also described in the localities section of this report.

Outcome 1	People are able to look after and improve their own health and wellbeing and live in good health for longer
Outcome 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

i. Community Smoking Cessation Service

A City wide review of the community smoking cessation model identified a number of improvement actions which continued to be implemented this year. For example, a new City Tobacco Group was set up in October 2017, led by Health Improvement, to develop a consistent, evidence based and cost effective approach for the delivery and development of tobacco work. The group has developed an action plan with clear priority areas to ensure consistency of delivery & monitor performance across the city. The group has identified key areas of good practice which will be adopted across the City and has developed new & innovative ways of working to increase numbers accessing community cessation groups, including the development of "golden ticket" invites to clients to encourage re-engagement with the service, and targeted Facebook campaigns.

In order to improve performance going forward, we have identified key areas where we will concentrate our efforts with the aim of increasing referrals to the community service. We will work closely to further build relationships with identified GP practices, primary care cluster groups, primary care implementation groups and pharmacies in our most deprived communities, in order to increase awareness of and referrals to our service. Our community smoking cessation service will also continue to provide support and contribute to quits which are recorded within services such as acute, maternity, mental health and pharmacy

At Q4 the service has seen **1240** people successfully quit smoking at 3 months in the most deprived areas, slightly below the target of **1388.** This is slightly below the 16/17 figure of 1250.

User Feedback
"Becoming Smokefree literally saved my husband's life. Fourteen months after stopping smoking, he suffered a stroke and was told by his consultant that he would not be alive today had he not quit when he did. Another benefit of us both stopping smoking is we enjoy more holidays and mini-breaks together. We feel that we are now financially better off as retired non-smokers than we were when we were both in full time employment and smokers". "I liked speaking to the Smokefree adviser, she listened, she understood and believed in me. I feel healthier since I quit, I don't get as breathless, and have more money to eat better".

The rates of women smoking in pregnancy have continued to decline and at the latest period, targets were being met as shown below.

Period	**Target**	**Apr 15 - Mar 16**	**Apr 16 - Mar 17**	**Jan 16- Dec 17**
Women smoking in pregnancy – General Population	**13%**	13.7%	13.4%	12.9%
Women smoking in pregnancy – most deprived quintile	**19%**	20.7%	19.7%	18.5%

ii. Food and Nutrition

Poor diet remains a major risk factor for many conditions including heart disease, cancer and diabetes. Over the past year the HSCP, working alongside partners, has delivered a range of programmes to improve diet and lifestyle choices and mitigate the effects of food poverty.

These include the 'Weigh to Go Service', which targets 12-18 year olds, supporting them to manage their weight, increase their physical activity levels, develop skills to enable them to prepare healthy nutritious meals, and build confidence and self-esteem. In the last year, **102** young people participated in the programme in Glasgow City, compared to 100 in 2016/17.

A range of cooking skills programmes have also been delivered in communities across the city, including cooking with confidence; cooking on a budget; and shopping for healthy options. In addition, we have also supported a number of community gardening and growing projects, as well as community led food initiatives

Case Studies
A young mother of two children attended the 'Get Cooking, Get Shopping course', indicating that she wanted to learn how to cook given her reliance on ready meals. She was very quiet when the course started and lacking confidence, required more support than the others in the group. As the course progressed, however, her cooking skills and confidence increased dramatically. She started to become more involved in the pre-session discussions, began cooking at home and the tutor indicated that she 'had completely come out of her shell'. This was also shown in other ways, as she started to play a lead role in supporting her local parent & toddler group and had joined the group choir.

iii. Alcohol Brief Interventions (ABIs)

During 2017-18, we have continued to work with partners to promote the delivery of ABIs within wider community based settings, with the aim of ensuring they become embedded in operational staff practice. In the last year, we have also sought out new partners, with work being pioneered with the Glasgow Dental Hospital and Oral Health Directorate, to incorporate ABI into the syllabus for both 2nd and 3rd year under- graduate dental students.

The City has achieved its annual target of 5,066, with **6,470** ABIs being delivered. This compares with 7400 last year. Recorded numbers are believed to be lower as a result of changes in the GP contract which has had an impact on the recording of ABIs in primary care. Higher than anticipated delivery within the wider community settings has ensured that the target has, however, continued to be met. Efforts will continue to address any under-recording issues going forward to ensure all ABIs delivered are included.

iv. Breastfeeding

Mechanisms are in place in each of the 3 localities to ensure that relevant staff are trained and mentored in supporting infant feeding. UNICEF's Baby Friendly Initiative accreditation continues to be maintained across all localities and we are working towards achieving the Gold Award. In 2017, **868** were trained as part of the Breastfeeding Welcome Award and Breastfeeding Friendly Nursery programmes. This is a reduction on the previous year 2016 (998), partly as result of changes to the criteria for maintenance of the award, which mean organisations are required to demonstrate their eligibility on a 3 year cycle, as opposed to 2 years. Participants have included nursery staff, college students, primary care admin staff, a range of Glasgow Life staff, as well as local businesses and other partner organisations. Managers in-house cascade training has also been introduced as a measure to improve the sustainability of the awards and reduce the requirement for face to face training by Health Improvement staff going forward.

There are currently 10 breastfeeding support groups across the city and two baby cafes. Breastfeeding figures have risen over the last two years for both the general population and the most deprived communities, as shown below, building upon improvements noted in the Care Inspectorate report for services for children and young people in Glasgow (May 2017). While targets for the general population are being met, performance remains below target in

the most deprived areas although there has been continued improvement over the period shown below.

Period	Target	Apr 15 - Mar 16	April 16- March 17	Oct 16- Sep 17
Exclusive breastfeeding at 6-8 week review	24.5%	**25.3%** (1414 exclusive/ 5587 total)	**26.5%** (1425 exclusive/ 5368 total)	**27.5%** (1439 exclusive/ 5240 total)
Exclusive breastfeeding at 6-8 week review (15% most deprived data zones)	21.6%	**18.2%** (469 exclusive/ 2571 total)	**19%** (471 exclusive/ 2481 total)	**19.8%** (519 exclusive/ 2618 total)

v. Mental Health

a) Mental Health First Aid

We have supported Education Services in relation to their agreed strategic priority of mental health and wellbeing through delivery of Scotland's Mental Health First Aid (Youth). This is a 14-hour evidence-based blended learning course for adults who support young people between the ages of 11 and 17 and has been offered to teachers in all secondary schools in Glasgow, as part of their Continuing Professional Development. During 2017/18, **3** courses were delivered by North East and North West Health Improvement staff to **36** attendees from city secondary schools.

Teachers attending the course have used the knowledge and skills gained to implement a range of strategies to support the mental health and wellbeing of pupils in their respective schools. These have included lunchtime drop-in zones; organisation of mental health awareness week, which was used to launch a campaign emphasising the need to talk about mental health issues and tackle stigma; and opportunities for young people to participate in a range of mental health and wellbeing workshops.

Teacher Feedback

- "*Most worthwhile CPD I have ever been on".*
- *"I am now so much more aware of mental wellbeing amongst my peers and the young people I work with".*
- *"I feel I am now much more alert to what young people say with regards to their mental health and feel I am able to support them".*

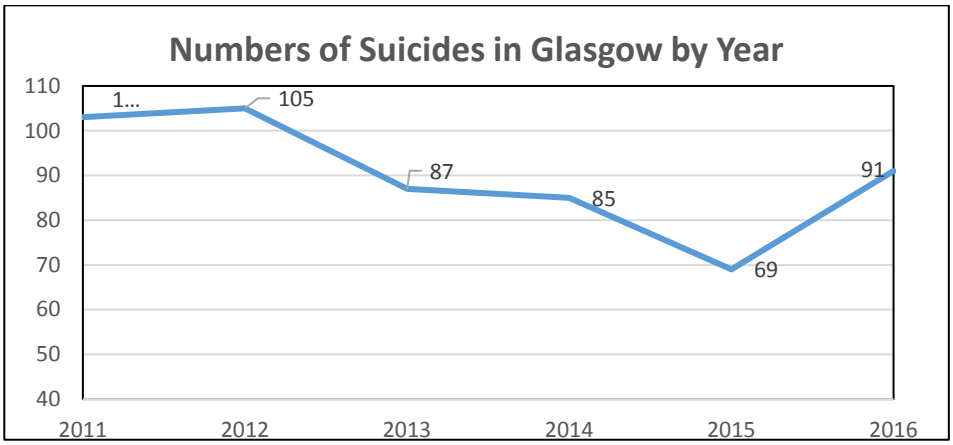
b) Mental Health Website and Social Media Project

There is recognition at HSCP, NHS, Local Authority and Scottish Government level of the importance of harnessing technology in promoting self-management and supporting our focus on prevention and recovery. Within Mental Health, development work has been undertaken on a website and social media project to support this agenda, which will be launched later in 2018/19. The design has been co-produced and involved a Glasgow School of Art Centre for Design Innovation project, with input from staff and local user and community representatives.

The website will provide a range of information about a variety of mental health conditions, including what helps, how to live with them, how to care for someone experiencing them, and how to find out more about them. Real life stories will also be included in video, audio or written form, along with members of staff sharing information on what someone can expect when they care seen by care professionals.

c) Suicide Prevention

After experiencing a significant reduction in deaths by suicide between 2011 and 2015, the numbers of deaths by suicide increased for the first time in several years in 2016, a trend reflected nationally.



All partners are continuing to work together to try and reduce deaths by suicide, which is being overseen by the multi-agency Glasgow City Choose Life Strategy Group, led by Glasgow HSCP. It has a range of suicide prevention training courses, including ASIST and SafeTALK, which are targeted mainly at NHS, social work and voluntary sector staff. In the past year, **15** ASIST courses were held attended by **273** participants; along with **20** SafeTALK courses attended by **240** participants. New SuicideTALK briefings were also introduced last year, targeted more at community members with **9** briefings delivered to **81** attendees from community groups, DWP staff, construction workers and housing staff amongst others.

We have continued to work with partnerships across NHS Greater Glasgow and Clyde on the EU-funded 'Aye Mind' programme for youth mental health, which is developing a range of digital resources to promote youth wellbeing at www.ayemind.com and on Twitter @ayemind99. A suite of training materials has also been developed including the "What's the Harm" training programme and the "On Edge" school curriculum resource.

Using mass communication, multiple media and creative methods is also an important part of the overall suicide prevention effort. One recent example has been support from the Glasgow Choose Life programme for the creation of a short film drama, "Bridge", by new Glasgow-based film company Stone Scissors Paper. This production presented a powerful message about "the kindness of strangers" and the benefits of intervention in situations of distress. The Health and Care Partnership collaborated in a civic launch event for the film held at City Chambers in March, with the world premier screening happening at the CCA in May as part of the Scottish Mental Health Arts Festival's short film event.

vi. Sexual Health

Sandyford Sexual Health Service (SHS) is hosted by Glasgow City HSCP on behalf of the six HSCPs in the Health Board area. It provides universal sexual health services, as well as specialist services for complex procedures and for specific population groups, many of which are also provided on a regional or national basis. During the last year, the service has been reviewed and we have been engaging with our service users and partners on proposed changes. These include new service models which aim to offer care in innovative ways, making better use of clinical time, further developing the nursing role, improving accessibility and making better use of resources.

Specific initiatives undertaken over the past year include efforts to better target the free condoms service at key population groups. For example, in response to the ongoing outbreak of HIV among people who inject drugs, the service has worked with needle exchange providers to ensure free condoms were available in all areas where the outbreak is concentrated. Youth organisations have also been engaged with, and the service has become kit sponsors for a young people's basketball team in the east end of the city. The large student population in the city have also been targeted, with the service working with partners to put free condom dispensers in further and higher education establishments and develop better signage and marketing for them. Free condoms were provided in all further and higher education campuses and in **19** student accommodation blocks. Overall, the service now operates from **308** venues across the city, an increase from 279 the previous year. During 2017, it provided **1,137,936 condoms** in Glasgow City, an increase from the previous year when 1,028,600 condoms were distributed.

Alongside these initiatives, the Sandyford health improvement team has been continuing to take forward the provision of comprehensive Relationships, Sexual Health and Parenthood education (RSHPE), which evidence has shown impacts positively on young people's sexual health, with delayed onset of sexual activity and less likelihood of negative physical and emotional consequences. The service has developed teaching programmes and training around RSHPE, which it has delivered to parents and carers, as well as to teachers, staff in children's health and social work services, and those working in informal youth settings. Over the course of the past year, over **330** people from across these settings have been trained.

In terms of performance, the service continues to successfully target key groups including men who have sex with men, with the % of male attendees who fall into this category consistently above target throughout the course of the last year (**42%** at March 2018 against a target of 10%). However, waiting times across a range of the services delivered have been longer than agreed targets and efforts continue to achieve improvements.

2.3 PROVIDING GREATER SELF-DETERMINATION AND CHOICE

Within this section, we profile some of the key developments progressed in relation to our strategic priority of Providing Greater Self-Determination and Choice. These activities 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 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

i. Learning Disabilities

a) Short Breaks

The Local Area Co-ordination (LAC) team have been developing and expanding the provision of short community breaks as an alternative to building based respite for people with a learning disability, in response to feedback from many service users who wanted to be "the Same as You", in how they exercise their right to choice and equality in relation to short breaks. **55** individuals now attend community short breaks, usually 4 times per year, who previously attended building based respite, with the numbers rising from 40 in the last 18 months.

Case Studies
The first short break was attended by three women who had been attending learning disability day centres for many years. Following the learning disability day service reform programme and personalisation, they were offered short breaks as an alternative to building based respite. The LAC team worked closely with the ladies and their carers prior to the break, providing reassurance where necessary as this was a big change in provision for them. The three ladies agreed they wanted to visit Blackpool and along with the LAC team and short break provider agency, picked a suitable hotel and a variety of activities. The ladies, now known as "The Blackpool Three", spent a long weekend there and have never looked back. They now regularly attend short breaks together and have maintained their friendships.

Feedback
"I love going away with my friends, it's great fun." "I wish I could have done this years ago." "We have so much to talk about now which wasn't the case before." "Our family life is better now, days before she goes on her next short break she has her bag packed. It's great for us all to see this."

b) Young People in Transition (YPIT)

The LAC team also support young people with learning disabilities as they leave school; working with them, their family and the professionals involved in their life, to agree a weekly programme of meaningful activities that will meet their needs and aspirations. During 2017, the team supported 32 young people in transition from school.

Case Study
Client A is an 18 year old girl who attended a special needs school in Glasgow leaving in May 2016. Her brother, Client B, who also attended a special needs school left in May 2017. Both have moderate learning disabilities. The LAC team worked with both of these siblings, ensuring they received community based support packages which met their assessed needs and provided a seamless transition from child to adult services. The transitional experience proved very positive for the whole family and both siblings are making great progress, as demonstrated by the feedback below. *"The LAC team helped our daughter and showed her that being out in the community isn't such a frightening thing. Firstly, by introducing her to new friends and clubs, then settling her with a service provider. Her confidence and self-esteem came on leaps and bounds as a result. The LAC team have shown her that she can learn to put her trust in new friends and her carers. When our son transitioned from secondary, the LAC team also showed us kindness, care and compassion. He found it extremely difficult to meet new people and tackle new places outwith his strict routine, but the LAC team has managed to help settle him".*

ii. Recovery Communities

We are continuing to take forward the development of alcohol and drugs services, including the roll out of an effective and earlier intervention approach across the city. A review of residential rehabilitation beds has also been carried out on a co-production basis, with a range of third sector providers and people who have experienced services. This review found that longer stays did not provide better outcomes for individuals, but that robust pre admission preparatory work did increase the likelihood of individuals completing the residential rehabilitation programmes.

In response, work is progressing to move towards recovery focused, shorter, more intensive programmes with stronger links to community services and the Recovery Communities. Around **600 – 800** people in the city participate in Recovery Communities in the course of a

week, with capacity growing on a continuous basis. Recovery Communities have strong aspirations for shifting cultures, creating community ownership and control, building on community assets and making best use of vital partnerships with service providers.

Case Study

I got involved in North West Recovery Communities during my stay in Phoenix Futures, as this was a commitment as part of the programme. I had been in and out of services for many years and soon discovered that the missing link was being part of a Recovery Community.

In my recovery I think it's vital that I am connected to people. I came from a past of isolation and had nobody to talk to that understood. Having done rehab, I was then around people who were also at the early stages of recovery, 24/7 for six months. I learned a lot about what I suffered from, and realised that I wasn't alone and needn't be alone again – as long I do what is suggested and keep my recovery as my top priority.

Being in recovery has allowed me to laugh again, appreciate my life and build relationships with people. I have found connections that I never thought I would. I have really good friends in my corner, a sponsor and connections with fellow people in recovery. Also by going to the Abstinence Project in Ibrox I further built my network and attended groups led by people in long term recovery, which have helped solve problems around my addiction.

I have found a balance and in addition to attending various recovery related groups and activities, I also spend time on myself by going to the gym and socialising and spending quality time with my family. I am looking to volunteer now and I hope to do other things to help spread the message that we can do this – recovery is possible! I need to keep reminding myself how far I have come from being on a host of medication, in and out of hospitals with serious mental health concerns, to now. Today the best things I have in my recovery is my mental health and HOPE!

iii. Children's Services

a) Corporate Parenting and the Young People's Champions' Board

Glasgow City HSCP has a corporate parenting plan which outlines a wide range of actions it will undertake to improve the quality of life and life chances for care experienced young people. A review of the first year of the implementation of the plan will be published in May 2018.

During the last year, Social Work Services and the Children's Right Team worked with Who Cares? Scotland and MCR Pathways, to establish a Young People's Champions' Board. The aim has been to ensure that the voices of young people are at the forefront of how we plan and deliver services for care-experienced children and young people, by establishing and embedding this Board within the city wide children's services planning structures. Funding for a development worker was secured from Who Cares? Scotland to support this.

Partners involved in the initial development group worked with residential services, foster care, continuing care and area team staff to identify care experienced young people, aged 14 plus, who were interested in getting involved in the Board. A core group of 8 were identified and are continuing members. Since January 2018, a more informal Participation Group has also been set up, which young people can attend when they wish to and it has been regularly attended by up to 8 young people.

User Feedback
Speaking about why they joined the Board, young people indicated "as a group we have the chance to influence the leaders of the council, corporate parents and others who can affect real positive change for care experienced young people. Together we can build more positive relationships with these bodies that have the power to help us achieve the changes we want".

b) Listening to Young People

As a Partnership it is important that we listen to our Children and Young People, particularly those who are most vulnerable. The Children's Rights Service (CRS) offers rights information, support and advocacy to children and young people from Glasgow who are looked after and accommodated, and to young people leaving care.

Social Workers also use several tools to help children and young people to express their views and encourage participation. In Glasgow, children and young people over the age of 5 who are looked after away from home; on the Child Protection (CP) Register; or subject to Vulnerable Young Person's (VYP) procedures; are offered the opportunity to use an interactive software package called Viewpoint in preparation for case reviews.

Viewpoint **a**llows the child or young person to complete a questionnaire; the questions being linked to the GIRFEC (Getting It Right For Every Child) Wellbeing Indicators: Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible and Included. The table below presents a selection of questions taken from the Viewpoint Survey, along with the percentage of children who responded positively. Some of the questions are not applicable to both categories of children shown, so this is denoted as "not applicable (n/a)".

Viewpoint Question	% responding positively in 2017/18 (16/17 figures shown in brackets)		Children's Wellbeing Indicator
	Children Looked after away from Home	Children on the CP Register or subject to VYP procedures	
Would you describe yourself as happy?	**92%** (94%)	**85%** (92%)	Healthy
Do you feel safe where you live now?	**96%** (99%)	n/a	Safe
Do you feel safe in your home?	n/a	**91%** (94%)	Safe
Are things going well for you?	**89%** (97%)	n/a	Achieving
Is your Social Worker someone you can talk to?	**85%** (94%)	**94%** (88%)	Respected
Do you enjoy school?	**78%** (92%)	**82%** (86%)	Achieving
Are you treated fairly where you live now?	**95%** (97%)	n/a	Respected
Do the people or person looking after you notice when you have done well at something?	**98%** (95%)	n/a	Nurtured
Do you think your views are listened to?	**88%** (93%)	**74%** (92%)	Respected
Do you take part in regular activities you like doing?	**92%** (93%)	**82%** (82%)	Active
Do you help out with the chores where you live now?	**78%** (81%)	n/a	Responsible
Do you see your friends when you want to?	**80%** (78%)	**68%** (79%)	Included

c) Family Group Decision Making

During the last year, we have progressed the Family Group Decision Making (FGDM) pilot and following impressive results have initiated the roll out across the whole city. FGDM is based on the principle of family and community empowerment and recognises the family as the greatest asset in the care planning process, ensuring collaboration and partnership with the child at the centre. A key aim is to transfer the control of decision making from professionals to the family group, reducing the need for long term statutory social work intervention and for children coming into local authority care. The model also works with children who are in care, ensuring a rapid return to family members wherever possible and reducing the need for long term foster care. Its scope has included children on the 'cusp' of care; children who have recently become accommodated; unborn babies who are likely to be subject to statutory processes; and young people aged 14 and over in high cost purchased/provided units often located out with Glasgow.

Using this approach, a trained independent facilitator engages with families and supports them to recognise the unmet need and risks for the child involved and to take the lead in

generating safe solutions for them. It involves individual face-to-face work with each family member, or family friend, who are identified as a significant person in the child's life. The families are then asked to work together with support if required, to develop a realistic plan which is owned by the wider family, meets the child's needs and keeps them safe.
This model has been extremely well received by front line staff and family members and owes much of its success to a close working partnership with education, third sector, health improvement and a strong partnership arrangement with Edinburgh City HSCP. In the first 12 months, the team received **415** referrals which has so far culminated in **58** family meetings, with agreed plans having a dramatic impact on the children involved, preventing their trajectory into care.

Alongside the launch of FGDM we have also introduced Extended Family Network Searches (EFNS), which seek to identify extended family members of children and young people who are in care or on the 'edge of care'. This has enabled relationships to be built or rebuilt and supported an increase in the number of kinship carers and placements in the city as alternatives to foster or residential care, substantially increasing the scope for reconnecting young people with their families. To date, **170** EFNS were completed and in total, **3084** family members were found who had not been known to Social Work Services previously. This creates enormous potential for ensuring a child remains connected to their family, retain an increased sense of identity and wherever possible, can be looked after by their extended family network as an alternative to local authority care.

Both FGDM and EFNS initiatives have generated substantial improvements for children and young people and generated major efficiencies, with a significant reduction in statutory involvement in children's lives. To date, a financial saving of £1.8m from reduced care costs has been achieved in the first 18 months of operation. In recognition of its success the FGDM team won the Scottish Association of Social Workers Team of the Year award in 2018, marking an excellent year for services designed around the family.

Case Study

In March 2017 two boys P (aged 14) and D (aged 8) were referred to FGDM, with a social worker describing this as a *"last gasp attempt before the boys were removed from their mother's care".*

In March 2015 they had been placed on the child protection register because of concerns related to their mother's mental health, alcohol and drug misuse history, behavioural problems, and child protection issues (child neglect). The children were not attending school and were missing health appointments to the extent that they were experiencing serious dental decay. There was very serious significant non-engagement on part of the mother, who did not turn up for meetings and wasn't responding to contact.

At the point the mother became involved with FGDM, a meeting was held in her mother's house. This was also attended by all the children's aunts and cousins who all wanted to come and be involved in the preparation work. Having all the family on board meant everyone understood the concerns, which they had not previously. One of the aunts was asked to become more actively involved and the boys' mother moved in with her own mum.

One of the FGDM workers stated that this was a major turning point with the mother *"realising how beneficial her family were to her; how much she needed them; and how they she was not on her own".*

The adversity the mother had experienced in the past for such a significant period of time, including bereavement and her own issues and trauma, had led to her feeling very isolated. However, eventually she was able to relay the trauma that she had experienced, having previously felt unable to talk about it.

There was also a great support team including social work, health, the school nurse and Barnardo's. The children attended school and health appointments and were checked up and monitored by other family members. The mother's mental health was managed and she attended meetings accompanied by family members. Her family could not believe the difference in her and they had their first family holiday in approximately ten years.

By May 2017, a comprehensive family plan had been completed and the risk to the children had been reduced substantially. Accommodation had been prevented and in June the children were removed from the child protection register. The chair of the review case conference noted :

"Mum's presentation has transformed – she has gone from an angry person who verbally abuses professionals then storms out, to a pleasant and fully participative woman, who thanked the various agencies and even gave the social worker a hug! Family members attended to support her, and they made really useful contributions as well".

iv. Employability

a) Learning Disabilities

There are a range of services in place to support priority groups to access and maintain employment opportunities. These include the Supported Employment Service (SES), which provides an all age supported employment service for people with learning disabilities and autism; as well as a project targeted specifically at young people between the ages of 18 – 29 years, which organises an intensive year of supported work experience within host businesses (currently Glasgow Royal Infirmary and the University of Strathclyde). During 2017/18, we supported **29** people into full time employment, building upon the 14 achieved in the first nine months of operation in 2016/17).

b) Care Leavers

Another key target group are care leavers, who experience significantly less positive employability outcomes than their peers on leaving school/care. Social Work services have developed four programmes tailored specifically for this group within its Continuing Care Team. These deliver a range of holistic employability supports for care leavers across the various stages of the employability pathway.

During 2017/18, **127** care leavers were supported, a decrease from 168 the previous year, as a result of staff departures. In terms of outcomes however, there has been a small improvement as shown below, although performance remains below the challenging target set for care leavers of 75% achieving a positive destination (employment, training or college place).

Target	16/17 Q1	17/18 Q1	17/18 Q2	17/18 Q3	17/18 Q4
75%	67%	65%	70%	69%	67%

c) Alcohol and Drugs

Elevate-Glasgow is a Public Social Partnership (PSP), formed to address a gap in service provision for individuals and their families affected by drug and alcohol. It is supported by Glasgow City HSCP, NHS Greater Glasgow & Clyde and the Glasgow Alcohol and Drug Partnership, in partnership with 30 third sector charitable organisations in Glasgow. Elevate aims to increase employability opportunities for individuals in recovery, reduce the number of adults in recovery who are unemployed and have a positive impact on their health and wellbeing. Placement opportunities have been provided by HSCP health improvement teams to 2 individuals in the last year, enabling them to gain work experience while working towards SVQ qualifications. One trainee who completed the programme, was supported to apply for employment opportunities and has since been successful in securing paid employment. Feedback from both is highlighted below.

User Feedback
"I had a very positive experience undertaking this training placement in the North West Health Improvement Team. The team was very supportive in helping me achieve the demands of the SVQ and I was considered a valuable member of the team. I would strongly recommend this opportunity to other trainees." *"I am thoroughly enjoying my time with the team here in the South Health Improvement. The team are friendly and welcoming. The work is productive and I am learning a lot through my SVQ3 Community Development work, attending training opportunities and by putting what I am learning into practice in the community at recovery initiatives".*

v. Personalisation

Personalisation, as outlined in the Social Care (Self-directed Support) (Scotland) Act 2013, has now been widely adopted across the City and is used as appropriate to individual needs and circumstances. At the end of March 2018, a total of **2,994** adult service users were in receipt of personalised social care services, an increase of **5.9%** since March 2017 (2,828). Children with disabilities in receipt of personalised services rose by **38%** over the same period (to **184**). Between March 2017 and 2018, there was no change in the proportion of service users who chose to receive their personalised budget as a direct payment with the figure remaining at **15%.**

vi. Power of Attorney

Power of Attorney (POA) is a written document giving someone authority to take actions or make decisions on another person's behalf if the person becomes incapable. Amongst other things, the consequences of not having a Power of Attorney can lead to people being delayed in hospital while awaiting legal documentation allowing them to be discharged. Glasgow previously launched a 'My Power of Attorney' public awareness campaign in 2013/14, which was subsequently supported by other neighbouring local authority areas.

This has been used in TV and radio advertising campaigns, bill posters, and various social media channels, as well as a dedicated website www.mypowerofattorney.org.uk. The campaign has continued to raise awareness and there is evidence of increasing demand for Power of Attorney with the numbers increasing in 2017, following on from a dip in 2016 which was reflected nationally and was due to a delay in processing by the Office of the Public Guardian. Nationally, HSCP Chief Officers have discussed building on these previous successes and agreed to share the costs for a 2018/19 campaign, which Glasgow will lead on.

2.4 SHIFTING THE BALANCE OF CARE

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

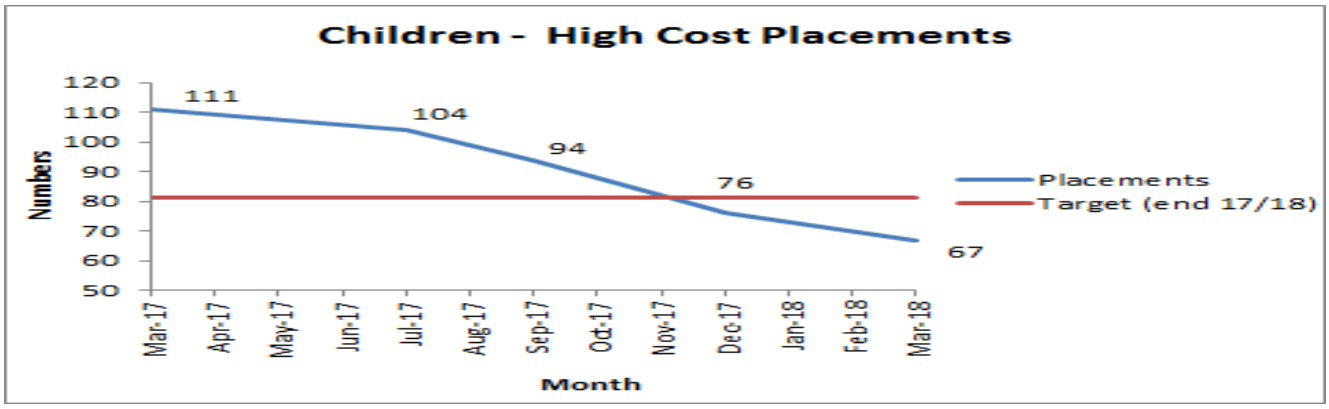
Outcome 1	People are able to look after and improve their own health and wellbeing and live in good health for longer
Outcome 2	People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
Outcome 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 9	Resources are used effectively and efficiently in the provision of health and social care services

i.Children's Services Transformation

Within children's services, we are seeking to ensure that more children are supported within the city itself and where possible, sustained at home and by their local neighbourhoods and schools. Key aims have therefore been to:

- Reduce reliance on high cost and/or out of city residential placements.
- Increase the focus on prevention and early intervention work being undertaken in partnership with a wide range of agencies working in the city.
- Enhancing community infrastructure and support.
- Developing comprehensive family support services for parents and carers in the most vulnerable neighbourhoods.

Over the last year, the number of high cost placements for young people has continued to fall, from **111** in March 2017 to **67** at the end of March 2018, meeting the target of achieving a reduction of **30** during 2017/18.



Over the course of 2017/18, the total number of children accommodated has fallen from 1227 to **1125**; with the number of children being looked after at home also falling from 1637 to **1614**. Overall, therefore, there has been fewer young people being looked after by the Council, which in part is likely to be linked to improvements in our assessment and care planning for children and joint work with family support services.

ii. Older People's Transformation

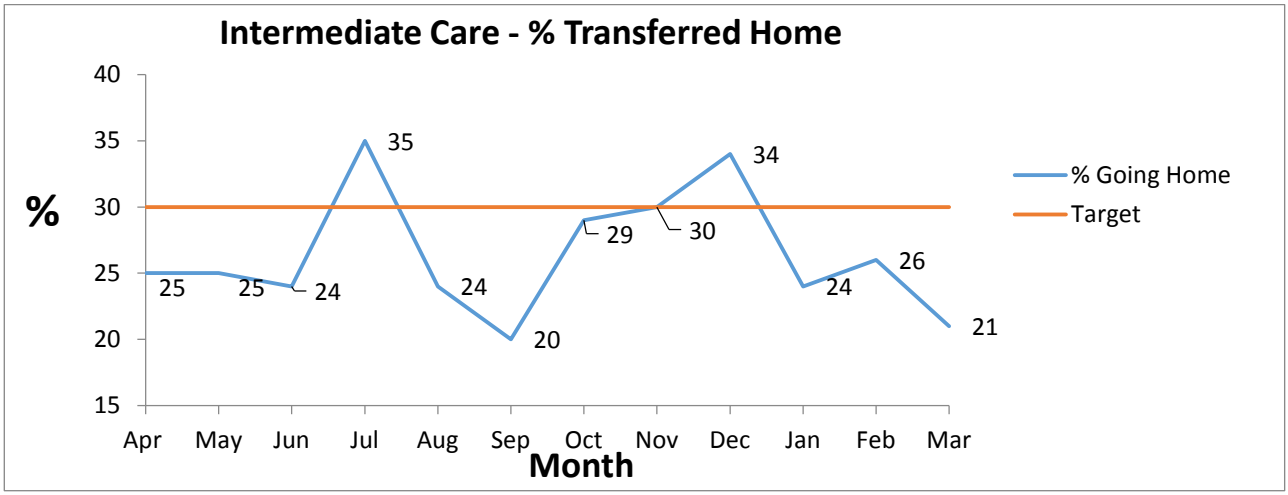
The demographic trends described in chapter 1, in particular the ageing population, are placing increasing demands and pressures on older people's services and budgets. In response, we have developed a range of initiatives which aim to support a shift in the balance of care away from institutional care (hospital and care homes) - which historically have had high levels of usage in the city - towards new community based service models, which focus upon rebuilding confidence and skills for independence amongst our older citizens.

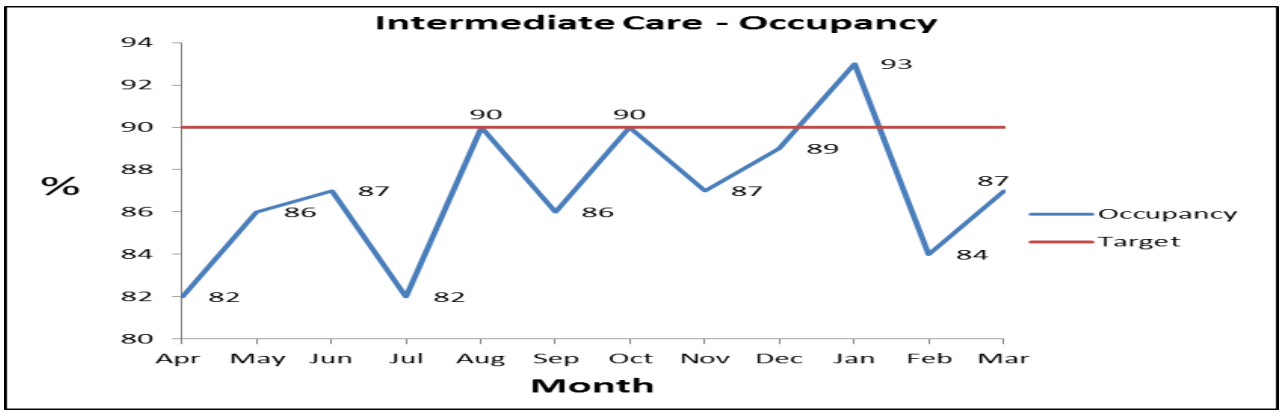
Within this section, we focus on those initiatives designed to reduce usage of institutional care and in section 2.5 describe some of the recent work being done to develop community infrastructure and supports.

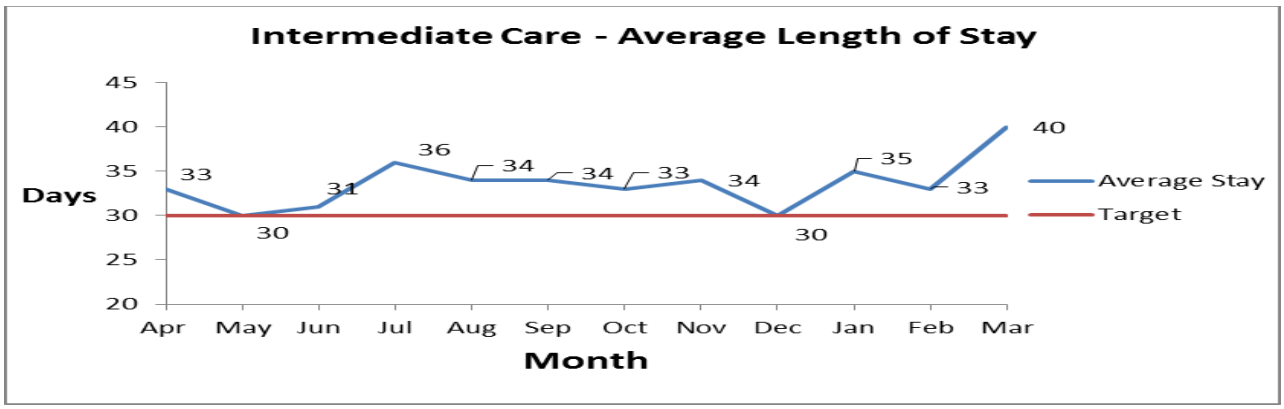
a) Intermediate Care

Intermediate care provides patients on discharge from hospital, with further rehabilitation and assessment, with the aim of preparing them for a return to their own home where possible. Over the course of the last year, we continued to develop the role of intermediate care in the city, introducing a service improvement programme which aims to develop practice and support increased throughput. Capacity was also temporarily increased to help alleviate pressures experienced during the winter period.

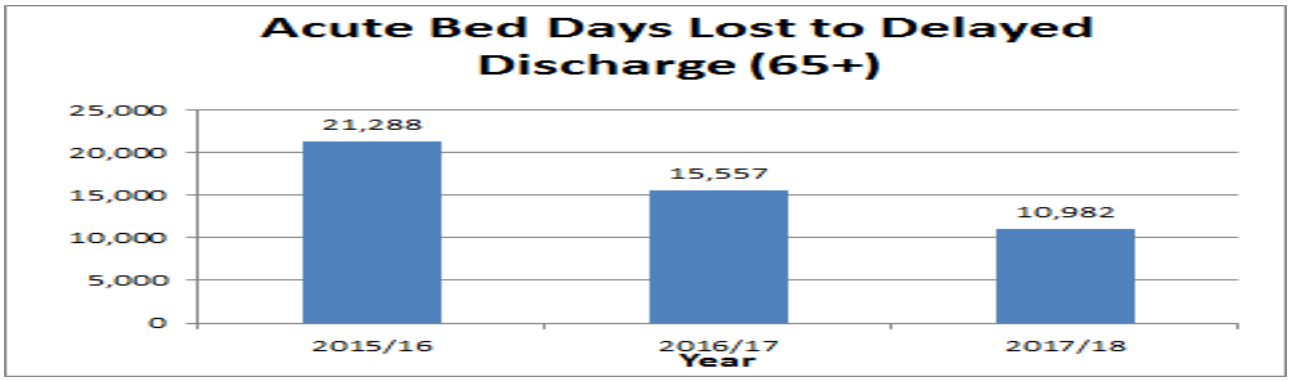
Key performance indicators in relation to intermediate care include average length of stay (target of 30 days or less); occupancy levels (target of 90% or above); and the percentage of people being discharged home (30% or more). Performance in relation to these has fluctuated over the course of 2017/18 as shown below and efforts will continue to ensure that targets are met more consistently.







In facilitating early discharge, intermediate care beds have contributed to recent trends in the total number of bed days lost to delayed discharge (65+). For the city as a whole there was a significant reduction between 2015/16 and 2016/17 (from 21,288 to 15,557), which has continued into 2017/18, with annual bed days lost falling by approximately **29%** to **10,982.**



b) Unscheduled Care Plan

Over the last year we have agreed a Strategic Commissioning Plan for Unscheduled Care and developed an Action Plan which sets out a programme of work, as set out below:

- Early intervention and prevention of admission to hospital to better support people in the community through for example:

  - expanding the supported living programme (risen from 576 to **734** in 17/18).
  - increasing the number of people with anticipatory care plans (risen from 484 to **824** in 17/18).

- developing a fall prevention programme with the Scottish Ambulance Service (fallen from 31 to **29** falls per 1,000 population aged 65+ in 17/18).
- developing the community respiratory service to better manage people with COPD in the community.
- expanding the community fast track palliative care service.
- reducing the number of hospital admissions from care homes.

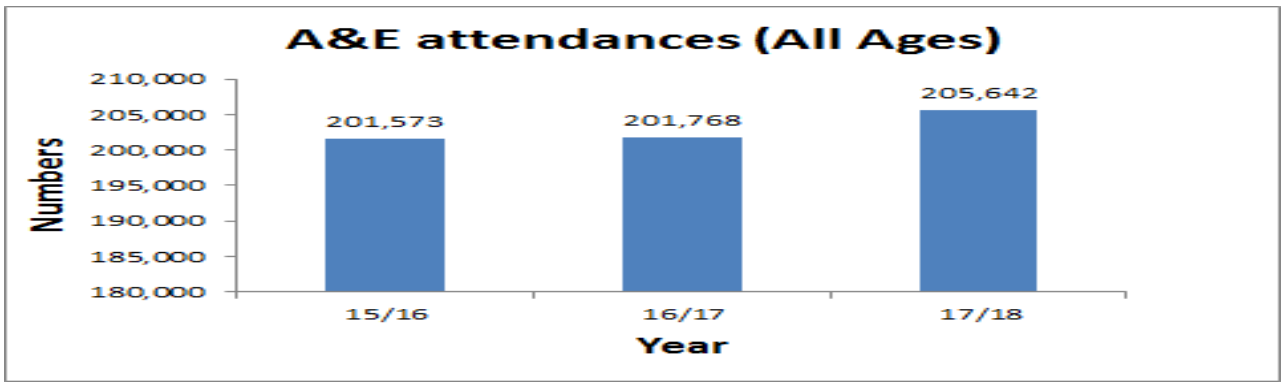
- Improving hospital discharge and better supporting people to transfer from acute care to community through for example:

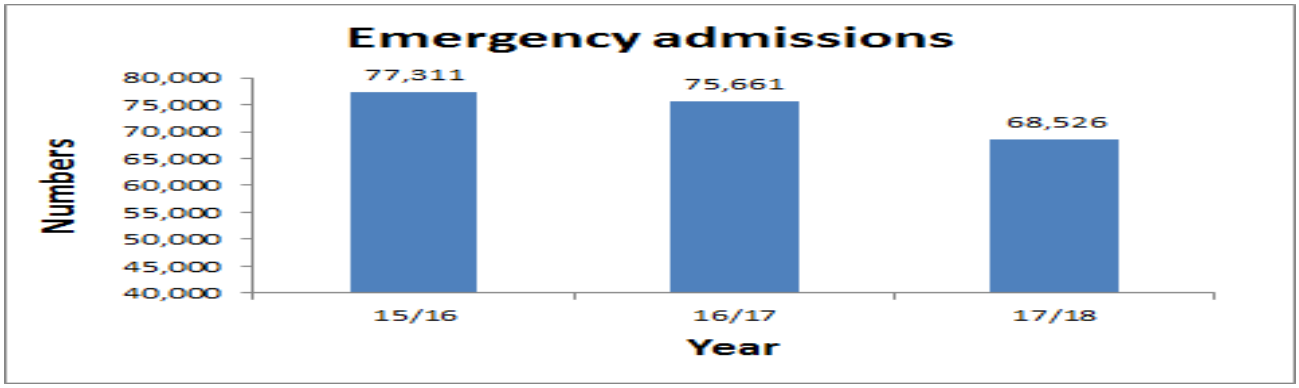
  - applying a robust process to improve the management of delayed discharges.
  - developing the model of intermediate care to increase the number of patients going home.
  - enhancing patient transport services by securing additional support from the Red Cross.
  - introducing a Home is Best team to improve discharge arrangements with our acute hospitals.

- Improving the clinical interface between GPs and secondary care clinicians

Joint unscheduled care working groups have been established at city and Health Board wide level. These are intended to strengthen partnership working between HSCPs and Acute Services to support delivery of the above aims. Progress in delivering these continues to be reported nationally to the Ministerial Strategic Group for Health and Community Care (MSG), who have also asked for plans to be submitted in relation to a number of unscheduled care indicators including delayed discharges, A&E attendances; and emergency admissions (chapter 5 provides details of performance).

As indicated above, continuing progress has been made in relation to delayed discharges over the last year. Over the same period, emergency admissions have fallen slightly, while A&E attendances rose slightly, as indicated below. Efforts will continue to achieve ongoing improvements across all of these indicators, particularly A&E attendances, given recent trends.





iii. Adult Services Transformation

a) Mental Health Strategy

Glasgow City HSCP currently has a lead co-ordinating role on behalf of all six HSCPs in NHS Greater Glasgow and Clyde in relation to mental health services. Over the course of the last year, Partnerships have been working together to develop a whole system five year strategy for mental health. This has now been produced and has the following key strategic aims:

- providing inpatient services with fewer beds/less intensive forms of inpatient care.
- maintaining spend on community and specialist services with increased capacity by way of improved productivity and performance.
- promoting good mental health, strengthening resilience and preventing crisis by focusing on more cost effective earlier intervention.
- minimising spend on other services including prescribing costs, management, facilities and procurement.

A detailed implementation plan will now be developed over the coming months and will establish a framework for the transformation of adult mental health services over the next five years. In addition, we are currently reviewing our mental health purchased social care services, as well as reforming the provision of rehabilitation and accommodation services across health and social care.

b) Computerised Cognitive Behaviour Therapy (CCBT) Project

Health and social care services are increasingly deploying technology assisted solutions to increase access to psychological approaches, with a local CCBT service going live in November 2017, following initial piloting across parts of Scotland.

The service offers an additional evidence-based psychological intervention for people who are experiencing mild to moderate anxiety and/or depression, and is referred to primarily by GPs. It comprises eight one-hour self-help sessions, which adopt a cognitive behavioural therapy (CBT) framework and can be completed at home. It is accompanied by handouts to support learning and change, and progress is monitored by a co-ordinator, with the referrer maintaining clinical responsibility throughout.

Across the Health Board, the Scottish Government set a target for the 6 Partnerships of 980 referrals in the first year (November 2017 to October 2018). The service has received **959** in the first 6 months (up to and including May 2018), so is on track to significantly exceed this target.

A conservative estimate is that over this period, the service has contributed to more efficient use of resources by freeing up and re-directing a minimum of **221** GP appointments; **334** referrals to PCMHT and **105** referrals to Third Sector Partners. Continuing to expand the service will, therefore, contribute to the aim within the mental health strategy of facilitating a self-management culture and reducing pressures across the health and care system.

2.5 ENABLING INDEPENDENT LIVING FOR LONGER

Within this section, we profile some of the key developments progressed in relation to our strategic priority of Enabling Independent Living for Longer. These activities 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 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 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 9	Resources are used effectively and efficiently in the provision of health and social care services

i. Community Health and Social Work Neighbourhood Teams

Progress has continued with the development of integrated health and social care teams across 10 local neighbourhoods in the city, which will include social work, rehabilitation and enablement, and district nursing. The recruitment process for service managers and team leaders has now been concluded and new working arrangements are being implemented in each locality. The benefits of closer working and information sharing are beginning to be experienced and will be fully realised as the integrated teams mature, working relationships develop, and health and social work staff forge ever stronger links with other professionals, GP clusters, local communities, carers, third and independent sector providers and community organisations.

ii. Home is Best Service

We have also commenced the introduction of the new Home is Best hospital facing service. This comprises of both health and social work staff and has responsibility for working with acute colleagues to divert hospital admissions; improve delayed discharge performance; and enable the smoother transition of patients from acute hospital care to intermediate care and other community based care settings.

iii. Supported Living

A key aim is to shift the balance of care by enabling greater numbers of older people to be supported at home with enhanced packages of care, while reducing the numbers going into

residential or nursing care. To this end the Partnership has been working with care providers to expand the number and range of Supported Living options in line with our wider accommodation based strategy. At Q4, the HSCP has exceeded its year-end target of 650, with **734** packages in place. In 2018/19, we will seek to build on this in order to maximise the number of older people in the city who can access and benefit from these enhanced packages of support.

Case Study
Mrs G stayed alone at home, with support from her son and had been receiving a mainstream package of care. She had a history of falls and was admitted to hospital following her latest fall which had resulted in a head injury. She was subsequently discharged to intermediate care and was very anxious; adamant that she needed a 24 hour care placement; and was reluctant to engage with rehabilitation staff who continued to encourage her independence. At the end of her time in intermediate care, she and her son remained nervous about her returning home but agreed to try a supported living package. He social worker visited her after a period of time and found that she was very relaxed and comfortable back in her home. She spoke highly of the carers and it was clear she has built a good rapport with them and was less anxious than before, admitting she had previously doubted her abilities. She was in good health and was wearing her falls pendant, something which she had been reluctant do before. Overall it was felt that the enhanced service had been very successful and that a mainstream package of care would have been insufficient, with the likelihood that it would have led to further readmissions given her history.

iv. Telecare

Following the completion of an evaluation of telecare services last year, a report was produced which recommended a number of changes aimed at improving the uptake and effectiveness of Technology Enabled Care. A dedicated telecare reform team was set up in March 2017 to progress these recommendations. Progress has been made with developments including a revised responder service model; an online referral form; refreshed training modules for all stakeholders; and new service branding. In recognition of the significant potential to harness digital technologies in the care sector, and following a successful application to the Scottish Enterprise Can Do Challenge Fund, the reform team are also working with the technology sector to develop innovation in this area.

Over the course of 2017/18, targets have been met for the number of referrals for both traditional basic telecare equipment (**2771** against a target of 2248); as well as more sophisticated advanced technology (**1222** against a target of 304). The latter includes for example, technology designed to track older people's movements and provide families with peace of mind when an older relative is at risk of wandering as a result of dementia.

Case Study

Mrs C is a 79 year old lady who has dementia and lives alone, with family support nearby. She was referred for a GPS device due to concerns from her family about where she was going during the day; on occasion she had been returned home by the Police.

A GPS device was used as an assessment tool to get a picture of Mrs C's everyday routine. Family and carers ensured the GPS device was fully charged and placed in Mrs C's handbag each day. A review of the information from the GPS device a few days later indicated that she travelled every day at the same time to Clydebank - a place where she used to live.

The GPS device continued to be used following the assessment period. This minimised the risks of Mrs C boarding the wrong bus or deviating from her usual routine as her family were able to trace the GPS at any time, identify where she was and assist if required. The GPS helped maintain her independence and kept her living in her own home for an extended period of time.

v. Home Care and Reablement Services

In Glasgow City Home Care is delivered by Cordia LLP on behalf of the Partnership and can include assistance with personal care and/or assistance with practical and domestic tasks. The Home Care service aims to provide care and support to people to live as independently as possible in their own home.

In addition to Home Care, Cordia also provide a Reablement Service on behalf of the Partnership. All service users who require a home care service are screened for suitability for this service, which provides tailored support to people in their own home for up to six weeks. This service aims to build confidence by helping people to regain skills to do what they can and want to do for themselves at home; promoting independence; and reducing dependency, with resultant reductions in future home care requirements.

User Feedback

Home Care services are delivered on behalf of the Partnership by Cordia LLP. During 2017 Cordia carried out a service user consultation on this service and headline figures are presented below.

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

The survey points to a high degree of satisfaction with the service in general, for example 86% of service users agree that they feel safer at home, and 86% agree that their home carers have improved their quality of life. The professionalism of home carers was particularly highlighted with 98% agreeing that their home carers are helpful and friendly, and 97% agreeing that their home carers treat them with dignity and respect.

vi. Supporting Carers

Over 17/18, **2,016** new carers have been identified who have gone on to receive a carer's support plan, exceeding the annual target of 1650. Another key aim of the service is to increase the number of self-referrals from primary and acute services, with targets also exceeded here (**893** referrals received against an annual target of 660).

All services involved with the Carers Partnership continue to ensure that adult and young carers are identified earlier in their caring role. Activity in this area includes:

- Significant work undertaken to raise awareness of carers within new GP cluster structures, which will be supported when GPs are able to refer electronically from July 2018.

- Education Services have designed training and information for distribution online within Glasgow Schools to ensure that young carers are supported and identified within the school environment.
- Further work has taken place to ensure that services provided are compliant with the Carers (Scotland) Act 2016. The Glasgow Carer Partnership has developed Adult carer Support Plans, Young Care Statements and implemented a set of Eligibility Criteria to meet the legal requirements of the Carers Act.

User Feedback
Feedback forms are sent to carers after their assessment has been undertaken and services are in place, with response rates varying between 10% and 18% across localities. Returns show that the percentage who believe the support they received has improved their ability to support the person they care for, has consistently been above **80%** throughout the year, exceeding the 65% target.

Case Study
B is a 90 year old carer who looks after her husband M. All previous supports were declined, but M was admitted to hospital several times as a result of urinary infections which resulted in changing behaviours and disorientation. Their daughter contacted social work requesting immediate respite with a view to M being placed in residential or nursing care. Initially the family were hostile to the idea of any alternatives, but after meeting with social work and the carers' service, they accepted the rationale for community based support. A carer support plan was drawn up which included daily personal care, telecare, day care and overnight respite support. M was, therefore, supported to continue to live at home which was the preferred outcome for both him and his wife, who was then able to benefit from breaks in providing personal care, without experiencing the distress which the thought of placing her husband in residential care caused. The family described how learning about the supports available had significantly reduced their levels of stress and anxiety, with one family member phoning after a meeting with social work to say '*thanks for your help, we now have a much greater awareness of the opportunities to support our mother care for our dad*.'

vii. Occupational Therapy Services Review

A systemic review of Occupational Therapy Services was undertaken in 2016/17 with the aim of making Occupational Therapy Services better for the people of Glasgow. In response to the review, during the last 12 months, we have supported and encouraged staff to highlight areas of duplication and where processes can be improved upon, in order to build upon the benefits of integration. One area was the provision of minor adaptations (e.g. rails), with staff identifying an opportunity to introduce changes which would reduce the steps in the process and ensure a swifter response to patients. A new process, order form and training materials were subsequently developed and delivered to all Occupational Therapy staff including acute across Glasgow City. The maximum waiting time for the order form to be turned round was

reduced from 12 to 1 working day in the pilot and this has had positive outcomes for patient safety and independence. As the changes become embedded, we expect to see further improvements within OT services and reductions in waiting times over the next 12 months.

Representatives of the Occupational Therapy review group have also been involved in a joint HSCP/Housing Equipment and Adaptations Working Group, supported by iHub. This aims to deliver a joint approach to the delivery of improved housing and adaptations options for individuals, which was identified by both the Occupational Therapy Review Group and the Housing Health and Social Care Forum as a priority. An example of the work progressed has been a pilot of Housing Solutions training module, with a focus on ensuring early conversations and preventative approaches to housing barriers. The training was delivered to 90 HSCP and Housing staff and has generated an enthusiasm and awareness of the importance of early housing conversations by multiple stakeholders. We now have plans to recommend the further roll out of this training to ensure maximum benefit.

The Occupational Therapy review group also identified the importance of information sharing and in response, practical solutions have been introduced to ensure shared access in patient records via Carefirst and Portal. This has supported effective communication between professionals to effect improved care provision for patients and reduce unnecessary duplication.

viii. Income Maximisation

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

Social Work Clients

The HSCP Welfare Rights service visit people in receipt of a range of chargeable social work services to ensure that they are receiving all relevant benefits which they are entitled to. In the period April 2017 to 13 March 2018 **£4.19 Million** (£2.55m ongoing and £1.64m in arrears) has been generated in successful claims for benefit for service users receiving a chargeable service. This compares to £2.95m made in the period August 16 to March 2017, with the data only available part-year following the introduction of a new information system.

Between 1st April 17 and 31st March 2018, the service also represented **1,715** clients at social security tribunals (mainly for adult disability and incapacity for work benefits). The overall success rate for the concluded appeals was **73%,** resulting in a total gain of **£ 5.86m;** representing an average financial gain of **£ 8,244** per successful appeal. These have all increased since 2016/17 when 971 appeals were made; the success rate was 66%; the total gain was £4m; and the average gain was £7300 per successful appeal.

Case Study
Client C is a 93 year old woman who lived in her own tenancy. She developed vascular dementia and could no longer safely live on her own. She moved in with her daughter and son-in-law so that her daughter could be her main carer. By doing so, this reduced the level of benefits that she could claim for herself, as she was no longer entitled to the severe disability premium as she was living with other people who were not disabled. The

family were advised by welfare rights to apply for a Severe Mental Impairment (SMI) disregard for the council tax for the client, as well as carer discount in respect of her daughter. This achieved a 25% reduction in the council tax for the household. The daughter was also supported with a carers allowance claim; and attendance allowance was claimed for the son-in-law who had just retired with ill-health. As a result of these successful claims, and the 25% council tax reduction, the family have been helped to overcome the loss of the mother's severe disability premium and this has enabled the new care arrangements to be financially viable.

Health Clients

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

Specific developments over the last year have included a new initiative for clients of the Special Needs In Pregnancy Service (SNIPS). This service aims to directly engage special needs in pregnancy/teenage expectant mothers, to develop, test and refine a process for embedding financial, housing, social security and debt advice in Deep End General Practices, which have relatively higher levels of deprivation people living in complex circumstances. The work has generated robust evidence that the embedded model contributes significantly to improvements in incomes, benefits claimed and debts managed compared to other delivery models. It also enables GPs to make better use of their time rather than focusing on non-clinical tasks.

For 2017/18, across the Financial Inclusion Partnership**, 4,311** referrals were made and **3,246** individual clients seen. Over **£7.3m** of financial gain was realised and over **£750k** of debt managed. Increases have, therefore also been seen since 2016/17, when 4007 referrals were received; 3154 clients were seen; and £6.6m of financial gain realised. The debts dealt with have reduced slightly since 2016/17 when £1.09m was dealt with.

User/Carer Feedback

Research commissioned for the above financial inclusion models indicated that clients reported high levels of satisfaction, reduced levels of stress and an increased sense of empowerment as a result of the interventions. Feedback from clients using the services included the following:

- *"They are fixing my benefits for me, council tax benefit, everything. I've been to see her five times to get my paperwork sorted, she's fixing my life really."*
- *"I never had anything to do with the system before. The paperwork is horrendous, without help I don't know what I would have done."*
- *"We aren't as stressed, my husband is a lot calmer now. We both feel better about life…."*
- *"I was really worried and I didn't know what to do. I can now eat properly and so can my baby. Life is OK compared to how it was when I first made contact with the service. I can feed myself and my kids".*

2.6 PUBLIC PROTECTION

Within this section, we profile some of the key developments progressed in relation to our strategic priority of Public Protection. These activities 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
Outcome 7	People using health and social care services are safe from harm

i. Public Protection

Public protection is central to the ethos and underpinning of the Partnership, it runs through every aspect of HSCP service delivery and is evidenced by its profile within our organisational structure. Key aspects in which it is specifically manifested include: Child Protection, Adult Protection, and the Multi-Agency Public Protection Arrangements (MAPPA) in respect to the management of sex offenders and other high risk offenders.

a) Child Protection

Trends in child protection figures suggest that some of the initiatives described in 2.4 aimed at shifting the balance of care are having an impact. At the end of March 2018, there were **311** children on the child protection register. This is a reduction of **174** from March 2017, when there were 485 children on the child protection register. 44% of these children were aged 0-4, 37% aged 5 to 11, 17% aged 12 to 15, and 2% aged over 15.

Between April 2017 and March 2018, there were **410** new child protection registrations, falling from 572 for the same period in 2016/17. The number of de-registrations was not dissimilar between the two years, with 587 in 2016/17 and **577** in 2017/18. The average number of days on the register before deregistration rose to **316** from 274 in 2016/17.

During 2017 there have been a number of key initiatives to support professionals to identify and address issues of child well-being and protection. Glasgow continues to prioritise neglect, with the neglect toolkit continuing to be rolled out and a summit on neglect being held specifically targeted at adult services.

Significant work has also taken place with regard to child sexual exploitation (CSE) and trafficking. This has included the undertaking of research with Stirling University; the Child Protection Committee annual conference focussing on CSE; multi-agency training; development of practice guidance; engagement with night economy providers in the city; and working with community groups in the South of the city to raise awarenes of CSE issues.

Concerns around an increase in referrals to social work for black African families were investigated previously and this prompted a review of learning needs and a recognition of the requirement to improve engagement with the Black African community. A small working group was established, who engaged with AFRUCA (Africans Unite Against Abuse) and identified the need to develop a training programme to ensure that HSCP children's services staff were equipped to recognise the cultural needs of African Families. Since the development of the initial training sessions, a comprehensive training for trainers course was introduced, supported by the Glasgow Child Protection Committee.

The working group has also established links with 'African Challenge', a voluntary organisation dedicated to supporting and promoting the lives of African people living in Scotland, who are working with 50 families in North Glasgow. They suggested that there is a deep rooted fear of statutory social work in the African community, which is being further fuelled by myths and a belief in racist professional practice. This relationship culminated in a workshop presentation on 'Safeguarding African Families' at the African Challenge summer 2017 event, which was a pivotal point in improving relations and ensuring a collaborative approach. The working group also presented a workshop to the national "Pride in Practice" conference in late 2017, which was well received by those in attendance and has resulted in requests for collaboration with other local authorities in order to share learning from Glasgow.

More recently, the working group have been approached by the Kenyan Women in Scotland Association (KWISA), praising Glasgow for their innovation and commitment and requesting to draw upon research and findings from the city. The working group members are also now affiliated members of the 'Safeguarding the African Child in Scotland' national forum and will be presenting on Glasgow's work to date and future plans at their national conference in June 2018.

b) Adult Support & Protection (ASP)

Within Glasgow City HSCP we have continued to raise awareness of adult support and protection in a number of ways including training. This has included staff from within the HSCP, partner agencies and the third sector. We have extended the briefing opportunities to our purchased providers and other organisations who have identified a need. During 2017 we offered **4** half days and **3** full days training to all front line staff and partner agencies on a range of issues including data scrutiny and performance, hoarding and neglect, significant case reviews and violence against women. These were attended by approximately **200** people.

In response to service user feedback, we have also implemented a service user information leaflet for those involved in ASP investigations, which give service users an easy read guide, highlighting council and independent advocacy contact information. Over **1000** copies have been produced and disseminated. This was a joint initiative with HSCP staff and the Service User sub-group of the Adult Protection Committee. We are also currently working with this group to design easy read service user feedback forms and a case conference leaflet.

Work in this area is overseen by the Adult Protection Committee (APC) and its various sub-groups which involve statutory and third sector organisations, including service users. The APC fosters a partnership approach to the complexities of Adult Support and Protection,

whilst making the cross cutting links with Child Protection, MAAPA and the wider public protection agenda. It has a well-established ASP newsletter and in the next year, the intention is to broaden its scope to incorporate the wider Public Protection agenda.

Other areas of activity undertaken in the last year have included:

- Self-evaluation to identify areas of development and areas of good practice.
- Commissioned an Independent Impact report for service user feedback.
- Presented at the National Adult Support and Protection Social Work Conference.
- Identified and promoted a National ASP day in agreement with others area in Scotland.

During 2017/18, there were **361** Adult Support and Protection investigations completed, a small decrease from the 372 completed in 2016/17.

User/Carer Feedback
A Service Impact report undertaken in 2017 found that the process was working well in terms of service response, with clients feeling that once an ASP concern was raised, things tended to happen quickly to make them feel safe. *"Things are better now I am in control."* *"The difference it has made – I wouldn't be sitting here now without it."* *"The ASP happened quickly after I reported how unhappy I was."* *"I feel a lot safer now."* *"I have a new lock on my door."*

c) MAPPA

The 2015 MAPPA Thematic Inspection highlighted seventeen "Areas for Development" for all MAPPA areas to progress and a workplan was developed in response. In November 2017, the progress that had been made locally was reported to the Scottish Government. Over the past year, and in response in part to recommendations from the MAPPA Thematic Review, we held a number of sessions to increase staff awareness around the particular group of offenders who sexually offend using the internet. This training was delivered by the Lucy Faithful Foundation, with inputs from Police Scotland's cyber-crime unit. This reflects Glasgow's commitment to the continued development of staff involved in MAPPA.

Progress has also been made over the past year in relation to securing permanent accommodation for registered sex offenders. A process has been agreed with the Homelessness Team who in Glasgow are responsible for the submission of Section 5 applications and referrals continue to be submitted regularly, with the response from RSLs generally positive.

On 31st March 2016 Other Risk of Serious Harm Offenders were formally included in MAPPA. The Guidance defines the Other Risk of Serious Harm Offenders as those who, by

reason of their conviction are considered to pose a risk of serious harm to the public. Glasgow has managed a small number of these offenders through MAPPA during the last reporting year. There were a number of further referrals which although would meet the criteria for inclusion in MAPPA, were not released from custody. Numbers of offenders included in this MAPPA category remain small across the country.

ii. Homelessness

The vision for Glasgow HSCP is to prevent homelessness where possible and when it occurs, ensure people are supported to access appropriate support and accommodation. Through partnership working with Registered Social Landlords, we are aiming to improve access to permanent accommodation for homeless households. Over the past year the HSCP has worked towards this vision by delivering the following:

- Opened 2 x 30 bed new build emergency facilities for males and decommissioned a temporary facility – a net increase of 20 emergency beds.
- Retendered and increased the contract value for an additional 450 units of private rented sector accommodation over the next 3 years.

Additionally, there has been a decline in homelessness assessments over the past few years, which was highlighted in a recent evaluation of the Housing Options approach. The Glasgow model was seen as being successful in protecting a rights based approach within its preventative framework, with more people who engage with frontline homelessness services in Glasgow proceeding to statutory assessment **(57%)** than for Scotland as a whole **(48%).**

The HSCP has also been working on an ambitious proposal with a range of partners to implement the Housing First approach in Glasgow to enable a more effective response to homelessness in the city. This is an evidence based approach, aimed particularly at those people with multiple and complex needs, as an alternative to building the new hostel provision that had been previously planned. Housing First significantly challenges established practice and tackles homelessness by shifting services from a tiered support approach, to rapidly rehousing multiply excluded people in the community as the first, rather than the last step.

The City Ambition Network (CAN) has identified and engaged with a number of rough sleepers offering accommodation and as we progress the Housing First approach, priority will be given to those identified as rough sleeping within the City.

iii. Alcohol and Drugs

Reducing harm

A range of activities have been undertaken in the last year to increase awareness and understanding of drug trends and seek to reduce associated harm. The Greater Glasgow and Clyde Drug Trend Monitoring Group held a Drug Trends in Glasgow event in June 2017 where **130** invited delegates were presented with information on drug trends and issues from a range of HSCP services and partners including Acute, Public Health, Police Scotland and

Forensic Toxicology. This has led to recommendations being developed which have been endorsed by the Glasgow Alcohol and Drugs Partnership. A contract was also tendered in the last year which is being delivered by Glasgow Council on Alcohol, involving a 'multiple risk' educational resource for young people and a new service that supports vulnerable children and young people at risk from their own alcohol or drug use. Contracts for delivering alcohol and drugs training were also tendered for, aimed at a range of community workers and teachers.

Work has also been undertaken in prisons with a resource being developed for health workers to engage with individuals who have been hospitalised due to drug use, which includes information on harm reduction and stopping usage. Naloxone training was also delivered to health staff within prisons and promotional materials advising on the specific dangers of polydrug use, street benzodiazepines and synthetic cannabinoids, were produced and distributed widely across all prisons. Two members of the Drug Trend Monitoring Group also took part in a prison radio show at Barlinnie which included a focus group and question and answer session. Feedback was extremely positive and prisoners have requested that this become a regular feature.

iv. Criminal Justice Services

Over the last year, we have been progressing the Criminal Justice Glasgow transition arrangements in line with the newly established national body. We have also implemented a review and redesign of unpaid work provision for the city in partnership with commissioned providers, and will continue to prioritise our approach to working with women in the justice system going forward.

2.7 ENGAGING AND DEVELOPING OUR STAFF

Within this section, we profile some of the key developments progressed in relation to engaging and developing our staff. These activities 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 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

i. Communications

Effective communication assists the Health and Social Care Partnership to increase awareness of its key priorities and to engage with key stakeholders including staff, in relation to the planning and delivery of health and social care services.

Communication and engagement activity in 2017-18 has been informed by a communications survey reported to the IJB Public Engagement Committee in March 2017, which identified where improvements could be made. Activities have been undertaken both at partnership and care group levels and have included the following

Partnership Wide

- Development and launch of a public website to increase awareness and understanding of the HSCP's vision, priorities and work, www.glasgowcity.hscp.scot.
- Development of good practice guidelines for consultation activity undertaken on behalf of the HSCP, which includes guidelines on accessible communications.
- Review of the Partnership's Team Meeting Communications Framework for staff.
- Development of a range of communication activity to keep internal and external stakeholders informed on the work of the Partnership. These include a two-monthly newsletter, Twitter profiles for the Partnership (@gchscp) and the Chief Officer (@dw_gchscp), an overview briefing of the IJB/GCHSCP and progress to date, and a range of public information leaflets.
- Further development and improvement of Your Support Your Way Glasgow (YSYWG), the Partnership's public website for social care supports available in Glasgow City, as well as activity to promote the website.
- Delivery of **9** engagement sessions for frontline and business support staff/teams across the Partnership with the Executive and Senior Management Team, to increase awareness of the work and priorities of the IJB and GCHSCP and provide an opportunity for staff to discuss ideas, make suggestions, raise issues and ask questions.
- Delivery of **2** Partnership-wide leadership sessions with the wider leadership staff group in the Partnership, to keep leaders up to date on IJB/GCHSCP work, priorities, challenges and opportunities across the health and social care system.

Care Group

Care group specific sessions have also been held on the following areas:

- Children's services transformational change.
- Mental health strategy.
- Older people's mental health.
- Older people's system of care.
- Unscheduled care.
- Palliative care.
- Primary care.
- Occupational therapy tests of change.
- Locality care group staff engagement sessions.

ii. Awards

Over the course of the last year, the Partnership have continued to recognise the efforts of staff through the following:

- Delivery of the Partnership's Facing the Future Together Awards to recognise individual staff/teams/projects that have 'gone the extra mile' in their work across a number of categories.
- Continued submission of nominations for external awards, with a number being recognised, including:

Glasgow Guarantee Awards for Apprentices
A modern apprentice at Crossmyloof day centre won Glasgow City Council and ALEO Modern Apprentice of the Year and the Leader's Choice Award.

Scottish Creative Awards
The Families for Children Team won Best Online Campaign for their #opentofostering campaign at the Scottish Creative Awards.

Society for the Study of Addiction Poster Award
Addiction staff were presented with the poster prize within the Service Evaluation and Audit category at the Society for the Study of Addiction Annual Conference 2017.

iii. Developing Our Teams

Over the course of the last year, a number of activities to support the development of our staff have been taken forward including the following:

i-Matter

We have rolled out i-Matter, the national staff engagement questionnaire which measures staff engagement within teams and supports the production of team development plans to improve and increase engagement. The 2017 response rates for the i-Matter survey are detailed below, with the Employee Engagement Index providing a summary measure of how engaged people feel at their work.

GCHCSP Locality	Response Rate	Employee Engagement Index
South	**69%**	**75%**
North East	**61%**	**76%**
North West	**69%**	**76%**
City wide	**39%**	N/A Requires response rate of 60%

Although there are variations across the city as shown above, the response rate in all areas has been considerably higher than previous staff surveys, where the average was 20%. The city wide figure includes residential care staff who would not all have had access to the online questionnaire. Teams have developed their own plans in response to the feedback generated and some have featured in the HSCP newsletter, sharing their action plans and the impact it has had on them. The survey will be repeated in June 2018 and results from this and the staff experience report will inform future staff engagement activity.

Team Effectiveness Framework

A Team Effectiveness Framework has been developed to support managers and team leads, who are coached to focus on the areas of team purpose, roles and objectives, and opportunities for review and reflection. The aim is to achieve a clearer sense of identity and link to the broader organisational priorities. Teams can use a number of tools to share feedback on their understanding of how they operate, and look at ways to be as effective as possible. This approach was initially piloted in the North East and will now be rolled out across the HSCP.

Staff Feedback
'*Participating in the team effectiveness process has consolidated a sense of team commitment and sharpened the focus of North East Children's Senior Management Team. The impact has generated greater focus on roles and responsibilities and culminated in a forward facing and more collaborative team, who are all clearer about the team's objectives. The team effectiveness process has provided a structure and has facilitated a direction of travel which has since been replicated with our extended management team. Defining lead areas of accountability and an agreed statement of purpose has helped define the team's roles and strengths, which will greatly assist in moving forward and help generate a more efficient operation during a time of significant challenge'.*

Health Improvement

Glasgow City Health Improvement (HI) Teams deliver training and awareness raising sessions across the city on a variety of health improvement topics. In the last year, these have included mental health; community smokefree services; breastfeeding; nutrition and food; violence against women; health behaviour change; young carers; oral health; and suicide prevention.

Sessions are targeted at HSCP colleagues, voluntary sector organisations and groups, partner agencies and local communities. Sessions are designed to raise awareness of health improvement messages, support lifestyle changes, and build capacity to enable participants to deliver training to their own service users and patients.

Over the course of the year, over **746** sessions were held with **6229** people attending. This was an increase on the previous year (2016/17) when 650 sessions were held, with 5495 people attending.

Trainee Feedback
'It increases your confidence - good to know what you can give to your child and get ideas from different people. I like to hear what other parents are doing and asking - you learn from that, get ideas from different people, more experiences, you learn from that' (Breastfeeding Course) *'Enjoyed the training. I feel prepared after this to deal with someone thinking of suicide should the event ever arise' (Suicide Prevention Course SafeTALK)* *'Excellent content. Should make all people who work with young people complete' (Mental Health Course)*

2.8 EQUALITIES

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

- Mainstreaming equality into the guidelines and training for community participation and engagement.

- Completed a range of Equality Impact Assessments - Equalities Impact Assessments.

- Delivered training/information sessions/events to health, social work and third sector staff on a wide range of subjects including HIV/AIDs; violence against women; equality and diversity training; LBGT awareness; and mental health. These were attended by approximately **550** people.

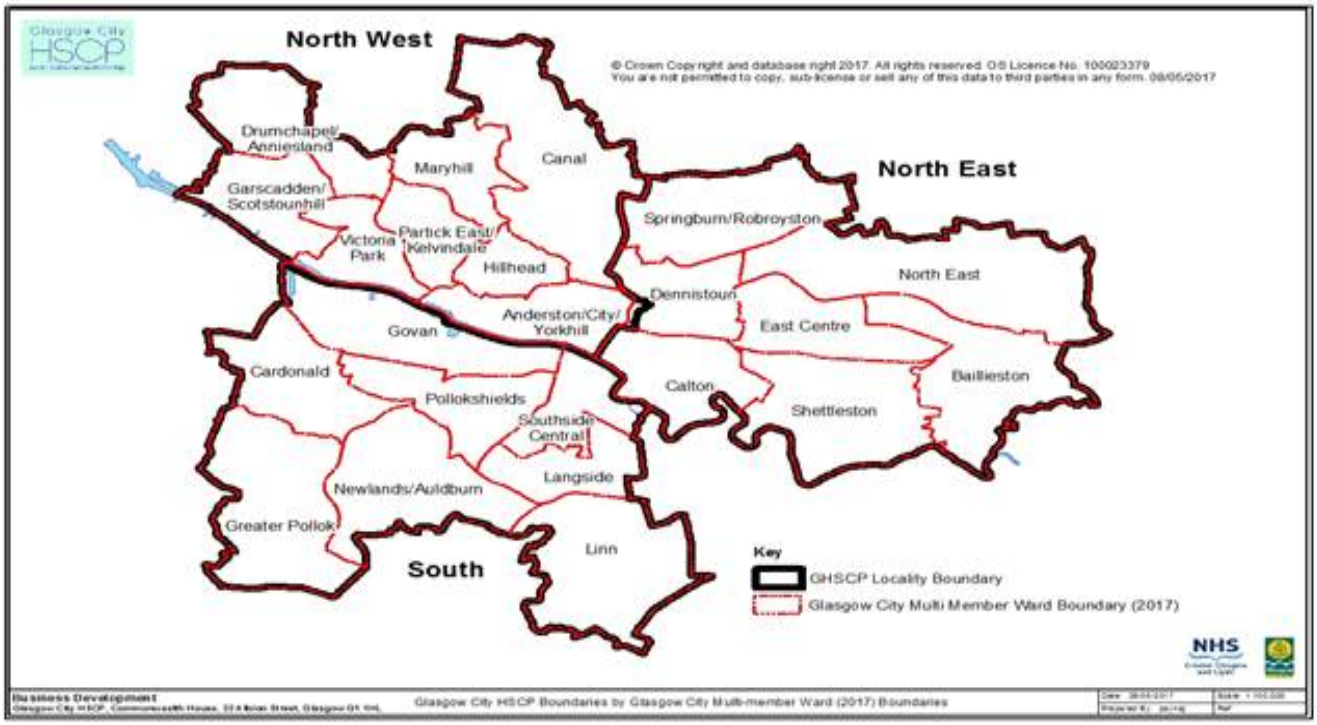
- Publication of the Black and Minority Ethnic Health & Wellbeing Study. This provided generally positive feedback but identified areas for improvement including the need to work with partners to improve health particularly for Pakistani people, certain groups of women and those who haven't had access to or been able to learn English. Issues also identified which require to be tackled included feelings of safety and inclusion and freedom from discrimination.

- Supported the Health Board wide Mental Health Services Equality Development Group which focused in 2017/18 on financial inclusion, human rights, and sensory impairment, with each HSCP preparing status reports and improvement plans. Development sessions for staff across Partnerships were also provided on these three areas, which were attended by approximately **100** people.

3. LOCALITY PLANNING IN GLASGOW

3.1 Locality Areas

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



North East Locality

North East Locality covers the following wards:

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

The total population of North East Glasgow is 173,935 people and a breakdown by age is shown in the following table (Source: NRS Small Area Population Estimates for 2016).

Age Band	Number of People	% of Population	% of this age band in Glasgow City
0 to 15 years	29,510	17.0%	30.0%
16 to 64 years	119,429	68.7%	27.6%
65 years and over	24,996	14.4%	29.8%
All	**173,935**	**100.0%**	**28.3%**

North West Locality

North West Locality covers the following wards:

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

The total population of North West Glasgow is 216,974 people and a breakdown by age is shown in the following table (Source: NRS Small Area Population Estimates for 2016).

Age Band	Number of People	% of Population	% of this age band in Glasgow City
0 to 15 years	29,717	13.7%	30.2%
16 to 64 years	160,164	73.8%	37.0%
65 years and over	27,093	12.5%	32.3%
All	**216,974**	**100.0%**	**35.3%**

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 224,161 people and a breakdown by age is shown in the following table (Source: NRS Small Area Population Estimates for 2016).

Age Band	Number of People	% of Population	% of this age band in Glasgow City
0 to 15 years	39,260	17.5%	39.9%
16 to 64 years	153,200	68.3%	35.4%
65 years and over	31,701	14.1%	37.8%
All	**224,161**	**100.0%**	**36.4%**

3.2 Management Arrangements

Each locality is managed by an Executive Team responsible for the overall delivery of health and social care services in that area. They are 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 in place which involve a range of partner agency representatives, service user and carer networks and groups, and GPs and other primary care professionals. Links with Community Planning partners are maintained at a strategic level through the Community Planning Area Senior Officers Group and the Community Planning Partnership Board. At a neighbourhood level, locality teams support the development of Thriving Places with community planning partners and others, as described in more detail in **section 3.5** below.

Last year we established Locality Engagement Forums. These bring together representatives from Public Partnership Forums (Health), Voices for Change networks (Social Work), and other local networks and groups, to form a key plank of our local participation and engagement arrangements, in line with the HSCP's Participation and Engagement Strategy.

Each locality has a Primary Care Implementation Group engaging with primary care contractors, which all link to the overall city wide Primary Care Steering Group. General Practice 'clusters' are now established to take forward the quality agenda in primary care. There are 20 GP clusters ranging in population size from 19,000 to 76,000. There are 7 clusters in both the South and North West localities and 6 in the North East. Each of the clusters has identified a Cluster Quality Lead and a development programme has been implemented to support their learning needs, with a specific focus on using quality improvement methodology.

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

3.3 Locality Planning

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

- Health and social care needs and any changes year on year.
- Service priorities: progress and future plans.
- Performance: an assessment of performance against key targets, identifying where they have done well and areas for improvement.
- Locality budgets and savings.
- Community engagement mechanisms and development.
- Equalities activity and priorities.

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

3.4 Participation and Engagement

Each locality has established participation and engagement mechanisms in place, as described in section 3.3. Over **30** Local Engagement Forum meetings and events have been held throughout the year across the city, which have been attended by over **900** people. These have been used to consult extensively on a number of key city wide and locality developments as noted below, with the feedback obtained shaping decisions and plans. These have been complemented where appropriate, by a number of engagement mechanisms including focus groups; face to face interviews; drop-in information sessions; questionnaires and user/care audits.

Citywide

- Review of NHS treatment rooms.
- Development of the 5 Year Mental Health Strategy.
- Development of the Palliative Care Strategy.
- Review of Occupational Therapy services.
- Establishment of Neighbourhood Teams for older peoples' services
- Review of the National Dementia Strategy 2017- 20.
- Review of Sandyford sexual health services board wide.
- Engagement with GPs on the Primary Care Improvement Plan.

Locality Specific

- Transfer of services from Parkhead Hospital to Stobhill Hospital.
- East End Health and Social Care Hub.
- Review of the West Glasgow minor injuries services.
- Development of the new Health & Care Centres in Gorbals and Woodside.
- Development of a South Locality Suicide Safer Communities Plan.
- Co-design of a BME health and wellbeing event in partnership with the South East Integration Network.
- Design and delivery of a national dementia demonstrator pilot at Leverndale Hospital.

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

North East – Transfer of services from Parkhead Hospital to Stobhill Hospital

At every stage of the planning and transfer process, the Head of Adult Services for the North East Locality provided regular updates to key stakeholders, regularly attended Locality Engagement Forum meetings, and organised drop-in information sessions for service users and their families. Feedback and information gathered through this and other engagement mechanisms informed the ongoing development and implementation of the plans. For example, through these liaison arrangements, the importance of having good transport links to the new site following relocation was highlighted as a major concern. As a result, this concern was addressed and a free bus service now operates from the former Parkhead site to the new site at Stobhill.

North West - Maryhill Health & Care Centre

As part of the process to evaluate the new Centre, a face to face questionnaire was carried out. In addition, an access and disability audit by Locality Engagement Forum members and key voluntary sector partners was completed in order to identify gaps and areas for improvement in patient experience. This gathered comments on the fabric and quality of the design and build; service and operational pathways; physical access to the new centre; and transport links

As a result of the audit and the questionnaire a number of access and safety concerns were identified by both staff and patients. A scheduled work programme is now in progress to address the issues identified. The project evaluation exercise, along with lessons learned, has also been shared with other planned capital build projects in the city.

South - National Dementia Demonstrator Pilot at Leverndale Hospital

Balmore Ward is one of four national specialist Dementia Unit improvement programme pilot sites in Scotland. The aim is to improve the quality of care, experience and outcomes for patients within specialist dementia units and their carers, who were involved in identifying and planning service improvements.

Carers are a key partner in the co-design process but often face multiple barriers that can prevent their participation and involvement. The co-design model was therefore adapted to reflect the needs of local carers and a programme of engagement activity was delivered on the ward instead. This included **10** drop-in consultation sessions some of which were held in the evening and at weekends; face to face conversations and interviews;on-ward questionnaires; written information about the pilot; and an engagement event involving staff, patients and carers linked to the launch of the new Balmore Ward Garden.

Two local carers have now joined the Dementia Pilot steering group. They have contributed to the written carer engagement reports and recently participated in a multi-disciplinary session with clinical and non-clinical staff, which organised all of the feedback into themes and identified core service improvement priorities.

3.5. Thriving Places

HSCP staff, in particular Health Improvement staff, continue to take a more focused neighbourhood approach in recognition of persistent inequalities within and between communities. This is aligned with the Community Planning Thriving Places approach, which aims to find a better way of working between organisations and with communities, making better use of existing resources and assets to achieve improved outcomes. This is being taken forward in **10** specific areas across the city (3 North East, 3 North West and 4 South) and a wide range of initiatives have been taken forward in the last year. A key role for HSCP Health Improvement staff in Thriving Places is in supporting and facilitating local partnerships often at a community level. This crucial support enables the development of co-produced localised programmes. Additionally, Health Improvement staff can provide guidance around data collection and analysis; monitoring and evaluation; and enabling access to funding streams. Examples, one from each locality, which the HSCP locality teams are involved in delivering are provided below:

a) Community Budgeting

A Community Budgeting initiative funded via the North West Health Improvement Team has been introduced in Drumchapel. This involves a small grants programme aimed at supporting smaller 3rd sector and community groups in the delivery of locally identified priorities. Local residents and workers were involved in the development of eligibility criteria and the decision making processes with regard to how the money is spent. A total of **19** projects were funded, with grants ranging for £300 to £1,000. Project themes included tackling isolation and loneliness; family based cooking and nutrition support; respite care; winter festivals; baby and toddler clothing exchange; physical activity; and integrating communities.

b) Family Meal and Homework Clubs

The HSCP instigated the first family meal and homework club in Bridgeton with the Thriving Places community organiser and Dalmarnock Primary School, providing the cookery element via their community health contract. Health Improvement staff engaged the support of a local nursery to provide activity for under 5s and helped run the club until it became established. The initial summer programme in 2016 in Dalmarnock was also initiated, funded and staffed by Health Improvement, leading to a significant shift in how Glasgow supports children during the long summer holiday period. Health Improvement staff continue to assist the establishment of new family meal and homework clubs and summer programmes across the city by facilitating partnerships, connecting organisations to funding opportunities, and providing advice and guidance on governance, delivery and evaluation.

Case Studies

"Susan" is a local resident who was born and brought up in Dalmarnock. Her children attend Dalmarnock Primary School and the local secondary school. Susan was herself an irregular attender at school and, as a result, left with no qualifications. She has been involved in the family meal and homework club since it started and her experience with the programme shows a transformation in her attitudes towards the school and its staff.

"I've lived in this area all my life - born here, went to school here - now live with my man and my kids here. I hated school to be honest and wasn't there much, so I never thought I would come here every week. The head teacher makes us feel so welcome.

The club is brilliant. Fourteen of us cook. Do you know we made up a recipe book with all the meals we liked? Imagine!! A recipe book!! We also got to do a certificate for food hygiene – I had to write an essay, I have never had a certificate before! I also use what I learn here at home and the kids help me too.

She has also taken the opportunity to use the rules from the school to reinforce how the children need to behave at home, particularly ensuring that they do their homework regularly. Before the club, Susan had found it difficult to get the children into a routine and to enforce rules – often resulting in family arguments and Susan becoming very stressed.

"The kids must do their homework to get out to play. This was always a battle but they want to do their homework now - they know no homework, no play."

Susan's feedback demonstrates the programme's impact in:

- Reducing social isolation.
- Increasing confidence and self-esteem.
- Improving family bonding and relationships.
- Providing skills to enabling preparation of healthy meals as cheaply as possible.
- Developing family routines through the application of key influencing strategies learned at the programme.
- Increasing opportunities for greater educational attainment through encouraging regular school attendance and completion of homework

c. Community Breakfast Clubs

Community breakfast clubs take place weekly in the Gorbals and Priesthill/Househillwood Thriving Places areas. They are run by local volunteers and are supported by the Health Improvement Team and local housing associations The aim is to provide a safe community space for local residents of all ages to come together to socialise, reduce isolation and help combat food poverty. They also provide informal access to a range of services in the area, with information on local services provided by in-house and partner organisations including Smoking Cessation services; McMillan; Police Scotland; Drink Wise Age Well; Scottish Fire Service; Welfare Rights and Glasgow Life. During the last year, they have been attended by approximately **60-80** people per week in each locality.

Case Studies

Case 1

A young woman attended the community breakfasts over a 2 week period, and her appearance and levels of hunger raised concerns amongst staff. This was passed to housing officers who upon further investigation, identified she was experiencing domestic abuse and had addiction issues. They were able to signpost her to other agencies, which enabled additional support to be put in place.

Case 2

An elderly man in a wheelchair started to attend one of the community breakfast sessions. Prior to this, he had experienced real isolation so he now values the opportunity to speak to neighbours and have a hot breakfast. Attending these has also provided him with the opportunity to raise issues with housing staff and receive an immediate response. In addition, he has been supported to identify appropriate activities locally which he has now started to participate in.

Feedback

"It gives us the chance to connect to and support our neighbours and friends".

"I was able to speak to housing officer without waiting 2 weeks for an appointment"

"This gives me a reason to get out the house"

"This has given me the chance to volunteer and give something back to my community"

4. FINANCIAL PERFORMANCE

4.1 Introduction

As indicated in Appendix B, National Outcome 9 relates to *'Resources being used effectively and efficiently in the provision of health and social care services'.* Within this chapter, we seek to demonstrate how we have achieved this by providing an overview of financial performance during 2017/18. We also describe the transformation programme we have been taking forward and the key capital investments progressed, before briefly considering the financial outlook for 2018/19.

4.2 2017/18 Partnership Budget

The total financial resources available to the partnership for 2017-18 were around £1.1billion, as outlined below.

Client Group	**Gross Expenditure Budget**	**Income Budget**	**Net Expenditure Budget**
	£000's	**£000's**	**£000's**
Children and Families	155,330	2,459	152,871
Prison Healthcare and Criminal Justice	23,807	18,433	5,374
Older People/Physical Disability	281,670	42,955	238,715
Addictions	44,133	2,264	41,869
Carers	2,104	298	1,806
Older People's Mental Health	29,630	1,115	28,515
Learning Disability	71,050	2,913	68,137
Mental Health	108,731	15,698	93,033
Homelessness	74,952	27,460	47,492
Prescribing	129,469	-	129,469
Family Health Services	182,405	8,787	173,618
Hosted Services	11,438	1,734	9,704
Other Services	70,290	6,338	63,952
TOTAL	**1,185,008**	**130,453**	**1,054,555**

4.3 2017/18 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 2017/18 was £120.8m, which excludes the budget value for Adult Mental Health and Older People’s Mental Health inpatient services.

4.4 2017/18 Financial Performance

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

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

Budget Monitoring throughout 2017-18 has forecast an underspend of £3.946m, against which an underspend of £4.200m was actually delivered. The main broad themes are:-

- An underspend within Children Services, mainly as a result of early delivery of future year savings (£2,577,000).
- Budgeted contingency not required to be utilised in 2017/18 (£1,725,000).
- An underspend within Older People services mainly in relation to slippage within the Older People’s Residential and Day Care Strategy and the over recovery of income (£2,701,000).
- An underspend within Addiction Services due to staff turnover and occupancy levels within residential rehabilitation services (£1,557,000).

This has been off-set by overspends, the main areas being attributable to unachieved savings from 2017/18 and 2016/17 (£1,868,000). The Transformation Programme Board continues to monitor these savings to ensure these are secured moving forward. There are also ongoing costs of beds in Darnley and Quayside, accommodating adults with incapacity (‘AWI’) who have been discharged from acute services for which there is no budget in 2017/18 (£1,748,000); and an increase in demand for packages of care within Learning Disability (£708,000).

A number of commitments made in 2017/18 in relation to local and national priorities (£15.417m) will not complete until future years. These are:-

- Funding received for the delivery of national and local priorities including Primary Care and Mental Health Transformation which is required to meet future year commitments (£12,412,000);
- Commitments which were made in 2017/18, where implementation has been delayed until 2018/19 (£3,005,000);

The IJB elected to earmark the full £19,617,000 underspend for specific commitments in 2018/19. Detail of the earmarked reserves can be found at

IJB Reserves

4.5 Transforming Our Services

Within the Partnership, we have been taking forward a Transformational Change Programme across the entirety of the HSCP's business over the course of the last year. 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 vision and 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 IJB Finance and Audit Committee through budget monitoring reporting. Good progress continues to be made in the Transformation Programmes, demonstrating best value for the IJB, Council and Health Board. 96% of budget savings targets in respect of the IJB's Transformation Programme were achieved in 2017/18. Key developments being taken forward within these transformation programmes are outlined in chapter 2, within adult, children and older people's services.

This year the IJB approved Transformation Programmes for Older People, Children Services and Adult Services. This demonstrates the continued commitment to transformation and outlines our plans for the next three years.

This will deliver a whole system change within Children Services which will reduce 'failure demand' by reducing the numbers of children and young people in our care outwith the city and in expensive and 'acute' facilities that do not provide outcomes commensurate with the scale of investment. This will not only improve the performance on securing better outcomes and more positive destinations for children and young people, but enable the whole system to operate more effectively.

The OIder People transformation programme will support people to remain living independently at home for longer, reducing demand for care home placements. This is supported by work in a number of areas including unscheduled care; delayed

discharges; support for carers; development of technology enabled care; palliative and end of life care programmes.

The Adult Services transformation programme is diverse and reflects the range of services offered to this client group. Within Homelessness the development of an Alliance Commissioned approach to purchased services with the 3rd sector will focus on outcomes rather than inputs and enable innovative approaches to be taken in delivering outcomes. A review of residential rehabilitation services in alcohol and drugs has been undertaken on a co-production basis with a range of third sector providers and in consultation with people with lived experience. The output from this will be used to move towards recovery focused, shorter, more intensive programmes with stronger links to community services and the Recovery Communities.

4.6 Capital Investment and Priorities

During 17/18 site work commenced on the development of a new £20m Woodside Health and Care Centre. This will accommodate a range of health and social care services as well as specialist children's services; community alcohol and drug services; and an older people's day care unit. It is planned for completion at the end of 2018 and will be fully operational by spring 2019.

Work also commenced on the new £17m Gorbals Health and Care Centre. The new Gorbals Health and Care Centre will accommodate four GP practices; dental services, a range of health and social care services; as well as specialist children's services; and community addictions services. It is planned for completion at the end of 2018 and will be fully operational by spring 2019.

The business case for a new health and care centre in the East End Health and Care Centre continues to be developed and will continue to be progressed during 2018.

Our programme of investment also continues in our residential care homes, with work commencing on a new £24m residential care home at Leithland and a new £14m residential care home in Blawarthill, both of which are programmed to complete in April 2019.

4.7 Financial Outlook for 2018/19

The financial position for public services continues to be challenging and the IJB must operate within significant budget restraints and pressures. In March 2018, the IJB conditionally approved its budget for 2018/19, subject to approval of Health Board funding by NHS Greater Glasgow and Clyde and discussion with Glasgow City Council in relation to corporate savings which have been allocated to the IJB.

A wide-ranging programme of service reforms and efficiencies has been identified which will deliver £17m to address budget pressures in 2018/19 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 and Audit Committee and in the 2018/19 Annual Performance Report.

A forward financial outlook was reported to the IJB Finance and Audit Committee on the 7 February and the link is attached below. This covers 2019-20 to 2021-22 and makes a number of assumptions about future funding levels, inflationary and demand pressures. Based on these assumptions an annual saving of 4% is estimated per

annum, equating to the need for a further £89m of savings to deliver a balanced budget over this three year period.

Glasgow HSCP - Financial Planning 2018-21

This is against a backdrop of significant demographic change, where demographic changes in Glasgow City will likely result in increasing demand for community health and social care services. The IJB remains committed to transforming services and the Transformational Change Programmes approved this year will put us in a strong position for dealing with the financial pressures which lie ahead.

5. PERFORMANCE SUMMARY

5.1 Introduction

In chapters 2 and 3 of this report we highlighted key areas of work carried out by the Partnership and localities during 2017/18. In this chapter we draw on a number of different sources to give a more detailed picture of how the Partnership is performing.

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

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

5.2 Inspections Undertaken, Grades Awarded and Requirements

i. Care Inspectorate Grades for Glasgow City HSCP Registered Services

The Care Inspectorate undertook both scheduled and unscheduled inspections across 37 services provided by Glasgow City HSCP between April 2017 and March 2018. The overall quality of care was assessed as 'good' or better (Grade 4 and above in each Quality Theme) in 30 (81%) of services inspected during this period. The following table details the individual services inspected during this period, the care grades achieved across each Quality Theme and the number of requirements made. Full details of these inspections can be accessed on the Care Inspectorate website via the following link:

Care Inspectorate Website

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

Unit	Date Inspection Completed	Quality Theme Care Grades (out of 6)				No. of Requirements
		Care and Support	Environ-ment	Staffing	Management & Leadership	
Care Homes (Older People)						
Crossmyloof Care Home	23/05/17	2	4	2	2	3
Davislea Home For The Elderly	18/07/17	5	5	5	5	0
Drumry House	22/08/17	4	5	4	5	0
Forfar Avenue	01/09/17	5	4	5	5	0
Rannoch House	14/11/17	5	4	4	4	0
Hawthorn House	14/12/17	5	6	5	5	0
Orchard Grove House	27/02/18	4	5	5	5	0
Riverside House	20/03/18	3	5	3	3	5
Day Care Centres						
Carlton Centre	19/04/17	4	4	4	4	0
Focal Point Day Centre	16/05/17	4	5	4	4	0
Budhill Day Care	01/08/17	4	5	4	4	0
Glenwood Day Care Centre	17/08/17	5	6	5	5	0
Crossmyloof Resource Centre	25/08/17	5	4	5	4	0
Oran Street Day Centre	21/12/17	5	4	5	5	0
Corkerhill Day Care	22/03/18	4	4	4	4	0
Residential Children's Units (RCU)						
Hamilton Park Av.	15/05/17	4	4	4	3	0
Monreith Road	21/06/17	4	4	4	4	0
Airth Drive	29/06/17	4	3	5	3	0
Crawford Street	05/07/17	5	5	5	5	0
Norse Road	05/07/17	3	4	4	3	1
Dalness	30/08/17	5	4	5	5	0
Milncroft Road	02/10/17	5	5	5	5	0
Plenshin Court	10/10/17	5	5	5	5	0
Wallacewell RCU	11/10/17	5	5	5	5	0
Kempsthorn RCU	13/10/17	5	5	5	5	0
Hinshaw Street	03/11/17	2	5	2	3	2
Newark Drive	09/11/17	4	5	4	5	0
Wellhouse	13/11/17	3	4	4	3	2
Crossbank Crescent	23/01/18	5	4	4	4	0
Netherton RCU	15/02/18	5	5	5	6	0
Main Street RCU	12/02/18	5	5	5	5	0
Chaplet Avenue	16/02/18	5	5	5	5	0
Broomfield Crescent	27/02/18	6	5	6	6	0
Seamill Street	07/03/18	5	4	5	4	0
Balmore CU	15/03/18	5	5	5	5	0
Other Support Services						
GCC SWS Hostels and Supported Accommodation	07/11/2017	5	Not applicable	5	5	0
Petershill Road Community Support Project	08/08/17	5	Not applicable	5	4	0

The percentage of services inspected between April 2017 and March 2018, graded "good" or better across all 4 Quality Themes, are presented by service area in the following table.

Service Area (No. of Units Inspected between Apr 17 and March 18)	% of Services graded 'good' or better* across All quality themes
Care Homes (Older People) (8)	**75%**
Day Care Centres (7)	**100%**
Residential Children's Units (20)	**75%**
Other Support Services (2)	**100%**

*Grade 4 and above in each Quality Theme

ii. Practice Audit

In addition to external inspections, the Partnership has an ongoing planned programme of audit and self-evaluation to give quality assurance across all service areas. A list of Practice Audit activity carried out by Social Work between April 2017 and March 2018 and submitted through the Social Work Professional Governance Board is listed in the following table.

Audit/Evaluation	Service Area
Self-Evaluation	Child's Plan - South Locality
Audit	Children and Families Permanence Re-audit
Self-Evaluation	South Locality Child's Plan – further evaluation
Self-Evaluation	Adult Support and Protection (ASP) Tripartite Audit (Social Work, Health, Police)
Evaluation	Service User Evaluation of Adult Support and Protection
Audit	Intermediate Care Audit report (Interim)
Audit	13za Findings Audit report (Interim)
Audit	Audit of Older People Services
Audit	Audit of Child Protection Register figures
Audit	Contract Management
Audit	Intermediate Care and outcomes for older people leaving hospital
Audit	Use of 13za Legislation

5.3 Performance Indicators

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

A full list of the key performance indicators reported to the IJB, comparing current and baseline performance, is provided in the following tables, along with a description of the system used to rate our performance. A more detailed set of operational indicators are reported quarterly to the IJB Finance and Audit Committee and management teams and are available online at:

IJB Finance and Audit Committee Meetings

HSCP RAG Rating System

Where status against target is available, performance measures have been rated on a traffic light basis using Red, Amber or Green (RAG) categories to reflect this. Outlined below is a key to the classifications used in this report. Please note that *Status* compares current performance with target, while *Direction of Travel* compares year-end figures for 2016/17 and 2017/18 with year-end figure for the previous year. Where year-end data is not available, the most recent data is given.

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

Key Performance Indicators

HSCP performance in relation to key indicators is shown in the following table.

Indicator	Outcome No.	Target	2015/16 Baseline	2016/17 Year End	2017/18 Q4	Direction of Travel since 2015/16	Direction of Travel since 2016/17
Older People							
1. Number of community service led Anticipatory Care Plans in place.	2	360 2015/16 & 2016/17 720 2017/18	61	482	824	▲	▲
2. Number of people in supported living services.	2	650 by year end 2017/18	231	231	734	▲	▲
3. Percentage of service users who receive a reablement service following referral for a home care service.	2	75%	Hospital discharges 83%	73%	72.8%	▼	▶
			Community referrals 79%	76.5%	78.2%	▶	▲
4. Total number of Older People Mental Health patients breaching the 72 hour discharge target (including AWI patients).	9	0	23	19	13	▲	▲
5. Intermediate Care: Percentage of users transferred home.	2	>30%	25%	29%	21%	▼	▼
Primary Care							
1. Prescribing Costs: Compliance with Formulary Preferred List.	9	78%	79.81% NE 78.35% NW 79.0% South	80.18% NE 78.7% NW 79.41% South	80.09% NE 78.72% NW 79.48% South	▲ All localities	▼ **NE** ▲ **NW** ▲ **S**
Unscheduled Care							
1. New Accident and Emergency (A&E) attendances for NHS Greater Glasgow & Clyde locations	9	Target TBC	201,573	201,768	205,642	▼	▼

2i. Emergency Admissions – Numbers and Rates/1000 population by month (Aged 65+).	9	Target TBC	No. 27,891 Rate 334	No. 28,557 Rate 342	No. 27,472 Rate 329	▲	▲
2ii. Emergency Admissions – Nos & Rates/1000 population (Aged 75+).	9	Target TBC	No. 17,844 Rate 450	No. 18,123 Rate 460	No. 17,661 Rate 449	▲	▲
3. Total number of adults and older people delayed	9	20	n/a	45	39	n/a	▲
4. Total Number of Acute Bed Days Lost to Delayed Discharge (Older People 65+).	9	Target TBC	21,288	15,557	10,982	▲	▲
5. Total number of Acute Bed Days lost to delayed discharge for Adults with Incapacity (AWI) (Older People 65+).	9	Target TBC	10,715	6,050	2098	▲	▲
Carers							
1. Number of New Carers identified during the year that have gone on to receive a Carers Support Plan or Young Carer Statement	6	1,650 per annum	New indicator from 2017/18	New indicator from 2017/18	1,942	n/a New indicator from 2017/18	n/a New indicator from 2017/18
Children's Services							
1. Percentage of HPIs (Health Plan Indicators) allocated by Health Visitors by 24 weeks.	4	95%	95% NE 93% NW 96% S	99% NE 98% NW 98% S	93% NE 96% NW 96% S	**NE** ▼ **NW** ▲ **S** ▶	**NE** ▼ **NW** ▼ **S** ▼
2. Access to specialist Child and Adolescent Mental Health Services (CAMHS): % seen within 18 weeks	9	100%	100%	100%	93.6%	▼	▼

3. Percentage of young people receiving an aftercare service who are known to be in employment, education or training.	4	75%	67%	61%	67%	▶	▲
4. Number of high cost placements. New indicator introduced for 2017/18.	4	Reduction of 30 by year end 17/18	126	111	67	▲	▲
5. Mumps, Measles and Rubella (MMR) Vaccinations: % uptake in Children aged 24 months	1	95%	94.6%	93.8%	93.5% (Q3)	▼	▶
6. Mumps, Measles and Rubella (MMR) Vaccinations: % Uptake in Children aged 5 years.	1	95%	95.9%	96.4%	95.6% (Q3)	▶	▼
Adult Mental Health							
1. Psychological Therapies: % of people who started treatment within 18 weeks of referral.	9	90%	n/a	87.1% NE 81.7% NW 96.5% S	88.3% NE 87.1% NW 96.5% S	n/a	NE ▲ NW ▲ South ▶
2. Total number of Adult Mental Health patients being delayed	9	0	17	12	21	▼	▼
Alcohol and Drugs							
1. % of clients commencing alcohol or drug treatment within 3 weeks of referral.	7	90%	97%	97%	96% (Q3)	▶	▶
Homelessness							
1. Number of households reassessed as homeless or potentially homeless within 12 months.	4	<300 per annum (15/16 & 16/17) <480 per annum for 17/18	395	493	444	▼	▲

2. Number of individual households not accommodated in last month of quarter.	7	< 150	351 Mar 16	209 Mar 17	186 Mar 18	▲	▲
Criminal Justice							
1. Percentage of Community Payback Order (CPO) unpaid work placements commenced within 7 days of sentence.	9	80%	64%	65%	67%	▲	▲
2. Percentage of Community Payback Orders (CPO) with a Case Management Plan within 20 days.	9	85%	94%	97%	80%	▼	▼
Health Improvement							
1. Alcohol Brief Intervention delivery (ABI).	4	5,066 per annum	5,643	7,400	6,470	▲	▼
2. Smoking Quit Rates at 3 months from the 40% most deprived areas.	5	New annual target from 16/17 1,388 (full year)	1,229	1,250	1240**	▲	▼
3. Women smoking in pregnancy – general population	1	Target introduced 17/18 <13%	13.7%	13.4%	12.8% (Jan – Dec 17)	▲	▲
4. Women smoking in pregnancy – most deprived quintile.	5	Target introduced 17/18 <19%	20.7%	19.7%	18.5%	▲	▲
5. Breastfeeding at 6-8 weeks (Exclusive).	1	24% HSCP	25.3%	26.5%	27.5% (Oct 16 – Sep 17)	▲	▲
6. Breastfeeding: 6-8 weeks (15% most deprived data zones (Exclusive).	5	21.6% HSCP	18.2%	19.0%	19.8% (Oct 16 – Sep 17)	▲	▲
Human Resources							
1. NHS Sickness absence rate (%)	1	<4%	6.3%	6.19%	5.42%	▲	▲
2. Social Work Sickness Absence Rate (Average Days Lost)	1	<2.53 ADL at Q4 (ave. days lost per employee)	2.6 ADL	2.7 ADL	3.3 ADL	▼	▼

Business Processes							
1. Percentage of NHS Stage 1 complaints responded to within timescale**	3	70%	n/a	n/a	96.4% (Q4)	n/a	n/a
2. Percentage of NHS Stage 2 complaints responded to within timescale**	3	70%	n/a	n/a	60% (Q4)	n/a	n/a
3. Percentage of SW Stage 1 complaints responded to within timescale**	3	70%	n/a	n/a	55% (Q3)	n/a	n/a
4. Percentage of SW Stage 2 complaints responded to within timescale**	3	70%	n/a	n/a	56% (Q3)	n/a	n/a
5. Percentage of elected member enquiries handled within 10 working days.	3	80%	93%	92%	94%	▲	▲

Notes

* Smoking Quit Rates at 3 months from the 40% most deprived areas: figures may be adjusted in July.

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

5.4 National Integration Indicators

The Core Suite of 23 National Integration Indicators 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: 9 are based on feedback from the biennial Scottish Health and Care Experience survey (HACE) and 10 are derived from Partnership operational performance data. A further 4 indicators are currently under development by NHS Scotland Information Services Division (ISD). The following tables provide the most recent data for the 19 indicators currently reportable, along with the comparative figure for Scotland, and trends over time where available.

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

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

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

ii. Operational Performance Indicators

Indicator No. /Outcome	11. Premature mortality rate per 100,000 persons: by calendar year	
Outcome 1	**2015**	**2016**
Glasgow City	634	617
Scotland	441	440

Indicator No. /Outcome	12. Rate of emergency admissions per 100,000 population for adults.			
Outcome 9	**2015/16**	**2016/17**	**2017/18**	**Direction of Travel 16/17 to 17/18**
Glasgow City	14,780	14,324	12,397	▲
Scotland	12,346	12,297	11,959	▲

Indicator No. /Outcome	13. Rate of emergency bed days per 100,000 population for adults.			
Outcome 9	**2015/16**	**2016/17**	**2017/18**	**Direction of Travel 16/17 to 17/18**
Glasgow City	142,275	143,391	127,766	▲
Scotland	127,965	126,302	115,518	▲

Indicator No. /Outcome	14. Rate of readmissions to hospital within 28 days of discharge per 1,000 admissions.			
Outcome 4	**2015/16**	**2016/17**	**2017/18**	**Direction of Travel 16/17 to 17/18**
Glasgow City	97	101	90	▲
Scotland	97	100	97	▲

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

Indicator No. /Outcome	16. Falls rate per 1,000 population aged 65+			
Outcome 7	**2015/16**	**2016/17**	**2017/18**	**Direction of Travel 16/17 to 17/18**
Glasgow City	29	31	29	▲
Scotland	21	21	22	▼

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

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

Indicator No. /Outcome	18. Percentage of adults with intensive care needs receiving care at home	
Outcome 9	**2015/16**	**2016/17**
Glasgow City	55%	55%
Scotland	62%	61%

Indicator No. /Outcome	19. Number of days people aged 75+ spend in hospital when they are ready to be discharged, per 1,000 population			
Outcome 9	**2015/16**	**2016/17**	**2017/18**	**Direction of Travel 16/17 to 17/18**
Glasgow City	627	464	321	▲
Scotland	915	842	772	▲

Indicator No. /Outcome	20. Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency			
Outcome 9	**2015/16**	**2016/17**	**2017/18**	**Direction of Travel 16/17 to 17/18**
Glasgow City	25%	27%	24%	▲
Scotland	24%	25%	23%	▲

Notes

Please note that the data for 2017/18 likely to be subject to change at next issue of data.

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

Indicator No.	Outcome
10. Percentage of staff who say they would recommend their workplace as a good place to work	8
21. Percentage of people admitted to hospital from home during the year, who are discharged to a care home	2
22.Percentage of people who are discharged from hospital within 72 hours of being ready	9
23. Expenditure on end of life care, cost in last 6 months of life	9

Ministerial Steering Group Indicators

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

Indicator	2016/17	2017/18
Number of emergency admissions	75,655	68,526
Number of unscheduled hospital bed days (acute specialties)	525,011	483,695
A&E attendances	201,768	205,642
Acute Bed Days Lost to Delayed Discharge (Over 65s including Adults with Incapacity)	15,557	10,982
Percentage of last six months of life by setting	85.7%	TBC
Balance of care: Percentage of population at home (unsupported)	98%	TBC

5.5 Key Achievements

In this section we highlight where performance has shown the greatest improvement over the past 12 months (April 2017 – March 2018).

Indicator	Baseline (16/17 Year End)	Year End 2017/18 (Q4)
Older People		
Number of community service led Anticipatory Care Plans in place	482	824
Number of people in supported living services	231	734
% Service users who receive a reablement service following community referral for home care	76.5%	78.2%
Unscheduled Care		
Acute bed days lost to delayed discharge	15,557	10,982
Children's Services		
% of young people receiving an aftercare service who are known to be in employment, education or training	61%	67%
Number of children in high cost placements	111	67
Homelessness		
Number of households reassessed as homeless or potentially homeless within 12 months	493	444
Number of individual households not accommodated in the last month of the quarter	209	186
Health Improvement		
Women smoking in pregnancy – general population	13.4%	12.8%
Women smoking in pregnancy – most deprived quintile	19.7%	18.5%

5.6 Areas For Improvement and Incorporation Into the 2019/22 Strategic Plan

Ongoing improvement is sought across all services within the HSCP and a range of mechanisms are in place to scrutinise performance at city wide and locality levels, as described in chapter 1.

Specific areas we would like to improve and key actions we will progress to achieve these improvements are summarised below. These will be incorporated into the new Strategic Plan which will cover 2019-22.

Area for Improvement	Actions
Unscheduled Care	
Working with NHS acute services: • Reduce the number of inappropriate A&E attendances and emergency hospital admissions • Reduce the numbers of people who are unnecessarily delayed in hospital across all client groups	Actions we will take to achieve improvement, as documented in the Unscheduled Care Plan include : • Review data on potentially avoidable admissions by GP practice and share with GP Clusters • Continue to develop Anticipatory Care and the Community Respiratory Service • Work with acute to pilot integrated models of care • Further develop intermediate care, and embed the home is best service and integrated neighbourhood teams as part of the older people system of care.
Children's Services	
• Further increase the percentage of young people in aftercare in employment, education or training. While there has been an improvement, performance remains below the target of 75%.	• Implement our children's transformation programme to promote effective early intervention and to support families as these are vital to ensuring improved longer term outcomes for children and young people. • Improve partnership with the large number of organisations in the City and nationally that are "corporate parents" to identify how they can help young people access positive opportunities.
• Access to specialist Child and Adolescent Mental Health Services (CAMHS): % seen within 18 week	Recent adjustments to criteria have led to an increase in referrals and demand for the CAMHS service. A number of actions are being undertaken to achieve improvement: • Temporary changes to core working hours. • Introduction of a Quality Improvement Programme to focus on four work streams; review of overall service provision, leadership and culture; service improvements; training and support; and supervision and leadership.
Criminal Justice	
• Increase the Percentage of Community Payback Order (CPO) work placements commenced within 7 days of sentence.	• Continue to work in conjunction with Court Services to increase the number of service users presenting for interview on the day of court. •

Health Improvement	
• Further increase exclusive breastfeeding in the most deprived neighbourhoods (at 6-8 weeks)	Actions we will take to achieve improvement: • Continue to support breastfeeding mothers individually. • Continue to deliver weekly breastfeeding support groups. Although these groups are all held within the most deprived neighbourhoods (SIMD 1 and 2) they are open to all mums to attend. • Continue to ensure that Glasgow services maintain the standards associated with the new UNICEF Baby Friendly standards which promote best practice in relation to breastfeeding. • Continue to promote positive attitudes to breastfeeding and seek to normalise it within all of our communities.
Human Resources	
• Reduce Social Work and NHS staff sickness absence rates.	Actions we will take to achieve improvement: • Managers to continue to maintain an overview of attendance for each locality, monitoring trends and patterns. • Continue to implement early intervention processes for psychological and musculoskeletal absences. • Managers to continue to engage with senior management teams to shift the focus onto 'promotion of attendance'.
Business Processes	
• Increase the percentage of Social work complaints responded to within timescales	Actions we will take to achieve improvement: • Additional staffing resources to respond to increasing demands on the Rights and Enquiries Team are being put in place. • Embedding and reinforcement of the new complaints timescales and procedures.

Appendix A

Glasgow City Profile – Additional Information

Development and Regeneration Population page	Information on the city's population and needs
Understanding Glasgow	Health and wellbeing profiles for adults and children
Greater Glasgow and Clyde Health and Wellbeing Survey	Survey information on adult health and behaviours in the city. The latest full survey report is for 2014/15. The 2017/18 survey is due to be published at the end of 2018.
Glasgow City Schools Health and Wellbeing Survey	Survey Information on secondary school children's health and behaviours in the city. The latest survey was for 2014/15. The next survey will be undertaken at the start of the 2018/19 school year, reporting during 2019.
Glasgow Health and Care Experience Survey	This is used for measuring perceptions in relation to GP, care and carers services. It also measures progress against the national integration indicators. The latest survey is for 2017/18.
Scottish Health Survey	Information in relation to the health and health related behaviours. Annual survey with latest results from the 2016 survey
Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS)	Conducted on a biennial basis, targeting secondary school pupils in local authority and independent schools. The SALSUS 2015 survey provides national level data on smoking, drinking, drug use and lifestyle issues amongst Scotland's secondary school children
2016 SIMD	Uses multiple indicators to provide comparative information on population deprivation at a small area level (data zones) within Scotland.
Scottish Public Health Observatory (ScotPHO)	Presents a range of information from routine health statistics to survey data.
Scotland's Census	Takes place every 10 years with the last one in 2011.

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