Item No: 16

Meeting Date: **Wednesday 19th September 2018**

Glasgow City Integration Joint Board

Report By: **Susanne Millar, Chief Officer, Strategy and Operations / Chief Social Work Officer**

Contact: **Jackie Kerr, Assistant Chief Officer, Adult Services**
Stephen Fitzpatrick, Assistant Chief Officer, Older People's Services
Mike Burns, Assistant Chief Officer, Children's Services

Tel: **0141 314 6240**

HEALTH AND SOCIAL CARE PARTNERSHIP LOCALITY PLANS 2018/19

Purpose of Report:	To present the 2018/19 locality plans of North East, North West and South Localities for approval. In doing so, to highlight progress made over the last year, local priority actions and key areas of work being undertaken within localities that contribute to the delivery of the IJB strategic plan.

Background/Engagement:	This is the third annual locality plan completed in line with the 3 year timeframe of the current IJB Strategic Plan. It continues to be influenced by extensive community engagement undertaken in previous years, along with regular and ongoing stakeholder engagement undertaken with localities. Draft locality plans have been presented to respective Locality Engagement Forums.

Recommendations:	The Integration Joint Board is asked to: a) approve the locality plans attached and note these will be circulated to stakeholders and be made available publicly along with user friendly summary versions.

Relevance to Integration Joint Board Strategic Plan:

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

Implications for Health and Social Care Partnership:

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

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

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

Provider Organisations:	None

Equalities:	Each locality plan sets out the equalities issues and actions to address these. Significant areas of service change referred to within the locality plans will already have been subject to an EQIA and made available on the GCHSCP website, accessible at the link below: https://glasgowcity.hscp.scot/equalities-impact-assessments

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

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

Economic Impact:	None

Sustainability:	None

Sustainable Procurement and Article 19:	None

Risk Implications:	None

Implications for Glasgow City Council:	None

Implications for NHS Greater Glasgow & Clyde:	None

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

1. Purpose

1.1 To present the 2018/19 locality plans of North East, North West and South Localities for approval. In doing so, to highlight progress made over the last year, local priority actions and key areas of work being undertaken within localities that contribute to the delivery of the IJB strategic plan.

2. Background

2.1 The Integration Joint Board's Strategic Plan 2016-19 describes the three localities that make up Glasgow City Health and Social Care Partnership, along with the commitment to develop locality plans on an annual basis in line with Scottish Government guidance on the production of locality plans.

2.2 The purpose of locality plans is to:

a) show how each Locality will contribute to the implementation of the HSCP's Strategic Plan 2016-2019;
b) how the locality plans respond to local needs and issues; and
c) to share and communicate the content with key stakeholders to improve local engagement and service planning.

2.3 The plans are a one year plan covering the period April 2018 to March 2019. The plans are based on:

- what we know about health and social care needs and demands and any changes from our 17/18 locality plan;
- our current performance against key targets;
- our key service priorities, informed by the HSCP's Strategic Plan
- the resources we have available including staffing, finance and accommodation.

3. Development and Engagement

3.1 This is the third year in which locality plans have been produced in GCHSCP. For continuity, the content and structure broadly follows that of previous year's plans.

3.2 Locality plans for 2018/19 have been developed to take into account progress made against actions in last year's locality plans, including improvement targets for key performance indicators.

3.3 The development of locality plans has been overseen by each locality's senior management team and implementation of actions is the collective responsibility of that team. This will be done in close collaboration with the 3 care group Core Leadership Groups within the HSCP.

3.4 As part of an on-going process of engagement and involvement, Localities will continue to engage with key stakeholders on the development and implementation of its key priorities and actions, as set out in the locality plans. Such engagement

will be undertaken in accordance with the IJB's Participation and Engagement Strategy. Targeted engagement on the detailed content of locality plans has included Locality Engagement Forums and HSCP Core Leadership Groups.

3.5 Approved locality plans will be presented to Community Planning Partnership Boards. Approved locality plans, along with the summary versions, will be published on the HSCP website and made available to a wide range of local stakeholders including elected members, community planning partners, third and independent sector partners, community groups and service user and carer representative groups.

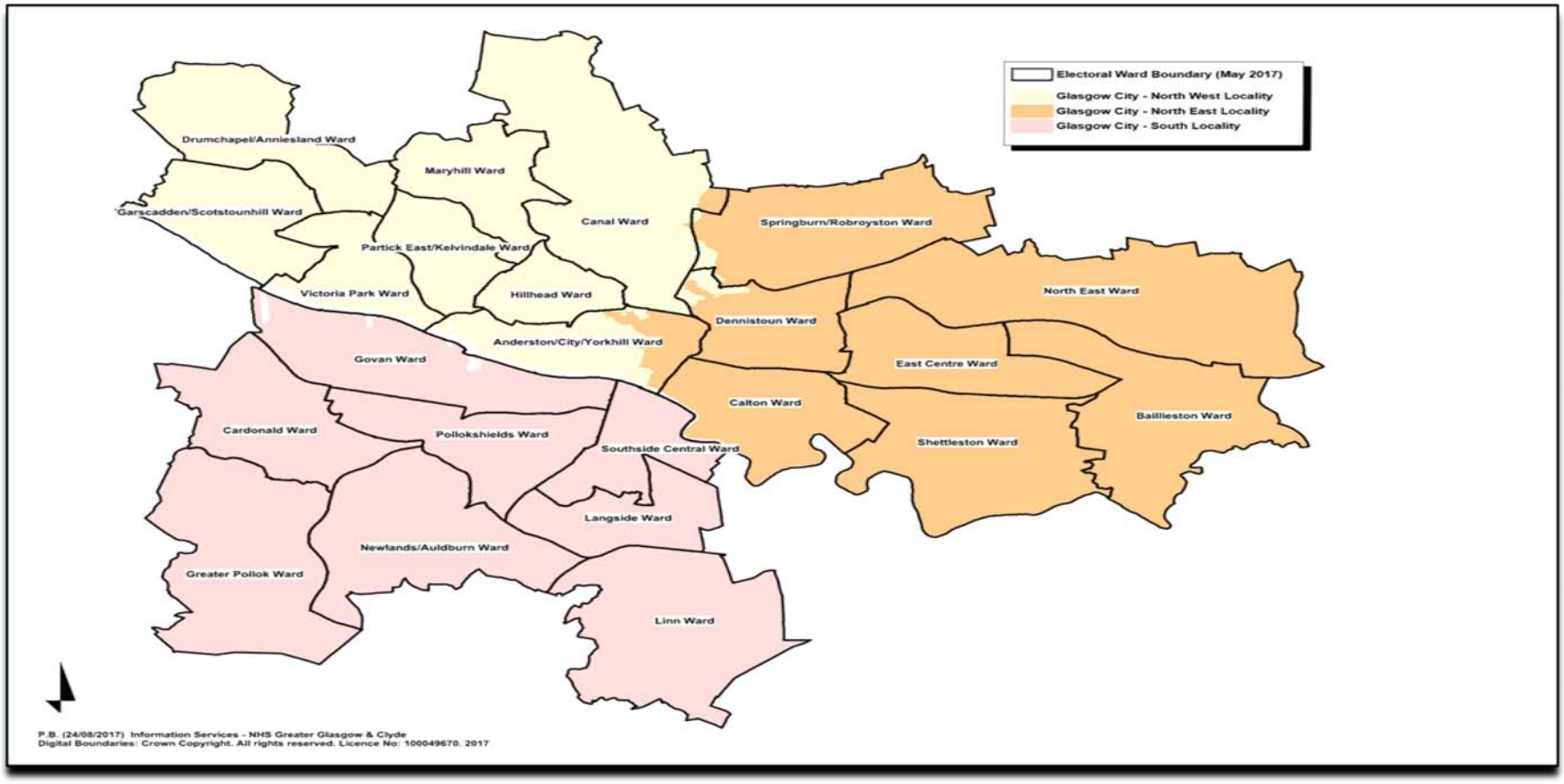
4. Recommendations

4.1 The Integration Joint Board is asked to:

a) approve the locality plans attached and note these will be circulated to stakeholders and be made available publicly along with user friendly summary versions.

Glasgow City HSCP
Health and Social Care Partnership

North East Glasgow Locality Plan 2018/19



FOREWORD

This Plan represents an update of the North East (NE) Locality Plan 2017/18. The plan aims to provide an overview of the progress made during 2017/2018 and to identify our priorities and actions for 2018/2019.

Over the last year, we have taken opportunities through a diverse range of forums to engage with community representatives, the housing sector and third sector colleagues in what we do and what we want to achieve. A significant focus of our engagement strategy has also been to focus on meeting our staff and hearing from them what opportunities Health and Social Care integration gives us to improve the services we are responsible for delivering in the North East of the city. I am delighted to report that we have achieved performance improvement in a number of areas (detailed later in this report) and this is directly attributable to the efforts of our frontline staff and managers who are focused on really making a difference to the lives of the people who use our services. Our aim is to continue this across our services in the coming year. We know the impact that poverty and deprivation has on the lives of people in places like the North East of Glasgow and we have worked on a number of initiatives to tackle poverty including the significant investment in financial inclusion and the Thriving Places approach across the North East area. Again, our aim will be to keep focused on that work.

We continue to work in a challenging financial context which means we need to continue to ensure that we are delivering services that genuinely and significantly impact positively on people's lives and redirects resources where they don't.

We are committed to building on our achievements over the last year and looking forward once again to working closely and in partnership with our local communities, our staff and other agencies/ organisations.

We will be consulting widely on our plan throughout this year, and if it becomes apparent that we need to amend/ change any of it, we will commit to do so.

Mike Burns,
Head of Strategy & Operations (Children's Services),
Glasgow City Health & Social Care Partnership

Introduction

Glasgow City Integration Joint Board (IJB) came into being in February 2016 and in March the Board endorsed a three year Strategic Plan for the period up to 2019. In that Plan the IJB set out its vision for health and social care services -that the City's people can flourish, with access to health and social care support when they need it. The IJB envisaged that this would be achieved by transforming health and social care services for better lives. This Locality Plan runs alongside and is driven by the Strategic Plan.

1. HSCP KEY PRIORITIES

The biggest priority for the HSCP is delivering transformational change in the way health and social care services are planned, delivered and accessed in the city. We believe that more of the same is not the answer to the challenges facing Glasgow and will strive to deliver on our vision as outlined 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 HSCP localities are an important part of our integration arrangements to improve the delivery of health and social care services for the people of Glasgow. We have agreed three localities in Glasgow – one covering the North East of the city, one covering the North West and one the South of Glasgow. A key responsibility of localities is to produce a locality plan for the area they serve. This document is the locality plan for North East Glasgow. Similar plans are also available for the North West and South.

The purpose of this plan is to:

- Show how we will implement the HSCP's Strategic Plan 2016-2019 in the North East of the city, and what this will mean for service users, patients and local communities; and
- How we will respond to local needs and issues.

The plan is a one year plan covering the period April 2018 to March 2019. The plan is based on:

- What we know about health and social care needs and demands and any changes from the 17/18 plan;
- Our current performance against key targets;
- The key service priorities as defined in the HSCP's Strategic Plan, including health improvement and what we are doing to tackle inequalities; and,
- The resources we have available including staff and accommodation.

We will report later in the year on how we are doing in implementing the plan and identify further areas of improvement for next year's plan. If you have any comments on this plan, let us know.

2. COMMUNITY ENGAGEMENT – LOCALITY ENGAGEMENT FORUM ►

Glasgow City Health and Social Care Partnership recently completed a consultation on how best to engage with local people about health and social care issues. North East sector held a number of public consultations asking for people to comment on the HSCP Participation and Engagement Strategy and the comments made by North East Representatives during the Consultation. This resulted in a number of key actions to be developed:

- Groups should receive information regarding changes to services
- The opportunity to comment on changes before the final decision is taken.
- The importance of providing consultation feedback to service users explaining the reasons for the decision and evidence that their views were taken into consideration.
- Two way communications is very important.
- Particularly important is the commitment to provide support to enable people to participate in engagement activity.

Representatives from North East Public Partnership Forum, North East Voices for Change, East End Community Addiction Forum and Carers Forum, met in March 2017 and agreed to establish the North East Locality Engagement Forum. Over the past 12 months the priorities for this new Forum have been:

- Development work with community representatives to agree working arrangements ensuring that the Forum can achieve the aspirations set out in its new remit
- Further develop the membership of the Forum and establish a wider network to include hard to reach vulnerable groups
- Focus on the North East Locality Plan to ensure that local people have their say on current and future service provision
- Support wider public involvement in the planning and decision making of services that are delivered locally
- Approve full engagement on the Parkhead Hub proposal be carried out by the HSCP from April to June 2017

The North East Locality Forum is now well established with regular meetings taking place between Forum members and Heads of Service who discuss the priorities and performance of services. The aim of the monitoring of the information is to measure the difference being made to local services. This allows forum members to help identify the outcomes and priorities that will make a real difference to the lives of local people.

The North East locality were asked to undertake engagement and communication across the area with staff, the local community and third sector organisations on the proposal to have a purpose built Health and Social Care Hub in the area. An engagement plan was developed to ensure appropriate coverage together with a poster, information leaflet, Q&A sheet and questionnaire available in hard copy or as a survey monkey on line questionnaire. Following the consultation period two public meetings were held to update on activity undertaken.

In the coming year 2018/2019 we will further develop the membership of the Forum and establish a wider network to include hard to reach vulnerable groups

To find out more about the Locality Engagement Forum please contact: Tony Devine, community Engagement Officer (North East Locality) on 0141-553-2861

4. PERFORMANCE INFORMATION

Where We Are Performing Well

Older People:	**Addictions:**
Open OT activities : % over one year	% of service users with a Recovery Plan
	% commencing treatment within 3weeks of referral
	%Parental assessments completed within timescale
Continence Service – Waiting Times	**Primary care:**
Home Care: % Reviews	Numbers on GP practice dementia registers
Reablement: % requiring no further home care support following reablement	**Unscheduled Care:**
number of Anticipatory Care Plans in place	Bed Days Lost to Delayed Discharge (Older People 65+)
number of Residential Care Reviews	**Health Improvement:**
number of referrals to Telecare	Breastfeeding: 6-8 weeks (exclusive)
Deaths in Acute Hospitals 65+ and 75+	Nos of Alcohol Brief Intervention deliveries
Homelessness:	
Number of individual households not accommodated over last quarter	
Prescribing Costs:	**Carers:**
Compliance with Formulary Preferred List	Qualitative Evaluation Question: Improved your ability to support the person that you care for
Annualised cost per weighted list size	Number of Carers who have completed an Assessment during the quarter
Children:	**Business Processes:**
Access to specialist Child and Adolescent Mental Health Services (CAMHS) services – Waiting Times	% of elected member enquiries handled within 10 working days
Nos of referrals to healthier and Wealthier Children's Services	NHS complaints within agreed timescale
	SW Complaints - % handled within agreed timescales
% of HPIs allocated	
	Human Resources:
	Social Work Sickness Absence Rate

Where Improvement Required

Older people:	**Health Improvement:**
	Number of 0 – 2 year olds registered with a dentist
Reablement: % receiving a service following referral	Alcohol brief intervention delivery (ABI)
Intermediate Care :	Smoking quit rates at 3 months (40% most deprived areas)
Average length of stay	Breast Feeding 6 – 8 weeks (exclusive) in 15% most deprived areas
Unscheduled care:	
Delayed discharge: No. of patients over 65 breaching the 72 hour target	**Criminal Justice:**
No. of patients over 65 classed as AWI breaching the 72 hour target	% of CPOs with a Case Management Plan within 20 days
Adult Mental Health patients breaching the 72 hour target (Under and over 65 including AWI patients).	% of Unpaid Work (UPW) requirements completed within timescale
Adults under 65 breaching the 72 hour target.	% of Community Payback Order (CPO) work placements commenced within 7 days of sentence
Children:	% of CPO 3 month reviews held within timescale
% of young care leavers in employment, education or training	**Homelessness:**
	Number of households reassessed as homeless or potentially homeless within 12 months
	% decision letters issued within target after initial presentation
	% of live homeless applications over 6 months duration at end of quarter
	Human Resources:
	NHS Sickness absence rate
	NHS staff with an e-KSF

5. SERVICE PRIORITIES

Children and Families

Local Priorities	Key Actions 18/19	Progress 17/18	Target/Timescale
Early and effective intervention aiming to give all children and young people the best possible start in life	Review duty and redesign services which target families sooner and reduce need for statutory services	Review of North East early years Joint Support Teams (JST) took place and remit now expanded to discuss well being concerns by Named Person	Consultation on findings June 2017
	Continue to reduce the number of children placed on the Child Protection Register and the length of time of registration.	Third sector engaged in assisting with the provision of family support services across the locality at immediate point of contact and improved rapid response to early intervention nos reduced by 50% Jan 2018. Lottery Bid successful to develop a consortium approach in partnership with third sector organisations Health Improvement team has established a link with the Family Group Decision Making (FGDM) team and a proposal has been drafted which outlines the potential HI contribution to this workstream; Review impact of Family Group Decision Making (FGDM) in reducing the need for child protection	Ongoing 2018/19 Information will be available for end of Feb 2018 on the Review of impact of Family Group Decision Making. (interim evaluation has been produced and has positive findings)
Involve children in decisions that affect them, have their voices heard	Continue to consult with young people and develop contemporary strategies which reflect how young people currently communicate through social media and determine how this can influence child protection and looked after children and processes	NE Safeguarding group established and have reviewed Have Your Say, Talking Mates and Viewpoint for all Looked After/Looked After and Accommodated Children Local consultation planned with health improvement, social work and planning detailing NE service user process and outcomes	Joint approach to this work with Children's Rights commenced June 2017 and will consider role of social media Work will be ongoing in 2018/2019

Children and Families (continued)

Local Priorities	Key Actions 18/19	Progress 17/18	Target/Timescale
Work with families to improve the life chances for children, with a specific focus on family resilience, health improvement, educational attainment and reducing the number of children looked after away from home	Implement the new Universal Pathway for Children aged 0-5 years Build on the success of the Early Years Joint Support Teams and repeat a Validated Self Evaluation for each one Implement Change to support children who require dental extraction and promote the Dental Health Support Worker (DHSW) role of health improvement and prevention of dental caries	No clear reason was identified in 2017/18 for the low uptake of Triple P discussion group in the North East Locality. This will be reviewed again as part of the Universal Pathway implementation in 2018/19	Ongoing in 2018/2019
	Implement the new antenatal support model identified by the Glasgow HSCP group working with the Scottish Government Children and Young Person Improvement Collaborative Roll out the Early Years Collaborative test of change to support children who require dental extractions	Team Established and Training Completed Steering Group established Research and Evaluation Resource identified	Interim Report completed February 2018 Work ongoing in 2018/2019

	Implement and evaluate the Family Group Decision Making team. (FGDM) Promote extended family network searches to offer a FGDM process to priority groups identified as cusp of care, recently accommodated young people, pre birth and young people placed in residential units within and outwith the city. Support the roll out of FGDM across the city Promote Life Long Links model of practice to those within the pilot age range (accommodated up to 3 years, 5-15), and work to embed the approach in services to support LAAC young people who do not fit the trial criteria	Team Established and Training Completed Steering Group established Research and Evaluation resource identified	Ongoing roll out of the service in 2018/2019
Review Permanence Planning process and improve performance	Introduce new review systems via permanence tracker and identify ASM champions Roll out development of permanence processes to children and young people in kinship placements	City wide target of permanence reviews of 96% met by Nov 2017 and sustained	Maintain performance level for 2018/2019

Criminal Justice

Local Priorities	Key Actions 18/19	Progress 17/18	Target/Timescale
Better Access to Addiction, Mental Health and homelessness services for Criminal Justice Service Users	Quarterly liaison meetings to continue between Criminal Justice and Addiction teams to monitor and address local issues Organise development sessions with the mental health team to look at improving joint working between teams	Local liaison meeting between Criminal Justice and Addiction Services led to development of paper looking at local processes / protocols Development session held with Criminal Justice and homelessness staff looking to improve joint working between the services	Quarterly monitoring meetings July 2018
Promote interface, communication and information sharing with Children and Families services in response to child protection concerns	Continue to raise awareness of the information sharing tool and ensure it is used appropriately. Evaluate impact of the tool in the Child Protection process	Information sharing tool developed and rolled out to Children and Families team Work done with Children & Families team leaders to raise awareness of tool and ensure use at Child Protection Meetings	Dec 2018
Evaluate North East Women's Team in terms of effectiveness and impact on service user's wellbeing indicators	Cohort of women to be interviewed, data to be collected and analysed and report to be completed summarizing findings	N/A	Dec 2018

Adult Services

- **Alcohol and drugs**

Local Priorities	Key Actions 18/19	Progress 17/18	Target/Timescale
Early Intervention and Harm Reduction by increasing Blood Borne Virus (BBV) and HIV testing and increase in harm reduction interventions	Implement further Hepatitis clinics within the Alcohol and Drug Recovery Service (ADRS) to support more patients to access Hepatitis treatment alongside Opiod Replacement Therapy (ORT) prescription	Increase in addiction patients that have engaged with Hepatitis treatment in the community through specialist ORT clinic	Further Hepatitis clinic to be established by July 2018. A further 10% increase in patients receiving Hepatitis treatment at ORT clinics by September 2018.
	Increase Blood Bourne Virus testing through dry blood spot testing and maintain overview of new HIV diagnosis in NE. Engage patients in treatment through links with community Brownlee service.	Numbers of patients tested by medical officers and nursing staff increased in 2016/17; Increase in numbers of patients accessing treatment through Brownlee assertive outreach	Data will be reviewed in June 2018 to consider whether further work is required to target testing;
	Access team to engage service users who require treatment quickly, identify vulnerabilities and complex needs, and outreach to the harder to reach population. Deliver harm reduction advice and support as a core task	Access teams established in 2017 with the aim of engaging patients appropriate to the service and linking with other services where required; Non-medical prescriber aligned to the New Patient Clinic; Pathways being developed with other teams within the service for speedy allocation to appropriate teams – Criminal Justice, Parents, Shared Care or Core.	Pathways to be developed and embedded by July 2018; Audit of access team and outcomes to take place in March 2018 and September 2018; Harm reduction toolkit to be rolled out by June 2018
	Continue to receive regular feedback from citywide ADP Harms Group (formerly drug and alcohol death prevention sub group). NE locality ADP Prevention Group, chaired by ADRS and Health Improvement to produce action plan and report quarterly to NE ADP Strategic Group. Link to full prevention and harm reduction agenda across all statutory and third sector services	Quarterly reporting from ADP Drug and Alcohol death prevention sub group took place and services were reviewed to take account of the increase of HIV Diagnosis, with an improved link with Brownlee service. Fire safety and young people were added to the NE ADP Prevention action plan.	Quarterly reporting and review of services

Ensure recovery is an integral part of treatment, from the first point of contact through to exit from service	Recovery planning from initial contact and throughout treatment and care, assisted by implementation of new model. Implementation of Recovery Outcome Indicator tool (ROI) in line with Scottish Government timeline	ROI was piloted and useful in recording recovery outcomes for service users. Awaiting Scottish Government guidance on timescales for full implementation.	At least 70% service users with recovery plans by December 2018. Implementation of ROI by December 2018

Alcohol and Drugs (continued)

Local Priorities	Key Actions 18/19	Progress 17/18	Target/Timescale
Ensure recovery is an integral part of treatment, from the first point of contact through to exit from service	Continue staff training in recovery planning through team development	Sainsbury's model for recovery planning was introduced in 2017 and requires ongoing development in setting priorities for the Alcohol and Drug Recovery Service	Review team development plans and priorities, and outcomes for service users by September 2018
	Continue staff training for recovery	Recovery training for staff (social care, nursing and medical) commenced June 2016	Completed June 2017
	Continue to Support and develop Recovery Communities and Recovery Hubs. All developments in service to consider recovery hubs and recovery community involvement. Develop recovery clinics led by peers.	Interface meetings with Recovery Hubs established; Recovery Hub staff are linked to sub-teams within ADRS; Service users accessing Recovery Hubs increased by 10%	A further 10% increase in service users accessing Recovery Hub by July 2018; Recovery clinics to be established and embedded in ADRS by July 2018.
	Increase the number of alcohol and drug users in recovery and using community supports	Reporting framework not available although numbers attending recovery initiatives have been maintained	Increase of 10% of service users leaving the service through planned discharge due to recovery by December 2018
	Continue to re-model the service to continue to promote recovery and lived experience input into service developments	Implementation of Alcohol and Drug Recovery Service complete; Lived experience represented at all NE ADP sub-groups and Strategic Group; Lived experience representation at Recovery Hub and Alcohol and Drug Recovery Service interface meetings.	Consult recovery communities, lived experience and wider community in September 2018 to review the effectiveness of community involvement.

Support Children and Young People affected by their own, or their carers', alcohol or drug use	Assess, and access support for, children and young people affected by parental alcohol and/or drug use	Parents sub-team established in the Alcohol and Drug Recovery Service, focusing on families where child protection issues have been identified, and early intervention cases; Homework clubs for children affected by parental substance use developed in Springburn and Haghill; Chronology began to be developed for use by ADRS Parents Team	Chronology to be developed and implemented by August 2018; Review of the Impact of Parental Substance Use assessment by August 2018; Further Homework Club to be developed in Easterhouse area by January 2019
	Increase support to young people who use alcohol and/or drugs. Identify specific Alcohol and Drug Recovery Service (ADRS) young person's workers to link to children's residential units in NE Glasgow to offer direct interventions or indirect support through advice to residential staff.		Service to be established with residential units by June 2018; Review outcomes for children and young people by December 2018

Learning disability

Local Priorities	Key Actions 18/19	Progress 17/18	Target/Timescale
Continue personalisation assessments for all people who have a learning disability and are eligible to receive a service	Ensure that all service users are assessed through personalisation, appropriate funding agreed commensurate with their level of need	- 67 new SNAs (resulting in 62 OBSPs). Remaining 5 are care home placements- OBSP not required.	Continues to be a priority area of work that will be reviewed every three months
	Outcome Based Support Plans (OBSPs) are developed in collaboration with service users, families and other partners ensuring that people are safe, protected and supported to live as independent lives as possible	- 62 new OBSPs in place	As Above
Partnership approach to remodeling of some of our social care provision to meet changing needs and financial challenges	Collaborative work ongoing with providers and HSCP in relation to service users profiles and modeling appropriate health and social care provision	4 service users in NE (2 are currently subject to13 discharge planning discussion).	Ongoing
	Continue to review all those brought through personalisation in the last two years, to ensure ongoing support is targeted to meet current needs and where appropriate remodel services/approaches	303 Reviews completed by Project Team to targets set (30 more being completed at present).	City wide panels set up to complete 1,100 reviews of all service users across the city receiving day time supports – to be completed by October 2018
	Phase 2 – service users who receive sleepover services as well as day time supports – 132 service users care packages to be reviewed	139 service users (previously subject to proportionate review) will require full care management review in line with commissioned services re-design/ Telecare development.	Locality Care Management Project Team established to review all service users receiving services from social care providers - to be completed 2018

Adult mental health

Local Priorities	Key Actions 18/19	Progress 17/18	Target/Timescale
Continue to improve waiting times to access Primary Care and Community Mental Health Teams	Collate the relevant data to establish a baseline and: Continue to monitor the 18 weeks to referral to treatment - Access target for Community Mental Health Teams (CMHTS)/Primary Care Mental Health Teams (PCMHTS) Review staffing profiles in the community and agree an action plan. Recruitment issues - reduce temporary/secondment post to encourage sustainability of the workforce	Standard operating procedures introduced across CMHTs Agreed response times to referrals of Emergency – same day Urgent within 5 working days and routine within 20 working days	Ongoing review throughout 2018/2019
	Continue to ensure we have the most appropriate and efficient staffing model as we further develop the future CMHT models and clinical care pathways.	Review of all CMHT staffing posts across all disciplines	Ongoing throughout 2018/2019
Ensure effective transfer of wards on Parkhead site to Stobhill Site	Continue to liaise with staff, patients and carers to ensure effective communication regarding progress.	Achieved - wards transferred to the Stobhill site.	Ongoing and transfer expected by early 2018

Adult Mental Health (continued)

Local Priorities	Key Actions 18/19	Progress 17/18	Target/Timescale
Complete personalisation assessments for all people who have a mental health difficulty and are eligible for services Support people to live as independently as they can within their own home with support	Improve performance in relation to the completion of Support Needs Assessments and Outcome Based Support Plans which will improve access to social care services. Additional performance targets to be set with all plans to be routinely completed within two month period Carry out a data cleanse exercise and ensure timely reviews	17/18 - 41 service users care plans were reviewed with support remaining in place	Continues to be a priority area of work that will be reviewed every three Months in 2018/2019
	Outcome based support plans(OBSPs) are developed in collaboration with service users, families and other partners ensuring that people are safe, protected and supported to live as independent lives as possible	37 new OBSPs completed (7 abandoned due to service being declined)	Ongoing in 2018/19
	There is a continued need for improvement, which would require to pick up on individual staff performance. However Mental Health (MH) input to Adult Care duty has increased to accommodate targets around sleepover reviews, where expertise sits with Learning Difficulties. The MH Team has lost 2 Mental Health Officers (MHOs) within the last year however a new MHO is now in post. Adult Care is subject to review where throughput of MHO work (less than 10%) will be balanced against staff commitment (28.5%)	60 Support Needs Assessments (SNAs) completed (17 abandoned due to non engagement by service users) Of 60 completed – 37 translates to OBSPs as per above. The other 23 translated to residential services/SARA supported accommodation placements where OBSP is not required There were 34 reviews completed, with an additional 30 completed by the NE Project team (therefore transferred from Original Worker)	Resource Allocation Panels to increase to weekly from monthly to ensure performance targets are met for completion of Support Needs Assessment and Outcome Based Support Plans
	Improve how we work across HSCP and the voluntary sector to ensure that the spectrum of need from mild to moderate mental distress/illness to acute chronic and enduring mental illness is addressed	Meetings with voluntary and social care providers have been ongoing throughout 2017/2018	Ongoing – agreed approach for 18/19 to be agreed at Adult Mental Health Management Team

Adult Mental Health (continued)

Local Priorities	**Key Actions 17/18**	**Progress 16/17**	**Target/Timescale**
	Review all models of support to take forward the reshaping of supported accommodation and supported living to meet current needs, ensuring that people in most need can be prioritised for high levels of support	44 people currently supported within supported accommodation in North East	Ongoing during 2017/2018
Inpatient Services	**Actions 18/19**	**Progress 17/18**	**Target/Timescale**
Reduce average length of stay ensure effective use of beds	Review inpatient pathways Review complex care reviews Reduce occupied bed days Investigate data behind absconsion rates and reduce by 10%	New Action	Work ongoing in 2018/2019
Ensure delayed discharges are within target range	Appoint a Discharge Co-ordinator	New Action	Post filled in 2018
Unscheduled Care – ensure early identification of barriers to discharge	Implement regular meetings at HSCP level with housing/social work/inpatient and community based services. Rehabilitation services – ensure effective use of beds in conjunction with NW	New action	Ongoing in 2018/2019

Inpatient Activity	Improve therapeutic interventions for inpatients Reduce illicit drug use Increase referrals to Link Workers, financial inclusion services and employment opportunities Implement supplementary staffing action plan Reduce the use of Bank staff	Development of increased staffing resource to provide therapeutic activities in evenings and weekends – due to commence April 2018. Roll out of PcPsych AIMS across all inpatient areas commencing April 2018	2018/2019

Homelessness Services

Local Priorities	Key Actions 18/19	Progress 17/18	Target/Timescale
Improve interface with housing providers to increase access to settled accommodation	Continue to input into Local Letting Communities	Represented at Local Letting Community Forums to achieve targets on settled accommodation	Ongoing
		Work ongoing to increase the number of available permanent tenancies through RSLs	Ongoing
	Registered Social Landlords (RSLs) to provide sessions to the Community Homeless Team highlighting areas of tenancies that are regularly void	Referrals for permanent accommodation has increased significantly in the last six months	Ongoing throughout 17/18
Increase in number of households securing permanent accommodation	Increase in homelessness referrals for permanent accommodation	20% increase in resettlement plans has been achieved	Achieved
Improving tenancy sustainment through early support and identification of need.	Continue to embed Housing Options approach in practice with registered social landlords and Community Homeless Team	Housing Option approach rolled out across team and continuing to be developed	Completed by September 2017
	Continue to improve access to third sector support services	New Flexible Housing Outreach Support Services launched March 2017	Ongoing and completed by March 2017
	Improve knowledge, access and interface with Health and Social Care Partnership services for people at risk of homelessness	Updates and interface meetings have taken place over the past six months and will continue throughout 2018	Regular updates to be provided at NE Essential Connections Forum, Homeless Providers Forum and NE housing events

Older People's Services

Local Priorities	Key Actions 18/19	Progress 17/18	Target/Timescale
Ensure effective Intermediate Care (IC) Service to deliver good outcomes for service users and their carers.	We will strengthen the multi disciplinary teamwork within IC by aligning dedicated staff, including social work, and a continued focus on supports at home Ensure effective use if Intermediate Care (IC) and service user *outcomes* via the development and implementation of the Intermediate Care Performance Improvement Plan	NE continues to increase the use of intermediate care and maintain high occupancy rates in 17/18.	Implementation of IC Performance and Practice Improvement actions over the course of 2018/2019
Balance of Care: Continue to optimize opportunities to support individuals to remain at home or to return home via effective multidisciplinary team working and optimizing community supports the city wide including carers support, supported living options and telecare solutions	We will continue to focus on supporting service users to return home, where possible, with the support of a range of health and social care services to meet their individual needs. Pivotal to this will be building supported living capacity and further application of the Cordia Supported Living Service	We have successfully developed effective multidisciplinary team (MDT) working in the implementation of a supported living MDT forum and staff development and awareness sessions The Cordia Supported Living model is well established in NE Locality, supporting individuals to return home.	Continue to support the development and establishment of Cluster Supported Living Models throughout 2018/19. Ensure outcomes of Glasgow City HCSP's Telecare strategy is embedded in practice and effectively communicated- 2018/19 Develop a locality Palliative Care Action plan and commence implementation- 2018/19
Support for individuals with Palliative Care needs and their families and ensure delivery of the key aims of Glasgow City HSCP's Palliative and End of Life Care Strategy.	Continue to develop a NE Locality Palliative Care plan in partnership with key stakeholders and partners taking account or key priorities outlined in the Palliative and End of Life Strategy		
In line with Glasgow City HSCP's Falls strategy ensure delivery of a NE Locality Plan to reduce the number of falls and falls injuries though awareness training and evidence based practice.	Deliver a North East Locality Falls Action and Plan with ref to include ref to the four priority areas, in partnership with key stakeholders Four key elements Stage 1: Supporting active aging, health improvement & self-management Stage2: Identifying high risk individuals and/or fragility fractures Stage 3: Responding to an individual who has fallen and requires immediate assistance Stage4: Coordinated management and specialist assistance		Action Plan developed and agreed July 18 Progress implementation plan Aug- March 19

Older People's Services (continued)

Local Priorities	Key Actions 18/19	Progress 17/18	Target/Timescale
Focus on and develop service capacity particularly in relation to prevention and early support	We will continue to build the numbers of service users who have an anticipatory care plan to reduce unscheduled admissions to hospital with a particular focus on a reduction of hospital admissions from a care home setting.	NE has met the target for anticipatory care plans	Work will be ongoing in 2018/2019 to continue to increase the numbers of service users who have an anticipatory care plan and ensure communication to optimize positive use across agencies/[partners 2018/2019
Post Dementia Diagnostic Support	Continue to Increase the number of service users with a diagnosis of dementia on the GP Dementia register and ensure effective delivery of post diagnostic support	NE continued to achieve good performance in relation to number of service users with a diagnosis of dementia on the GP Dementia register (target 1,218, 1,457 registered	Ongoing
Establish Integrated Neighbourhood Teams and the Home is Best (Hospital Discharge) Service	Develop the agenda and implement Neighbourhood Teams for Older People and Adults affected by disability, including the implementation of the Occupational Therapy Review and Home is Best (Hospital Discharge) service. Ensure a focus on maintaining independence, health and well being, access to the right service at the right time, working effectively with communities partner agencies acute and GPs	HR Process has been concluded over the course of 2017/18 which will enable the new structures to be implemented and developed	April to July 2018: NE will transition into the new integrated Neighbourhood Management and City Home is Best (Hospital Discharge Team) arrangements

Health Improvement

Local Priorities	Key Actions 18/19	Progress 17/18	Target/Timescale
Support the further development of Thriving places work stream in Parkhead/Dalmarnock/ Camlachie and in Easterhouse, Springboig/Barlanark	We will develop an Action Plan with short, medium and long term actions for the three Thriving Places (TP): Parkhead/Dalmarnock/Camlachie/Easterhouse/Springboig	A range of community led activities delivered across 2017/18 including: 'Charrette' approach in E'house which involved 1,000 local people in sharing their thoughts and aspirations for a new town centre action plan. Winterfest 2017 Play Cafes Tea Dances Drop Ins Family Meal and Homework clubs	Continue to report on Health Improvement Neighborhood work via: Collection of a range of evidence including case studies, photographs and via supporting University Masters students in their research dissertations
	Continue work on the delivery of the Local Plan and Action Plan work streams above. Continue to support specific partnership working in Dalmarnock	TP places Plans were approved in October 2017	Work ongoing to implement local action plans in 2018/19

Health Improvement (continued)

Local Priorities	Key Actions 18/19	Progress 17/18	Target/Timescale
Support individuals and families with health related issues: build positive mental health and resilience, reducing alcohol, drugs, tobacco use and obesity	We will review the funding requirements for Lifelink and continue to support and oversee the contract	Lifelink has been ongoing and delivering well, exceeding targets	Work ongoing in 2018/2019 Quarterly Performance Monitoring Reports produced
	Oversee the delivery of the Lifelink Youth contract	2017-18 Quarter 1, - 3 there has been 296 young people seen for counseling this is 52% over target.	Quarterly reporting meetings; extract case studies and utilise in HSCP performance monitoring. Ongoing in 2018/2019
	Include consideration of mental wellbeing and resilience into all family focussed programmes e.g. family meal homework clubs Within our tobaccco cessation services we will continue to further develop innovative targeted approaches to increase referrals into our community service Continue to build positive relationships with GP practice and Pharmacy staff	As part of the Health Issues in the Community certificate. which is a recognized evidence based community capacity building course, people and groups were encouraged to explore local issues which were giving them concern. This included successful alcohol and traffic campaigns A new City Tobacco Group has been set up to develop a consistent, evidence based and cost effective approach for the delivery and development of tobacco work.	Report on impact of resilience building work in a place context at midyear and end year via HSCP performance framework
	Develop the health improvement contribution to the North East kinship pilot model	Links have been established through representation on the Family Group Steering Group with Quarriers Care management which includes access to Health Improvement activities and services in general: support for young people and kinship carers/signposting to other services.	Continue to develop links with Quarriers in 2018/2019

Health Improvement (continued)

Local Priorities	Key Actions 18/19	Progress 17/18	Target/Timescale
Contribute to reducing poverty and supporting people living in poverty in North East Glasgow	Provide financial inclusion services delivered in a range of settings across North East Glasgow and influence other service areas and primary care to make referrals into this service	Referrals to money advice services continue to increase from NHS staff . Work has been on going to improve and increase referrals. Have worked closely throughout 2017 with a Deep End Cluster of GPs to embed advice provision within their GP Practice Pilot funded via iHub	Continue to increase referrals to financial inclusion services in 2018/2019 Implementation of service re design including small tests of change. Quarterly reporting
	Extend approaches to income maximisation in primary care building on the Parkhead Health Centre	IHUB funding in place for ongoing pilot with GP deep end practices. Have been able to extend the early work in Parkhead Health Centre to Parkhead Cluster Practices (9 in total)	Secure further funding to continue to develop and learn and learn from the programme for a further year
	Alleviate food poverty through the provision of programmes which include, as part of a wider activity, the provision of food e.g. extend the network of breakfast clubs in the North East for school aged children	Dalmarnock Family Meal and Homework Club continuing, new clubs commenced in Easterhouse Aultmore Park and Parkhead Quarrybrae. A number of organisations across NE have been supported with small grants to develop family nutrition work this includes growing, cooking and provision of kitchen equipment.	Develop a *how to* guide following experience and best practice for establishment of Family Meal and Homework Clubs

Primary Care

Local Priorities	Key Actions 18/19	Progress 17/18	Target/Timescale
Improve health life expectancy	Continue to improve publicity and ensure health promotion opportunities at all contacts and locations ensuring all contractors are linked in Develop and encourage wider use of online digital technology, including the GP website GPs to be encouraged to use website and reception redirection to ensure best use of resources	All Know Who to turn To posters developed and distributed to GPs, Optometrists and Community Pharmacists	Ongoing in 2018/19, and will maximise publicity materials
	Continue to support the benefits of screening. Work with McMillan to ensure Information Stalls are kept up to date Encourage clusters to access data sets to inform good practices including: Referral data from the Community Respiratory team Chronic Obstructive Pulminary Disease(COPD), PARS, (Practice Activity Reports) and SPIRE	Prostate Cancer stands now in Health Centres 28 weeks McMillan@glasgow libraries stands now in Health Centres COPD referral data can now be provided to clusters for improving referral rates to the community respiratory services	Ongoing in 2018/19, and will maximise publicity materials
Carers are encouraged to have life outside caring	Continue to promote the use of "A Local Information System for Scotland (ALISS) Ensure Carers booklets are available in primary care premises. Ensure Public Health Directory is kept up to date	A Local Information System for Scotland" (ALISS) being launched 31/1/2018 Carers booklets are now being distributed to optometrists and community pharmacists. Electronic translated language versions of the booklets are available. Public Health Directory being accessed by Practices	Work ongoing 2018/19

Primary Care (continued)

Local Priorities	Key Actions 18/19	Progress 17/18	Target/Timescale
Support older people to live healthier lives	Continue to identify 'vulnerable' population and ensure they are linked into appropriate services through using • Anticipatory Care Plans • Chronic Disease Management Establish a Test of Change Project in Riverside for Anticipatory Care Plans/Chronic Disease Management Encourage Clusters to request reports from the Carers Services in respect of numbers of referrals and actions taken. Encourage practices to use electronic versions of the carers referral form.	Anticipatory Care Plans promoted regularly including at 17c annual visits and at Primary Care Implementation Group meetings GEMAP services and chronic disease management services promoted at Primary Care implementation Groups Meetings and 17c annual visits. Share widely outcomes from GEMAP iHUB bid for Parkhead area.	Ongoing with particular focus on widening the number of staff who contribute to Anticipatory Care Plans Ensure chronic disease management programme continues Encourage practices to refer to GEMAP services.
Support sustainable Primary Care services (including out of hours and urgent care)	Better utilise all members of the primary care team (for example increase access to treatment from community pharmacy and optometrists) Work with Clusters and Cluster Quality Leads (CQLs) to promote training/signposting to other organisations/health professionals/community infrastructure	Know Who To Turn To poster incorporating Optometry distributed to GP Practices and all North East community pharmacy and optometrists Making the most of Your Practice developed and translated into 21 languages	Support the development and delivery of the Primary Care Improvement Plan to ensure the implementation of the new GP contract.
Support sustainable General Practice	Continue to pilot new ways of working with GP Practices Share information on good practise based on evidence and Evaluation from Pioneer Projects. Promote Patient education, self management of Long Term Conditions (LTCs) promotion of available resources including the third sector. Continue to work with Clusters on developing Patient Education - information access (NHS Inform) and learning events	Link Worker in four NE Practices Pioneer Project in four practices to provide additional clinical support Pharmacy initiative in 21 practices Learning sessions held on resilience for Small Practices < 3,500 pts. Patient education events e.g. diabetes are ongoing	Support the development and delivery of the new Primary Care Improvement Plan to ensure the implementation of the new GP contract.

Support GP Cluster working	Continue to drive the agenda for Quality Improvements with/ across the NE GP Clusters Support integrated/multidisciplinary working across Clusters and neighbourhood teams Access Scottish Government funding to develop Cluster working Continue to develop links with secondary care through cluster working and the Primary Care Implementation Group	7 GP clusters and 7 Cluster Quality Leads identified. Working city clusters arranging educational meetings and patient self management documentation	Ongoing 2018/19

Cross cutting service priorities

Local Priorities	Key Actions 18/19	Progress 17/18	Target/Timescale
Continuing to further develop strong interface with the housing sector	Housing and Homelessness Lead will work with landlords as first point of contact for any tenancy sustainment issues and will continue to work with Housing Options staff in the North East	We have continued to hold joint meetings with Housing Options staff during 17/18 and our Housing and Homelessness Lead has been based in local housing associations to assist in the roll out of Housing Options approach	Work ongoing into 2018/2019
	Further housing events to be held during 18/19 with themes/topics developed in partnership with local landlords	Three housing sessions held with over 40 housing representatives at each event	Housing sessions will continue 2018/2019
	Training will be offered to all landlords and any specific training needs will be identified	North East Training Plan developed in partnership with local housing providers	Training Plan will be updated throughout the year to show uptake and topics delivered
	Statements of Best Practice (SOBP) revised and will be disseminated across all housing providers	Essential Connections Forum continued to meet and share best practice during 2017 and SOBP refresh discussed	Statements of Best Practice have been shared with all housing providers and relevant staff teams .
Corporate Parenting	Ensure that all NE HSCSP staff are aware of their responsibilities to Corporate Parenting within the organisation	We have consulted staff and managers about the content of the Corporate Parenting plan, but now require to ensure it is presented and discussed on an annual basis at all team meetings.	April17 - March 18

Cross Cutting Service Priorities (continued)

Local Priorities	Key Actions 18/19	Progress 17/18	Target/Timescale
Continue to review all of our accommodation, both leased and owned across the North East to ensure that we have accommodation which meets the needs of services users and staff	We will continue to rationalise our use of buildings across North East We will complete the communication strategy for the development of Parkhead Health and Social Care Hub and continue to identify capital and revenue funding to finance this initiative	Accommodation Strategy Group set up and meeting bi monthly	Ongoing 2018/ 2019
Provision of employability support for local people	40 students attending NQ (Level 4) and 16 students attending SVQ 2 Health and Social Care courses and all will work towards placements within NE locality	Joint initiative with Glasgow Kelvin College with new Placement Coordinator in post as of February 2016. 53 students on courses and 50 placed within health and social care placements, with 47 progressing to further training/employment	Students across both courses to complete and take part in placements with 100% progression to further training/employment to be achieved 2018
Continue to raise awareness of adult carers and promote the single point of access within the health and social care teams	Continue to build increased links with all older people, primary care, acute setting and adult teams to promote carer pathways	300 adult carers and 100 young carers per locality (target for 17-18) 16-17 Actual 641 referrals – 581 AC & 60 YC Aiming to utilise Sci-Gateway as a new referral	Target remains 300 new adult carers with aim to increase preventative referrals from Primary Care and Acute Care
	Ensure all staff are aware of their roles and responsibilities in identifying and supporting carers	Carers Act Scotland [2016] Implementation Group has a communications strategy with dedicated Young Carers (YC) information workers as well as generic	Official launch 3rd April and then ongoing
Continue to identify and support young carers (YC) through a family based approach	Ensure all staff are aware of their roles and responsibilities in identifying and supporting young carers	Carers Act Implementation Group have a communications strategy which dedicated YC information workers as well as generic information workers have contributed to launch in April 2018	Annual Target is 100 young carers to be identified in NE. School online YC resource pack and updated Young Carers Statement will be officially launched on 3rd April 2018
	Continue to work in partnership with Education Services to develop a pathway from schools to young carers' services	New worker completed induction and work is now underway in schools in NE. New Carers Partnership Logo designed. New material developed to promote service, increase YC awareness and support staff to deliver Young Carer Statements	Pathway embedded and resources developed across all schools will be ongoing work

8. EQUALITIES

We have continued to ensure that local equalities priorities flow from Glasgow HSCP Equality Plan 2016-18. Our Equalities Group has continued to meet and during 2017/18 actions undertaken have included:

- Work with the acute sector on leaflets for the redesign of older people's services at Lightburn, especially in relation to making sure that public information is accessible
- Follow up on the event hosted by the Glasgow Disability Alliance to develop a set of actions to improve quality of and access to services for disabled people
- Provided multi-agency training to raise awareness of referral pathways
- Hold development sessions on a number of equality topics
- Funded various local organisations to deliver projects, workshops and seminars on violence against women and related topics
- Review of equality impact assessments undertaken across the various services

We will continue to monitor this work and link in with the city wide Equality Action Plan for the coming year.

9. BUDGET

The table below shows the budget for North East 2018/19.

Strategic care Groups Grouped	Health Annual Budget £'000	SW Annual Budget £'000	Total Annual Budget £'000s
Children & Families	4,564.9	10,832.7	15,397.6
Prison Services & Criminal Justice	0.0	2,630.9	2,630.9
Carers	0.0	555.4	555.4
Older people	10,068.8	21,382.2	31,451.0
Elderly Mental Health	8,357.1		8,357.1
Learning Disability	925.6	20,519.7	21,445.3
Physical Disability	0.0	5,731.5	5,731.5
Mental Health	18,718.2	3,245.1	21,963.3
Alcohol + Drugs	1,953.7	2,544.3	4,498.0
Homelessness	2,672.1	1,784.4	4,456.5
GP Prescribing	40,774.7		40,774.7
Family Health Services	55,960.7		55,960.7
Hosted Services	5,951.7		5,951.7
Other Services	5,193.9	804.0	5,997.9
Expenditure	155,141.4	70,030.2	225,171.6
Children & Families	0.0	(2.0)	(2.0)
Prison Services & Criminal Justice	0.0		0.0
Older people	(69.4)	(754.4)	(823.8)
Elderly Mental Health	(434.6)		(434.6)
Learning Disability	0.0	(13.0)	(13.0)
Physical Disability	0.0	(20.5)	(20.5)
Mental Health	(922.8)	(15.0)	(937.8)
Alcohol + Drugs	(166.2)	(0.7)	(166.9)
Homelessness	(107.7)		(107.7)
Family Health Services	(2,706.5)		(2,706.5)
Hosted Services	(336.3)		(336.3)
Other Services	(109.5)		(109.5)
Income	(4,853.0)	(805.6)	(5,658.6)
Glasgow Hscp	**150,288.4**	**69,224.6**	**219,513.0**

10. PARTNERSHIP WORKING

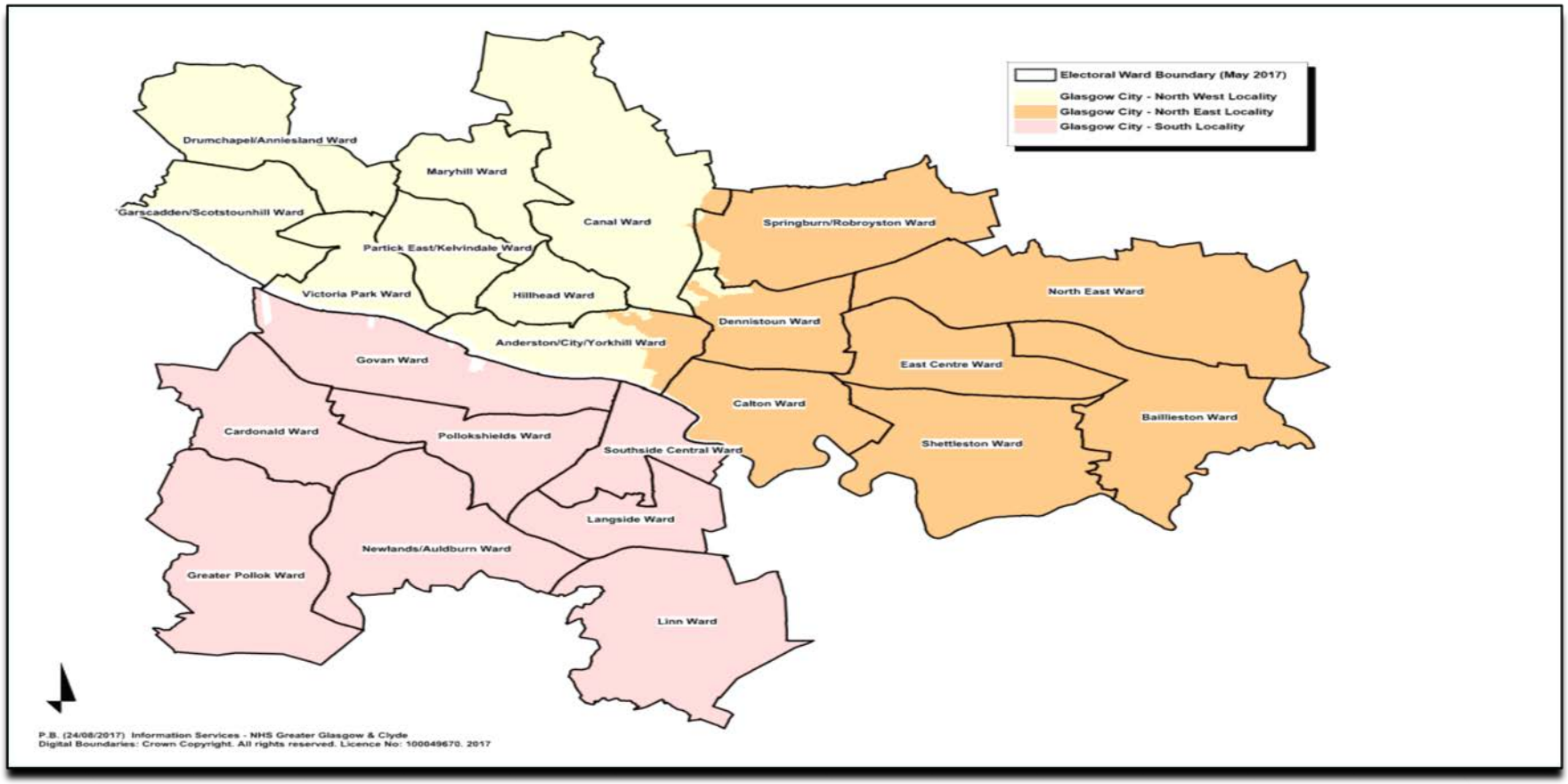
We will continue to work with our community planning partners (including Education, Police Scotland, Scottish Fire and Rescue, Voluntary Sector, Glasgow Kelvin College, Glasgow Life, Skills Development Scotland)through the Area Senior Officers Group and the Community Planning Partnership Board and will ensure that we continue to take forward the community planning strategic objectives to address the issues of alcohol, youth unemployment and vulnerable people whilst contributing to the emerging community planning transition process.

In addition, a main priority for the North East in 17/18 was our partnership working with the housing sector to improve housing access within the community as well as linking this to our accommodation based strategy for older people. During 16/17 we hosted three events with the housing sector and this will continue over the coming year. Events for this year will again focus on our HSCP services and how we can best work with housing providers more effectively and efficiently.

Glasgow City HSCP
Health and Social Care Partnership

North West

Locality Plan 2018/19



FOREWORD

I am pleased to introduce the third Locality Plan for the North West since the establishment of Glasgow City Health and Social Care Partnership (GCHSCP). The aim of this document is to provide a review of progress during 2017/18 and to identify priorities for the area for 2018/19.

Our plan for 2018/19 highlights the priorities and actions that will be progressed in North West to address local needs and contribute to the wider strategic agenda set out within the Strategic Plan of Glasgow City's Joint Integration Board. These will be progressed in partnership with our stakeholders, including service users and carers, 3rd sector organisations and community planning partners. We are keen to build on the successes of last year, which includes work commencing on-site to build the new Woodside Health & Care Centre which is scheduled to be completed later this year; the establishment of Neighbourhood Teams for Older People's Services to work more closely with local communities and partner organisations; supporting the ongoing development of General Practice (GP) 'clusters' to provide a greater opportunity for joint working at a local community level as well as providing a more co-ordinated approach for delivering primary care improvements; and continuing to deliver on the vast majority of our performance targets to meet standards and improve access to our services.

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

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

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

1. INTRODUCTION

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

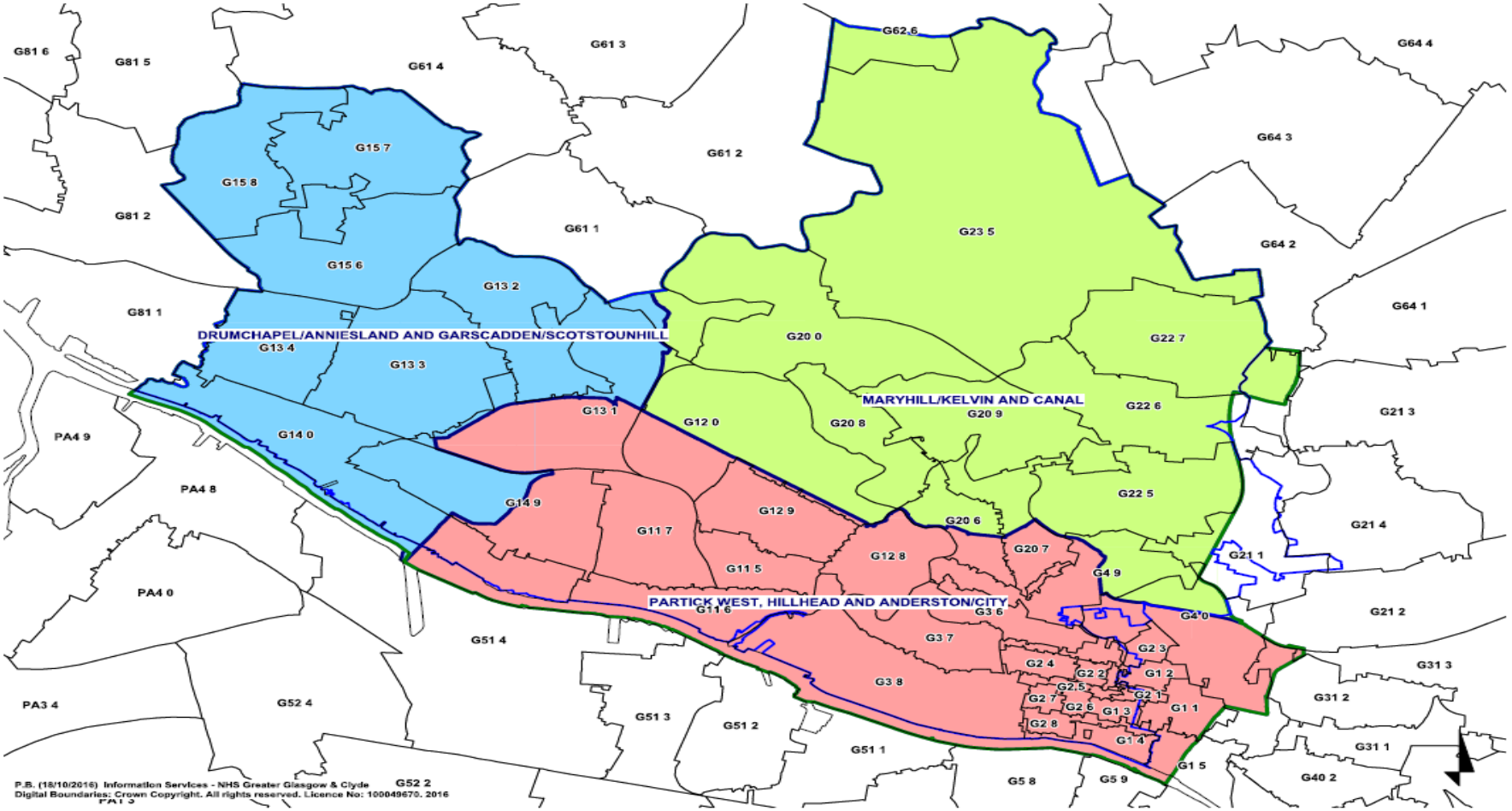
- Anderston/City/Yorkhill Area Partnership
- Hillhead Area Partnership
- Partick East/Kelvindale Area Partnership
- Garscadden/Scotstounhill Area Partnership
- Drumchapel/Anniesland Area Partnership
- Maryhill Area Partnership
- Canal Area Partnership
- Victoria Park Partnership

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

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

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

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



2. HSCP KEY PRIORITIES

Glasgow City Integration Joint Board (IJB) came into being in February 2016 and endorsed a three year Strategic Plan for the period up to 2019 (see: https://www.glasgow.gov.uk/index.aspx?articleid=17849). In that plan, the IJB set out its vision for health and social care services:

> 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

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

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

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

The purpose of this locality plan is to:

- show how we will contribute to the implementation of the HSCP's Strategic Plan 2016-2019; and
- how we will respond to local needs and issues within the North West of the City

The plan is a one year plan covering the period April 2018 to March 2019. The plan is based on:

- what we know about health and social care needs and demands and any changes from our 17/18 locality plan;
- our current performance against key targets;
- our key service priorities, informed by the HSCP's Strategic Plan
- the resources we have available including staffing, finance and accommodation.

Although the detailed priorities and actions set out in this locality plan are grouped under each of the main service delivery headings, we recognise the shared nature and interdependency of many of them.

3. COMMUNITY ENGAGEMENT – LOCALITY ENGAGEMENT FORUM

North West Locality Engagement Forum (LEF) over the last year has acted as a catalyst for communication, engagement and participation. Local people, community groups and organisations had an opportunity to discuss and give their opinions on a range of Locality topics including:

- North West Locality service priorities;
- Establishment of Neighbourhood Teams for Older Peoples' services
- Review of West Glasgow Minor Injuries Services
- Monitoring progress of the Woodside Health and Care Centre development
- HSCP Palliative Care and End of Life Strategy
- HSCP Occupational Therapy Review
- 5 Year Adult Mental Health Strategy
- Sandyford Sexual Health Services Review
- The National Dementia Strategy 2017-20

In 18/19, North West LEF will continue to have regular meetings to discuss and contribute to Locality care group priorities as well as topic focused discussions to encourage participation and involvement from the wider community. Priorities for 18/19 include:

- Developing a closer partnership with North West Voluntary Sector Network by organising joint events around disability and equalities in order to promote greater representation of vulnerable people and groups;
- Creating opportunities to develop closer links with established networks and forums in North West Glasgow such as the Recovery Communities, Carers Forum and Childcare Forum; and
- Continue to encourage services and teams to engage and gather comments at the point of service delivery.

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

4. PERFORMANCE INFORMATION

This section summaries our performance in North West against key targets and indicators

Where we have performed well in 2017/18
Meeting waiting time access to specialist children's services
Percentage of Health Plan Indicators allocated by Health Visitors within 24 weeks
Number of new carers identified that have gone on to receive a carers support plan or young carer statement
Number of people in supported living services
Breastfeeding rates
Access targets for alcohol and drug treatments
Meeting the target timescales for assessing all unintentionally homeless applications
Reducing the duration pregnant women or dependent children stay in bed & breakfast accommodation
Percentage of criminal justice community placement orders (CPO) with a 3 month review within agreed timescale
Alcohol Brief Interventions undertaken
Reductions in women who smoke during pregnancy
Number of referrals being made to Healthier, Wealthier Children Service
Waiting times for access to Podiatry and Dietetics
Improved uptake of sexual health services by men who have sex with men (MSM)
Percentage of service users leaving the service following re-ablement with no further period of homecare
Percentage of service users with an alcohol or drug problem that have an initiated recovery plan following assessment

Where further improvement is required in 2018/19
Percentage of children receiving ready to learn assessment (27 to 33 months assessment)
Percentage of young people receiving a leaving care service who are known to be in employment, education or training
Meeting delayed discharge targets for people (i.e. discharge within 72 hours of being assessed as ready for discharge)
Increase the number of offers of permanent accommodation secured from Registered Social Landlords
Bowel screening uptake rates
Waiting times for access to LARC (long acting reversible contraception) appointments
Cervical screening uptake rates
Physiotherapy waiting times

5. SERVICE PRIORITIES

Primary Care

Priorities	Key Actions	Progress in 17/18	Target for 18/19
Working with GPs and the wider primary care team to develop 'clusters' to improve quality and integrated working	• Continue to support the development of GP clusters • Embed Older People's 'neighbourhood' team approaches to align broadly with GP clusters where possible.	GP Clusters in place within North West (NW) -totalling 7. Cluster Leads and Practice Quality leads in place.	Support the production of cluster quality improvement workplans.
Improve the unscheduled care pathway across primary and secondary care services	• Further develop Anticipatory Care Plans (ACPs) and Intermediate Care approaches	Guidance and 'tool-kit' produced for practitioners. ACPs launched within mainstream Older People's services	Increase the number of Key Information Summaries to GPs
Contribute to the development of the GCHSCP Primary Care Improvement Plan associated with the new GP contract	• Support initiatives to deliver improvements to patients and release GP capacity for core activities, including: - The Vaccination Transformation Programme - Pharmacotherapy services - Community Treatment and Care services - Urgent Care - Additional Professional Roles (incl for musculoskeletal focused physiotherapy services and community clinical mental health) - Community Links Workers	N/A	Primary Care Improvement Plan to be drafted by July 2018 and will include specific actions and targets. Establish a procurement framework and commissioning process to enable the roll-out of the Community Link Worker programme for the HSCP

Carers

Priorities	Key Actions	Progress in 17/18	Target for 18/19
Carer (Scotland) Act 2016 – Comply with requirements of new carers act including implementation of new GCHSCP carers eligibility criteria	Ensure all NW locality carers partnership staff are aware of role and responsibilities in complying with new carers act. To include wider carers partnership awareness training and ensure eLearning available to both carer team staff and wider HSCP staff groups	Preparatory work for carers act via IJB, City Carers Partnership operational group, staff working groups, consultation with carers and HSCP staff regarding new carers eligibility criteria	Continuation of implementation of different parts of carers act, monitor and evaluate compliance levels and effectiveness via NW locality reporting and operational quarterly and annual carers reporting structure via IJB
Establish sci-gateway as primary care / GP referral pathway for carers	Agree content of referral information via sci – gateway including pathway of referral to carers services Identify and action cross mapping exercise via NW carers locality group / CIS Carer Information Post action	Progress and agreement in place to have sci-gateway carers referral pathway for May 2018	Establish cross reference / mapping exercise re- carer referral take up via sci-gateway including focus on existing GP clusters and evidence of carers early intervention and prevention opportunities with carers

Children and Families

Priorities	Key Actions	Progress in 17/18	Target for 18/19
Support the Wellbeing of Children and Young People through Prevention and Early Intervention	• Continue to improve breastfeeding rates in NW Locality particularly in deprived areas.	At quarter 3, NW performance met target for exclusive breastfeeding at 6-8 weeks, and was just under the target set for this relating to the areas of highest deprivation.	Current NW target is 30.8 % (and 23.9% in deprived areas)

	• Implement programs to deliver on Child Healthy Weight. • Increase referrals and uptake of parenting support programmes • Promote income maximisation and financial inclusion to have positive impact on addressing child poverty. • Carry out 3monthly UNICEF (United Nations Children's Fund) Practice Audits • Increased awareness of harm associated with alcohol and drugs	Delivery of 'Weigh to Go' Programme (for 12-18 year olds) - Board wide service managed by NW. 33 young people by March 2018 in line with target. 17 completed interventions at January 2018 At quarter 3,400 referrals from NW health visiting and midwifery staff. At Dec 17, NW achieved 62.5% compliance against Delivered booze busters P6/7 in 26 schools S1 transition input on Multiple risk – all secondary schools	33 young people (NW) by March 2018 (100 young people across Glasgow City service) Health Improvement will deliver a minimum of 12 parenting interventions to include: Triple P –Teen, Discussion , Group,1:1 interventions Health Improvement will deliver minimum of 8 Two day Solihull Foundation Training courses Continue to increase the number of referrals to Financial Inclusion Services in the Early Years 70% compliance rate Contract will deliver, subject

		S4/5 – input drugs & alcohol – all secondary schools	to school engagement input to: :P6/7 pupils- all Primary Schools ; S2 pupils in all Secondary schools; S4/5 pupils in all Secondary schools; P6/7 pupils in all Primary SEBN schools; S2pupils in all Secondary SEBN schools Development 1:1 Support for vulnerable Children & Young People (contract target approx 80)
	• Continue to progress transformational change programme explore opportunities to re-settle children and young people placed out with Glasgow in residential care settings to alternatives within the City. • Reinvestment of funding released from high-cost care residential care packages into further developing family support infrastructure.	Successful resettlement of a number of young people in NW through effective multi-agency / multi-disciplinary working Ongoing	Improved outcomes for young people: greater stability through reduction in the number of disrupted placements and through maintaining close connection to their home community (for 18/19, approx 10 young people to be resettled in NW)
Early identification of children and families who need support	• Health Plan Indicators (HPI) allocated by health visitors to identify children requiring additional services beyond the universal child health pathway • Improve 27-33 months assessment uptake	At October Dec 17, NW achieving 92% HPI allocation within 24 weeks against a target of 95%. An improving performance of	Increase number of HPI care plans for children with additional needs in line with target. Ongoing review to improve

	in NW Locality	79% achievement rate in NW at Dec 17 against a target of 95%.	uptake in line with target
	• Evidence increased referral to the 3 Early Years Joint Support Teams (JST) in NW Locality.	JSTs self evaluation process was ongoing in 2016/17. Action Plan being developed for 2017/18	Baseline and targets to be confirmed
	• Continue to improve service access across specialist children's services	Met waiting time target of maximum 18 week referral to treatment (RTT)	Maximum 18 week RTT
	• Establishing Family Group Decision Making Team (FGDMT) in NW (enabled by additional investment in 3rd sector services to deliver kinship care which will release social worker time to participate in the FGDMT).	Successfully piloted in North East. 'Family Finding' service initiated to review family history at Mitchell Library to identify extended family members who may be able to provide at home	Team operational by September 2018. Increase the number of young people looked after by extended family member
Keeping Children Safe	• Identify and respond to children and young people affected by Domestic Violence	There has been an increased uptake in the Save Lives training by Health Visitors and School Nurses	Target to be confirmed
	• Support looked after children, including those in kinship care and promote permanency plans where appropriate	72% of looked after children (aged <5 years and looked after for >6months) have a permanency review. Target 90%.	Increased number of permanency plans in place and meet review target All children 5-18 years newly looked after at home and or in Kinship Care a Comprehensive Health
	• Specialist Children's Service vulnerability team to offer a health assessment to looked after children, including those in kinship	85 Child Health Assessments for children and young people currently looked after at home /	

	care • Identifying and support children in need of protection with particular focus on reducing neglect	Kinships have been carried out at April 2017. Training on use of neglect tool being rolled out across NW Team leads. 6 trainers in place.	Assessment within 28 days of receipt of referral. Developing a monitoring Tool and will set baselines and targets for 2018/19.
Raising attainment and achievement	• Every school/establishment has a named co-ordinator for looked after children (LAC), named officer at centre and Glasgow Psychological Service has existing workstreams in place for young people who are looked after	All Secondary establishment LAC co-ordinators attend quarterly, Education Services' LAC co-ordinator meetings, to share information and practice, ensuring consistency of approaches to improve outcomes	All establishments will undertake training in new Health and Wellbeing Planning Tool
Building mental well-being and resilience across the Northwest via direct service delivery and capacity building	• Delivery of mental health improvement service for young people aged 11-18 • Commissioned Service to Improve the Mental Health and Wellbeing of Young People	Commissioned contract began in July 2016. Two quarters data: 260 appointments with 104 young people; mentoring just beginning; 68 young people accessed group work/wellbeing awareness sessions; Youth Health Service 434 appointments with 138 young people accessing service. High demand at Youth Health Service and have invested temporary additional support.	Schools Offering: • 992 one to one appointments in schools (260 young people) • 8 Groups (48 young people) Youth Health Service: 152 young people will be seen via YHS

Adult Services

Adult Mental Health

Priorities	Key Actions	Progress in 17/18	Target for 18/19
Implementation of 5 Year Adult Mental Health Strategy	Contribute to the implementation of service change and improvement within NW and other localities including: • Review efficient and effective working practices within CMHTs (community mental health teams) • Implementation of unscheduled care action plan • Promoting opportunities for prevention and early intervention • Promoting adherence to the physical health policy • Supporting the review of commissioned social care services to inform the phasing of proposed reduction to inpatient beds • Improving care pathways between community and inpatient services to maximise the efficient and effective use of resources and opportunities to support people moving through services • Refresh multidisciplinary discharge planning arrangements to explore opportunities for more integrated practice and processes.	The production of a comprehensive draft 5 year adult mental health strategy, including engagement and involvement of various stakeholders.	Contribute to the development of a robust implementation plan by Summer 2018
Improve integrated working	• Re-align community crisis services for the Maryhill catchment from North East Glasgow to North West Glasgow	Realignment achieved for inpatient services for the Maryhill catchment	By March 2019
Building mental well-being and resilience across the North West	• Delivery of community based stress service for adults	By quarter 3, 3803 appointments with 1504	5264 1:1 counselling appointments 1800 beneficiaries

via direct service delivery and capacity building	• Provision of range of mental health training programmes to build capacity of local communities, groups and organisations • Co-ordinate NW Suicide Safer Communities Forum (SSCF)	people accessing counselling service Training Delivered: Scottish Mental Health First Aid (SMHFA) x4 SMHFA: Young People x 4 Safetalk x 6 Assist x 4 Forum meetings x3 NWSSCF x 6 Suicide talks x 7	Training Courses offered: - Scottish Mental Health First Aid training x 4 -Scottish Mental Health and Wellbeing Training -Young People (SMHFA:YP) x 2 - Safetalk x 6 - Assist x 4 - Understanding Mental Health Training x 2

Alcohol and Drugs Recovery Services

Priorities	Key Actions	Progress in 17/18	Target for 18/19
Improve access to addiction treatment and care and opportunities for Recovery (including progressing a Recovery Orientated System of Care – ROSC)	• Further embed 'Access Teams' within existing alcohol and drugs community services to improve assessment and access to appropriate services. • Continue with the input of "lived experience" representation along with recovery hubs within Access Teams to support individuals not requiring/eligible for formal Tier 3 Care and Treatment provision • Facilitate transfer of Closeburn Street element of NW ADRS to the New Woodside Health & Care Centre-relocate Access Team/Point along with wider	Access Team formed and operational in both main sites of NW Alcohol & Drugs Recovery Services. Parents in Recovery Team Access response incorporated into this set up. 100% of service users being seen within Waiting Times target of 21 days. Ongoing development of community based Recovery Clinics. Independent	Continue to focus on more intensive, shorter-term interventions to maximise opportunities for recovery Continue with implementation of Eligibility criteria, applied consistently Achieve and maintain Waiting Times targets Recovery Plans established within 7 days of first contact and being updated and reviewed within 21 days

	Alcohol & Drugs Recovery Services • Progress Action Plans developed via ROSC Seminars and Workshops with a particular focus on Recovery Workforce/Joint Training and Development; Families/Parents in Recovery and development of a Recovery Orientated System of Care	Prescriber recruited March 2018 with a view to develop Community based Recovery Clinics Recovery Hubs established and model agreed within NW Sector for progressing Recovery Orientated System of Care	Deliver 12 x ROSC Seminars Deliver 3 x Recovery Matters Workshops involving a range of key stakeholders
Continue to shift the balance of care from the community alcohol and drug teams to GPs, where appropriate (via 'Shared Care Scheme')	• Work closely with GP colleagues to review all patients and identify how best to meet the needs of patients who are prescribed Opiate Replacement Treatment (ORT) • Promote increase in referrals to Recovery Hub from Shared Care settings via "lived experience" presence within 3 x Health Centres	Completed transfer of Clinics to dedicated Shared Care Clinic team May 2017. To date this has not achieved the target reduction within Care and Treatment Services	Deliver 2 x Recovery Events centred around Shared Care and GP interface Increase the number of individuals being prescribed ORT via their GPs
Reduce Alcohol Related A&E admissions/ presentations	• Roll out the Assertive Outreach approach for those hard to reach individuals who do not use service or present to their GPs, but use A&E frequently	Alcohol & Drugs Repeat Presentations at Emergency Department Short Life Working Group established	Introduce Complex Case Review Meeting discussion for all service users with 8 or more A&E attendances within a year
Work with community planning partners and the Alcohol and Drugs Partnership to reduce alcohol consumption	• NW Health Improvement Team to host the Health Improvement Lead (Alcohol Licensing) post on behalf of the city. • Continue to co-ordinate a Glasgow City / NHSGGC contribution to the licensing Forum and Board. • Citywide contract in place to deliver ABI	Recruitment of HI Lead (Alcohol licensing) post – shared between Glasgow HSCP and Renfrewshire HSCP 9 objections and representations made to Licensing Board: 6 were refused on public health and	Continue to influence alcohol availability as part of our role as a 'Statutory Consultee' in the Alcohol Licensing process by providing provide information on levels of alcohol related health harm at locality levels. Recovery Orientated System of Care Seminar Programme is in

	and drug/alcohol awareness training – targets set at city level • Administer small grants programme to support the delivery a Local Community Alcohol Campaign in 1 priority neighbourhood in NW	overprovision grounds;1 withdrawn; & 2 granted. Provided input to the new licensing policy including recommending that 'Thriving Places' are considered in terms of 'overprovision localities' or 'areas of potential concern'. Presented Public Health information at Licensing Board evidence session.	place which will inform the prevention and education work to be planned and taken forward in 18/19. As part of citywide P&E work NW will take lead for 'AFFIT' programme Facilitate a series of workshops x4 to identify priority actions in 4 neighbourhoods. Scope potential deliver a Local Community Alcohol Campaign in 1 priority neighbourhood linked to localised Ripple Effect action plan

Criminal Justice

Priorities	Key Actions	Progress in 16/17	Target for 17/18
The efficient processing of community payback orders (CPOs) and criminal justice social work reports	• Ensure all CPOs are reviewed by a Team Leader at the 3 month stage and throughout the order. • Improve percentage of CPOs work placements commencing within 7 days of sentence • Ensure service users have a supervised action plan in place within 20 days of a CPO.	NW achieving 87% of 3 month reviews within timescale. Target 75%. NW showing 65% compliance against a target of 80% Target of 85% compliance met	75% of CPOs 3 month Reviews held within timescale 80% compliance Compliance target of 85%
The safe management of high risk offenders	• Ensure all people released on license or a supervised release order receives a post-release interview within 24 hours of release.	100% compliance	100% compliance

Homelessness

Priorities	Key Actions	Progress in 17/18	Target for 18/19
Improve interfaces with Housing Providers to increase access to settled accommodation	• Work with Housing Access Team, continue to coordinate citywide casework input to the 3 NW Local Letting Communities (Drumchapel, North West & West) to achieve targets on settled accommodation	From 1/4/17 to 31/12/17 the following lets were achieved: Drumchapel: 16 lets North West: 151 lets West: 97 lets Wheatley Group (to 22/12/17): 210 lets (24% of all lets in area)	Targets to be confirmed
	• Monitor number and duration of homelessness applications	As at 5 March 2018: Total Live Cases: 695 Total Live cases over 6 months duration: 285 (41% - target 40%)	Homeless applications over 6 months duration: target 40% or less
Increase throughput in temporary and emergency accommodation to settled accommodation	• Work to agreed targets for provision of initial decision, prospects / resettlement plans and case durations.	For Q3 2017/18 (1st September to 31st Dec 17), 93% of decisions (based on Audit Scotland guidelines) were made within 28 days. At 19 February 2018 there were 112 cases assessed as unintentionally homeless, of which 67 were over 28 days from decision date (60%). From 1st April to 31st December 2017 NW CHT provided 482	Targets: Provision of 95% of decisions made within 28 days; Completion of Prospects / Resettlement Plan within 28 days. The target for NW CHT for provision of new resettlement

		new prospects and resettlement plans (target 466). As at 5 March 2018 – 59% of live applications were of 6 months or less duration (target 60%). At 19 February 2018 North West CHT had 44 cases in B&B, of which 20 (45%) had been in for 35 days or more.	plans is a minimum of 12 per week. 60% of live applications are 6 months or less duration Weekly monitoring now against 35 days or more (previously 60 days or more)
Develop a sustainable, holistic response to homelessness by ensuring collaboration across housing, health, social work, third and independent sectors	• Continue to deliver a Community Homeless Team based Housing Options approach, working alongside RSL partners (Registered Social Landlords) • Working alongside the Flexible Homeless Outreach Support Service (FHOSS), locality Welfare Rights Teams, and Mediation Services, continue to develop integrated working with money advice, mediation, and housing support services	From 1/4/17 to 31/12/17 there were 1,362 Housing Options approaches to North West CHT. Of these, 835 were closed to 'Made Homeless Application' (61%). This indicator is monitored monthly. Turning Point (Scotland) is the FHOSS provider for all households requesting Housing Options or homelessness assistance in the NW area. Housing support needs for all households have been reassessed and joint training plans put in place. Ongoing provision of Money	Monitor quarterly: % of closed housing options approaches which progress to homeless application Co-location proposals continue to be progressed through NW Planning Group. Ongoing weekly monitoring of Mediation Services around Housing Options prevention and homelessness activities, and continued development of

		and Debt Advice is currently being provided by the Locality Welfare Rights Team. Work continues to identify funding sources which may assist in development of a dedicated Money and Debt Advice Service.	links with Women's Services (Chara House) and Young People's Services (James McLean Project). This will continue to be developed through 2018/19. Maintain / improve referrals to FHOSS /Welfare Rights/ Mediation Services – weekly/monthly monitoring
	• Facilitate a broader involvement from HSCP services in supporting tenancy sustainment and good practice, and continue to improve partnership working with Registered Social Landlords (RSLs)	Essential Connections Forum oversaw update of Statements of Best Practice, RSL training and engagement events	Continue to progress through Essential Connections Forum

Learning Disability

Priorities	Key Actions	Progress in 17/18	Target for 18/19
Undertake a review of health and social care learning disability (LD) provision to maximise the opportunities for people with a learning disability to live in the community with appropriate levels of support.	• Scope current practice and develop more integrated approaches between social work and health service teams	In progress. NW contributing to citywide review of integrated LD teams. Staff engagement sessions planned for March and May 2018 to develop an LD strategy.	Integrated Service Manager posts for NW for LD Examine options for full or partial co-location of team.
	• Identify appropriate models of care and future accommodation requirements, including consideration of: - NHS long stay and assessment / treatments beds provision	Ongoing	Will be considered as part of developing a City-wide 5 year LD strategy

	- Respite facilities - Day Services - Community provision and potential commissioning options		
Targeting resources effectively	• Continue to review of all clients who have personalised packages to better align need with available resources to ensure best value • Examine options for overnight supports, including assistive technology • Develop alternative models of care, including core and cluster	Policy paper under development.	To note progress in reducing cost of packages while ensuring needs are met
Young people in transition to adult services	• Continue to identify efficient and effective supports for young people • Focus on high cost placements	Inclusion Officers and Local Area Coordinators continue to identify community supports Continue to identify suitable placements	Create a young people in transitions team, with staff from children's & families services and adult services
Autism review – on behalf of Glasgow wide services	• Undertake a review of the Autism Resource Centre (ARC) • Update the Glasgow HSCP/Education services autism action plan	Approval to concentrate the work of the ARC on specific areas, including young people with autism Continue working with all relevant agencies to ensure that autism services are key priorities. Promotion of Autism Friendly Glasgow	Implement new focus of service delivery Develop a Glasgow autism policy that ties in with the 2018 Scottish Government priorities
Sign Language and Interpreting Services (SLIS) - on behalf of Glasgow wide services	• Review of the service	Approval to analyse and review the work of the team, and future demands on the service	Implement findings of review

Sexual Health Services

Priorities	Key Actions	Progress 17/18	Target 18/19
Fewer newly acquired HIV and sexually transmitted infections	• Improve access to testing at current clinics, and introduce some test-only walk-in clinics and targeted home or self-testing • The sexual health service review to identify ways to increase the provision of urgent care slots and develop test express services in Sandyford and other community locations	Urgent Care target currently breached, and Test Only waiting times not met since September 2017.	Waiting times for Urgent care appointment - 2 working days. Waiting times for Test-only appointments – 15 working days
	• Ensure increase in Partner Notification undertaken for people diagnosed with a sexually transmitted infection.	Data is difficult to collect but there has been a slight increase	60 % Contacts of Chlamydia, of GC?, and of syphilis Reported Attended <28 days
	• Ensure HIV testing is being targeted appropriately at groups who are most at risk • Assess findings from national working group examining ways to promote testing in a range of settings; development of Test Express services, exploration of home testing and new outreach settings will be undertaken as part of service review	Introduction of HIV-PrEP in 2018 has not led to increase in testing in MSM (men who have sex with men). Other priority groups (Black African men and women, people under 20) have not shown significant improvement and may represent ongoing difficulties with access. Secured funding for development of the social marketing intervention.	90% of people with HIV should be diagnosed with HIV – this cannot happen until testing increases and requires significant change to culture out with sexual health services as well as within The social marketing intervention will be implemented fully from summer 2018.
	• Improve access to Free Condoms • Deliver renewed objectives to ensure a high-quality service is being delivered concentrating on priority groups	There has been an increase in the number of venues regularly ordering condoms, to enable provision to identified priority groups	Target – 90 venues across GGC regularly ordering condoms. The service will undertake a full marketing campaign in 2018 specifically focussing on the target populations.

Fewer unintended pregnancies	• Increase the uptake of very long acting reversible contraception (vLARC) across Sandyford services • Sexual Health Service Review to identify ways to increase the provision of vLARC appointments across all Sandyford locations	Numbers for women from Glasgow City HSCP are slightly down since 2016, ie 2016-4979, 2017-4778. (NW unknown at this time). Waiting times not being met.	Waiting times for vLARC appointment – 10 working days
	• Increase the uptake of vLARC in women who have undergone a termination of pregnancy procedure	Proportion has been increasing and most recent data is at 38%. A fast-track post TOPAR (termination of pregnancy and referral) IUD (intrauterine device) clinic has been established in 2018 to reach women who have a medical abortion and want an IUD. Uptake is expected to be low to begin with but this should increase over time.	Proportion of women receiving post-abortion LARC (immediate prescriptions and bridging contraception) within 6 weeks – 40%
	• Work with partners in the acute sector to increase access to the Termination of Pregnancy assessment services for all women from outside Glasgow City	Negotiations with partners continue; number of women attending from out with Glasgow city shows slow increase.	Proportion of women receiving post-abortion LARC (immediate prescriptions and bridging contraception) within 6 weeks – 40%
	• Improve access to Free Condoms • The service will undertake a full marketing campaign in 2018 specifically focussing on the target populations.	There has been an increase in the number of venues regularly ordering condoms, to enable provision to identified priority groups	Target – 90 venues across GGC regularly ordering condoms. Deliver renewed objectives to ensure a high-quality service, concentrating on priority groups.
Sandyford specialist sexual health services are accessible to all – including people and population groups who	• Improve service access: - reviewing opening hours and locations (as part of the Service Review) - establish a call-centre model to improve telephone access	Service review has developed service model - presented to IJB March 2018. A new telephone system has	Next phase of the Service Review will include development of access targets, including opening times, and the timescales

are more likely to experience poor sexual health	- improve electronic access through the introduction of self-arrival kiosks, self-registration, and online booking of appointments	been installed to manage calls more efficiently. Additional resource into the switchboards has been identified and needs recruited to. Support has been given from acute services for this. Self-check in has been introduced into Sandyford Counselling and Support Service (SCASS) and will be rolled out across all other service areas throughout 2018.	for implementation.
	• Explore outreach provision to the most marginalised people with third sector and other partners	Ongoing	Part of the next development phase of service review
	• Review the Steve Retson Project (SRP) for men who have sex with men (MSM), and all Sandyford services, to ensure the most vulnerable men are offered the right services at the right times	The SRP Community Hub was not able to be progressed due to the lack of accommodation. Proportion of MSM of male attendances 24% at December 2017 but depends on location; within NW, range from 11% at Drumchapel to 45% at Sandyford Central	The refreshed service model will be agreed with Public Health for funding, and then implemented as part of the wider Service Review.
Improved service access across all Sandyford services for young people aged under 20	• Increase the rate of attendance at all Sandyford services of sexually active young people aged under 20	A future service model for young people has been agreed as part of the Service Review. These figures have continued to fall with some minor exceptions at some locations. This remains a priority area for service review	The new young people's service model will be implemented at part of the wider Service Review.

	• Plan and Implement pilot to extend young people's clinic opening hours into late afternoon and early evening	A pilot extended hours service was run at Parkhead Hub and increased the number of young people attending.	The new young people's service model will be implemented at part of the wider Service Review.
	• Assess training needs for staff working with young people and address where necessary	Training plans for staff working with young people has been agreed with three local authorities.	Further work will be undertaken with the remaining three local authorities to formalise staff training plans.
	• Strengthen links with Youth Health Service across North west and Glasgow city by responding to the outcome of the city-wide review as appropriate	The Review was completed in 2018.	Sandyford is participating in the implementation group established following the review.

Older People's Services and Physical Disabilities

Priorities	Key Actions	Progress in 17/18	Target for 18/19
Develop Neighbourhood Team approach to promote greater integrated working	• Support the further development of 3 neighbourhood teams within NW for older people's services, including: - Strengthening links with GP clusters - Clarifying referral pathways and contacts for housing providers - Building relationships with local 3rd sector providers	Structure for Neighbourhood Teams agreed and service leads for each area identified	Full implementation of neighbourhood team model and evaluation of its impact.
	• Further develop 'Knightswood Connects' project to build community networks and capacity	Established community connector post with Loretto Housing	Produce a report by March 2019 to reflect on the work undertaken in first 9 months
	• Local implementation of service changes arsing from City-wide review of Occupational Therapy services		

Implementation of HSCP Palliative Care implementation plan	• Identify priority actions for NW from HSCP implementation plan	NW had lead role in development of HSCP plan	Local action plan to be developed by July 2018.
Deliver improvements for people with Dementia	• Develop local action plan in response to recommendations from national strategy • Deliver post diagnosis support (PDS) to everyone with a new diagnosis of Dementia.	Developed young onset dementia service, which is now led by a Clinical Psychologist. Work ongoing includes developing a referral pathway from neurology services. Developed training for housing providers; and the setting up of two dementia cafes.	Develop local action plan by August 2018 to meet recommendations within 3rd national dementia strategy
Extending service access and times of operation	• Explore opportunities to move to a 7 day a week access to DN single Point of access	Options paper produced detailing resources required and costs	Identify funding to support move to 7 days service by September 2018
Reviewing delivery of citywide Respiratory Service	• Review capacity of service to deliver service to original specification • Provide consultancy to other HSCPs considering development of Community Respiratory teams	Development session involving key stakeholders planned for June 2018	Develop options by August 2018 that consolidate weekday service provision and extend the service to cover Saturday and Sunday
Deliver timely Speech & Language Therapy interventions within residential settings (care homes/inpatients)	• Complete city-wide review of speech and language therapy partnership services • Develop protocols to ensure robust management of referrals.	An additional 1 wte post has been funded permanently for the SLT Care Homes service. A new email protocol for referrals for Care Homes & mental health referrals has been implemented.	Complete initial review of Adult SLT services within Glasgow City by July 2018. Develop action plan from its findings and recommendations.
Supporting people to live for longer at home, independently	• Ongoing evaluation of the impact of intermediate care beds • Ensure best practice is adopted locally from outcome of intermediate care audits	2 x 15 intermediate care bed commissioned.	Target of 30% of intermediate care users transferred home. Target of <30 days average length of stay.

	• Review clinical support to residential care provision • Improve integrated working across primary, community and Acute services to promote principle of seamless care for the individual	Preliminary discussions with one GP cluster in North West to undertake a review of clinical support needs with local care home provider Ongoing.	Develop action plan from findings of review and wider implications for support to other care homes Evidence as part of effective intermediate care arrangements and through GP cluster improvement planning.
Focus on and develop service capacity particularly in relation to prevention and early support	• Develop anticipatory care and enabling approaches across services and reduce unscheduled admissions to hospital. • Support early discharge from hospital, contributing to the ongoing development of Intermediate Care approaches and an accommodation based strategy, along with input from community rehabilitation services.	Guidance on anticipatory care plans (ACPs) produced for practitioners. ACPs launched within mainstream Older People's services. Contributed to city-wide 'home is best approach' to develop multi-disciplinary team approach across hospital and community service NW had 5 delayed discharge breaches of target at Dec 2017 (for patients over 65 years, excluding mental health and learning disability patients)	Review processes to identify and increase the number of people that have been introduced and offered an anticipatory care plan (ACP). Increase the number of Key Information Summaries to GPs All hospital discharges < 72 hours from treatment completion date ('included codes')
Improve access to services and outcomes for people with a physical disability	• Collaboration with housing providers to improve accommodation, including the processes for adaptations	Work completed / in progress Eroboll Lambhill– Lorretto Housing: completed Linkin Avenue Knightswood –	Progress current developments and identify new priorities

		GHA: completed Maryhill Garbraid, Cube Housing- current build Drumchapel GHA & Kernake – Current build Patrick Housing Association – due to start Anderson Sanctuary – current build Cube new build in Milton Liddesdale - just completed Yoker Housing – plan for new build - not on site yet	

Health Improvement

Priorities	Key Actions	Progress in 17/18	Target for 17/18
Tackling poverty and health inequalities	Delivery of financial inclusion and employability services including income maximisation, debt management and building financial capability. Work to increase referrals across service areas.	£1.3m of extra benefits generated and £222k of debt managed to date. The Scottish Legal Aid Board (SLAB) service (Possilpark) has had national recognition of good practice, funding extended for a further year and invited to bid for additional funds. The Bridging service continues to deliver	Implement a neighbourhood approach to employability and financial inclusion. Embed money advice service model within Possilpark. Work in partnership to increase knowledge of the impacts of welfare reform and support available to individuals

		good outcomes in the NW.	
	Lead the delivery of programmes to address Gender Based Violence (GBV) in NW, including training, capacity building and inter-agency responses.	Model slightly changed in that we now have a NW Violence Against Women (VaW) Working Group in place covering all the NW via 3 delivery hubs Youth Guidelines have been launched 120 people attended 65 people attended for VAW basic awareness workshops training in North West. Also delivered two sessions Citywide as part of the Glasgow VAW Partnership 6 ½ day training sessions (April 2017 – March 2018) FGM x 2, Childhood sexual abuse, domestic abuse & coercive control, commercial sexual exploitation. Violence Against Women ½ day workshop x 2. - 16 Days of Action (November 2017) - International Women's Day (March 2017) North West Women's Festival (25th November) Monthly neighbourhood event leading up to the festival.	NW VAW working group will develop an action plan: Support local delivery groups x 4 to feed into the Working Group. Explore potential to extend to 5. Develop a White ribbon neighbourhood Develop NW VAW networking lunches for 3rd sector agencies Deliver Violence Against Women Basic Awareness ½ day workshop x 2 as part of city Glasgow VAW partnership and x4 for HSCP and 3rd sector organisations in NW Support programme of activities around: - 16 Days of Action (November 2018) - International Women's Day (March 2019) Facilitating and coordinating the Integrated Grant Funding for VAW work at neighbourhood level
Creating a culture for health – reducing	Continue roll-out of targeted area based	NW tobacco team continues to deliver the highest number of community 12 week	<15% women smoking during pregnancy (<20% in most deprived quintile)

alcohol , drugs and tobacco use and obesity	approach to smoking cessation services Establish Action Plan for reformed NW Prevention & Education Group. Delivery of community based Prevention and Education contracts	quits across the whole health board area. We project an increase of 22% on the number of 12 week quits in comparison to 2016/17	- From 40% most deprived (TBC) quits at 12 weeks) Roll out the good practice identified in Maryhill Undertake and disseminate a research programme around the tobacco asset based approach in NW
Taking a place-based approach to community health and wellbeing	Use a variety of asset based methods and tools to work with local communities to identify their priorities	The Drumchapel 'Breakfast and a Blether Group' has met 5 times. Interim Drum chapel Thriving Places local Steering Group is in place which will expand this year. In Milton, the Thriving Places Anchor organisation is NGHLC and the Community Connecto5 post has been filled. Milton and Ruchill/ Possilpark Thriving places are working together to asset map current food poverty activities and to identify sustainable and inclusive programmes of support for the coming year with local people and local	Drumchapel – Communities plan will inform the (CPP) Locality Plan. Breakfast & Blether group continue to meet 4 x p.a. Support Aspiring Communities Fund Steering Group. Develop a Thriving Places Steering Group. Milton & Lambhill - Produce an action plan for year 2. Deliver plan across 3 neighbourhoods. Continue to support Connecting Milton group and extend reach into Lambhill and Cadder Ruchill & Possilpark – work towards implementation of the community planning partnership (CPP) Locality Plan which will be progressed through thematic groups. 4 Thriving Places meetings p.a. Recruitment

		organisations.	of new Community Connector. Support collaborative action for the benefit of young people and families in the neighbourhood through the YP and Families Sub-group. <u>Work across Thriving Places</u> Develop a response to food poverty issues in the Canal Area Partnership following the work undertaken during 2017/18. Undertake small scale community budgeting in the three Thriving Places.
	Support community based capacity building through the delivery of community based health contracts	Ongoing	In line with annual targets set out within AXIS contract (a partnership between North Glasgow Healthy Living Community and Annexe Communities – a charity and community enterprise.

6. PROMOTING EQUALITY

North West locality will contribute to delivering the actions and priorities set out within Glasgow City HSCP's Equality Plan 2016-18. Key actions and priorities for North West locality in 2018/19 include:

- Maintaining accessibility audits of new buildings
- Participation in Equality Impact Assessments of cost savings, service redesigns, service developments and policies
- Hate crime awareness and reporting
- Routine enquiry money worries, gender based violence (GBV), employability and appropriate onward referral
- Extend number of GBV local delivery groups from 3 - 5 to deliver on Equally Safe strategy
- Participation in age discrimination audits as required

- Responding to findings of the Fairer NHS staff survey alongside staff training priorities (Asylum seekers & Refugees, Poverty e-learning module, Key care groups, GBV)
- Meeting the requirements of the HSCP's participation and engagement strategy including equalities monitoring of community engagement
- Analysing performance monitoring and patient experience by protected characteristics as required
- Provision of a programme of equality and diversity training for NW HSCP staff and local organisations in North West

In 2017/18, the North West Equalities Group organised a number of meetings local events and also promoted citywide events across on a variety of topics. Almost all events were well attended and received very positive feedback. Examples of the sessions included:

Human Rights Based Approach within HHSCP – Scottish Human Rights commission	Amaan Training
Black History Month	Violence against Women and Children Training
Equality and Diversity Training	Equalities – Our story so Far
Health Inequalities for Lesbian, Gay, Bi-sexual Young People in NHSGG&C Schools Survey	HIV/AIDS and HEP B Masterclass
Human Rights and Right to Health/Hate Crimes	An introduction to Visual Awareness and Complex Need
BSL and Mental Health	Female Genital Mutilation Awareness Sessions
Freedom from Torture	What is Religion and Belief
LGBT Awareness	Launch of the 2016 BME Health and Wellbeing Study

7. RESOURCES

7.1 Accommodation

New Health and Care Centre

Site work has commenced on the development of a new £20m Woodside Health and Care Centre. This follows on from the new Maryhill Health and Care Centre that opened in 2016. The new Woodside Health and Care Centre 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.

Sandyford Sexual Health Services

Sandyford, located in Sauchiehall Street, Glasgow is the NHS Greater Glasgow & Clyde hub for the provision of a wide range of specialist sexual health care services and advice. However, limitations with the current accommodation are restricting the volume of patients that the service can see, resulting in waiting time pressures. NW Locality is therefore leading a piece of work to explore the feasibility of finding other suitable accommodation for these services or alternatively, whether substantial upgrading of the existing facility is possible. Plans will also be developed to transfer Archway services from Sandyford to improved accommodation at William Street Clinic (currently accommodating specialist children's services who will relocate following the opening of the new Woodside Health and Care Centre).

Reviewing Accommodation Requirements and Promoting Co-location

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

7.2 Human Resources

North West Locality directly manages a staffing compliment of approximately 1800 people across a range of services and disciplines. This includes Sandyford Sexual Health Services, which North West Locality has a 'hosted' management responsibility on behalf of HSCPs across Greater Glasgow and Clyde.

7.3 Finance

North West Locality has a total net recurring budget for service provision of approximately £230m and directly manages a staffing compliment of approximately 1800 people. The budget for North West Locality in 2018/19 is set out below.

North West Locality Budget	**2018/19**
	£'000
Children and Families	12,426
Prisons Healthcare & Criminal Justice	2,458
Older People	30,144
Addictions	3,614
Carers	589
Elderly Mental Health	5,502
Learning Disability	15,823
Physical Disability	5,616
Mental Health	18,607
Homelessness	995
Prescribing	39,650
Family Health Services	59,056
Hosted Services	30,233
Other Services	5,167
Total	**229,880**

South Glasgow

Locality Plan 2018/19

FOREWORD

This is the third Locality Plan for the South since the establishment of the Health and Social Care Partnership (HSCP) in 2016. The aim of the plan is to provide a review of the progress made in 2017/18 and to identify our priorities for 2018/19.

There are challenging times ahead both in financial terms and also in delivering improvements in our performance. As well as progressing on-going work, within the plan you will see ambitious and exciting new projects which we plan to implement in the year ahead which will improve lives and to further reduce inequalities. These include:

- completion of the £17m New Gorbals Health & Care Centre replacing the old health centre, South Bank Centre and the Two Max building. The development as well as improving services is a major contribution to the on-going regeneration of the Gorbals area;
- introducing new integrated neighbourhood teams to better support older people in the community and work more closely with GPs, third sector partners and others;
- continue to support the implementation of the Thriving Places agenda with community planning partners and local communities in Gorbals, Govan, Priesthill/Househillwood and Govanhill to improve health and well-being;
- implementing a "test of change" approach to community support where all services pull together and attend "Early Help" meetings with a solution focused approach to helping families;
- developing a community immunisation model across the South to improve childhood immunisation rates;
- implementing new alcohol and drug access team arrangements in line with the realignment of team locations across the South; and,
- review links between Primary Care Mental Health Teams, Community Mental Health Teams and GP practices to identify a link with each cluster.

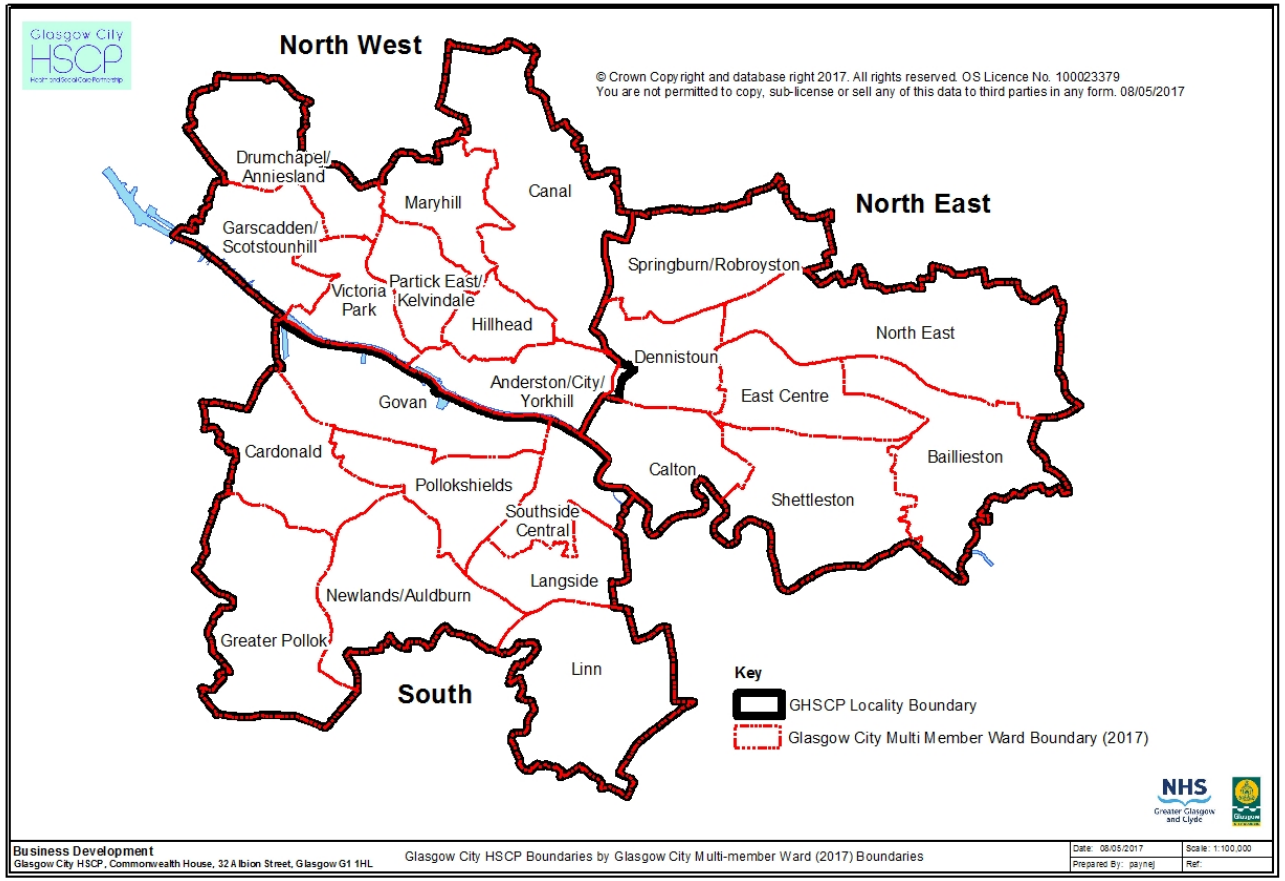
This plan for 2018/19 highlights the challenges we face in the South in taking forward this agenda, the key issues for users and carers, and the actions we are going to take over the course of the year to implement the HSCP's Strategic Plan and respond to local needs. We are keen to build on the first year of our status as an integrated organisation, working closely with our partners, local communities and organisations.

Stephen Fitzpatrick
Assistant Chief Officer (Older People & South Locality)
Glasgow City HSCP

1. INTRODUCTION

Health & Social Care Partnership Strategic Plan 2016-19

Glasgow City Integration Joint Board (IJB) came into being in February 2016 and in March that year the Board endorsed a three year Strategic Plan for the period up to 2019 (see https://www.glasgow.gov.uk/index.aspx?articleid=19044). In that Plan the IJB set out its vision for health and social care services - that the City's people can flourish, with access to health and social care support when they need it. The IJB envisaged that this would be achieved by transforming health and social care services for better lives. This Locality Plan shows how we intend to implement that plan in the South of the City. The figure below shows the three localities in Glasgow, and the areas covered.



2. OUR KEY PRIORITIES

The biggest priority for the Health & Social Care Partnership (HSCP) is delivering transformational change in the way health and social care services are planned, delivered and accessed in the city. We believe that more of the same is not the answer to the challenges facing Glasgow and will strive to deliver on our key priorities as outlined below:

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

In the HSCP localities are an important part of our integration arrangements to improve the delivery of health and social care services for the people of Glasgow. We have agreed three localities in Glasgow as shown above. A key responsibility of localities is to produce a locality plan for the area they serve. This document is the locality plan for South Glasgow for 2017/18. In last year's plan we gave a profile of the locality and the services we provide. Similar plans are also available for the North East and the North West.

The purpose of this plan is to:

- show how we will implement the HSCP's Strategic Plan 2016-2019 in the South of the city, and what this will mean for service users, patients and local communities; and
- how we will respond to local needs and issues.

The plan is a one year plan covering the period April 2018 to March 2019. The plan is based on:

- what we know about health and social care needs and demands and any changes from the 2017/18 plan;
- our current performance against key targets;
- the key service priorities as defined in the HSCP's Strategic Plan, including health improvement and what we are doing to tackle inequalities; and,
- the resources we have available including staff and accommodation.

We will report later in the year on how we are doing in implementing the plan and identify further areas of improvement for next year's plan. If you have any comments on this plan, let us know.

3. COMMUNITY ENGAGEMENT – LOCALITY ENGAGEMENT FORUM

Glasgow City Health and Social Care Partnership has a Participation and Engagement Strategy that sets out the principles and approach to engaging individuals, groups and communities in service planning and development for community health and social care services. Each locality has its' own arrangements to meet this commitment. South locality launched its' Locality Engagement Model in April 2017 at an event attended by 60 local groups, organisations and community representatives. The model consists of three key strands:

1. A Locality Engagement Network of individuals, community representatives, groups and organisations with an interest in local health and care services. The Network has produced three Locality Engagement Bulletins sharing news and information about health and social care services in the South and wider HSCP. The bulletin also highlights services provided by local groups and projects. It is circulated to 350 Network members in South Locality and is also available on the HSCP website.

2. A programme of feedback and engagement activities that enable people using HSCP services to share their experience at the point of access. This includes support for citywide consultation and engagement opportunities. Support is provided to frontline staff to enable them to develop feedback opportunities, consultations and user involvement activities.

3. A series of Locality Engagement Forum meetings bringing together users, carers and community organisations with experience of particular care groups or HSCP services. The forums have helped plan and deliver four public engagement sessions and over 180 people participated in one or more of these session in 2017/2018. Participants gave feedback on a range of health and social care issues including;

    - Treatment Room services
    - Occupational Therapy Services
    - Palliative and end of life care
    - Access to interpreting and translation services
    - Pathways into health and social care
    - Community views on the new Gorbals Health and Social Care Centre
    - Support services for older people in the community
    - A new neighbourhood model for Older People's Services
    - Creation of a Suicide Safer Community in South Glasgow
    - A new model for adult mental health services in Glasgow

    Key messages from these sessions included;

- An understanding amongst the wider public of why we need to review how we deliver services and make them fit for the future
- HSCP must communicate better and at the earliest opportunity with patients, users, carers and third sector partners
- HSCP should work more closely with community planning partners to ensure better communication and joined up decision making
- Person centred care needs to remain at the heart of all decision making in spite of the financial and other challenges facing public services

The HSCP is committed to listening to a wide range of user, carer and public views and feedback, comments, concerns, ideas and suggestions are used to inform future service planning and delivery. Key locality engagement priorities for 2018 include:

- Continue to grow the Locality Engagement Network
- Deliver a further three public engagement sessions in partnership with members of the Locality Engagement Forums
- Create opportunities for people to share their views on key HSCP plans and priorities including:

    - review of Out of Hours services
    - primary Care Improvement Plan
    - Moving Forward Together Programme
    - HSCP Strategic Plan, and,
    - HSCP Locality Plan

To find out more about our South locality engagement arrangements please contact: Lisa Martin, Community Engagement officer (South Locality) on 0141 427 8300.

4. PERFORMANCE INFORMATION

This section summaries our performance against key targets and indicators. There are a number where we need to make improvements in 2018/19 and these are included in the action plans that follow.

Where We Are Performing Well
Percentage of Older People who go home after a stay in Intermediate Care
Compliance with Older People - Prescribing Costs: Compliance with Formulary Preferred List.
Older People - Prescribing Costs: Annualised cost per weighted list size.
Number of new carers identified that have gone on to receive a carers support plan or young carer statement
Percentage of Health Plan Indicators allocated by Health Visitors within 24 weeks
Number of referrals being made to Healthier, Wealthier Children Service
Percentage of children and young people who accessed specialist Child and Adolescent Mental Health Services within 18 weeks of referral
Percentage of people who started treatment within 18 weeks of referral to Psychological Therapies:
Percentage of people commencing alcohol or drug treatment within 3 weeks of referral.
Percentage of Parental Assessments for people accessing alcohol or drug services completed within 30 days of referral.
Percentage of people who initiated a drug or alcohol recovery plan following assessment
Percentage of criminal justice community placement orders (CPO) with a 3 month review within agreed timescale
Percentage of Unpaid Work (UPW) requirements completed within timescale.
Percentage of post sentence interviews held within one day of release from prison.
Number of women smoking in pregnancy.
Number of women exclusively breastfeeding at 6-8 weeks.

Where improvement is required
Percentage of older people (65+) within care homes reviewed in the last 12 months.
Percentage of service users leaving the service following re-ablement with no further period of homecare
Meeting delayed discharge targets for people (i.e. discharge within 72 hours of being assessed as ready for discharge)
Primary Care - Flu Immunisation Rates
Percentage of children receiving ready to learn assessment (27 to 33 months assessment)
Percentage of looked after and accommodated children aged under 5 who have had a permanency review (who have been looked after for 6 months or more).
Percentage of new SCRA reports submitted within 20 days/on time.
Percentage of young people receiving an aftercare service who are known to be in employment, education or training.

Where improvement is required
Length of Stay within Short Stay Adult Mental Health wards
Meeting the target timescales for assessing all unintentionally homeless applications
Percentage of Community Payback Order (CPO) unpaid work placements commenced within 7 days of sentence.
Percentage of Community Payback Orders (CPO) with a Case Management Plan within 20 days.
Percentage of Criminal Justice Social Work Reports (CJSWR) submitted to court within the timeframe
Alcohol Brief Interventions undertaken
Smoking Quit Rates at 3 months in our most deprived areas .
Women exclusively breastfeeding: 6-8 weeks in the most deprived area.

SERVICE PRIORITIES – Review of 2017/18 and Targets for 2018/19

Primary Care

Priority	Key Actions	Progress 2017/18	Target 2018/19
Improving GP Premises All GP surgery premises assessed as being compliant with agreed standards.	• Work with the GP practices concerned to agree plans for improvement.	New premises for Arden still to be identified. Butterbiggins MC applying for funding to upgrade premises	Continue to support
New GP Contract Taking forward the formation of GP clusters using a "bottom up" approach, and identifying GP Practice Quality Leads and GP Cluster Quality Leads.	• Continued support and facilitation to agree GP clusters and quality leads	7 GP Clusters identified with a CQL identified for each cluster 1 PQL for each practice identified (51)	Engagement sessions planned for key stakeholders for information and comment for Primary care Improvement Plan (PCIP). 1st July 2018
	• Development sessions set up with CQLs and LET to discuss services in clusters and training and development for CQLs	3 CQL development sessions taken place QI training taken place with additional available as required	CQL/LET sessions to continue. Now to be held monthly while working on the PCIP
Anticipatory Care Plans Introduction of anticipatory care plans within GP practices to support management of patients at risk of admission.	• Work with practices to support continual improvement of anticipatory care plans	ACPs are identified as a priority for clusters	Continue to work with practices to increase the number of ACPs.
Primary/Secondary Care Interface Develop a local clinical interface between primary and secondary care to support the HSCP's plans for unscheduled care and implementation of the Clinical Services Strategy.	• Discuss with clinical leads, to further develop the interface • Monitor rates of new A&E attendances by GP referral to improve management of unscheduled care	Acute/ primary care interface group created to link with QEUH. Acute rep identified for GP committee – as required	Meetings now set up with CDs in QEUH and GPs that use their services.

Priority	Key Actions	Progress 2017/18	Target 2018/19
Improved Healthy Life Expectancy for Men & Women Support the delivery and development of Community Orientated Primary Care within East Pollokshields.	• COPC to be introduced in East Pollokshields • Improve health of the population by encouraging more social prescribing using Sole Riders, Walking Groups and Urban roots.	COPC is in place, group meet 6 weekly to discuss areas of concern Diabetes collaborative established 18 families identified. Work underway to co-produce a culturally appropriate self-management & prevention plan GPs now using green care prescribing with a case study approach adopted	To further develop the social care and green care prescribing agenda. Progress the development of the Diabetes Collaborative in conjunction with local families, HSCP and third sector organisations. Continue to work with partners to address oral health agenda within Govanhill.
EU Care and Support to Govanhill GP Practices Continue to support GPs in Govanhill, and other areas, in registering patients where there is a need for specific support such as interpreting services through agreed action plan	• Continued discussion with GPs and others to address issues as they arise, and implement the agreed action plan	Govanhill Primary Care Action Plan has improved access to Roma/Slovak interpreters. Govanhill practices meet regularly with interpreting services and attend their management reference group.	Continue working to support GPs in Govanhill
	• Community Orientated Primary Care model established within Govanhill	COPC established and meeting on a 6 weekly basis, priorities identified	Continuing with 3 Community Link Workers agreed, 1 for each of the Govanhill GP practices.
Govan SHIP The HSCP will continue to support sharing the learning form the SHIP project, subject to available resources.	• Continue to monitor and evaluate outcomes and disseminate learning. • Explore how the components of the model can be implemented in line with HSCP and the new GP contract developments.	Tested inclusion of Pharmacist and MSK physio in MDT. Funding secured for first 6 months of 2018/19. Alternative plan is being developed in line with existing funding. All 2017/18 targets delivered Mental Health work stream is now underway	Continued delivery across key areas including Additional GP time, structured MDT working, including social work and effective utilisation of new MSK Physiotherapy and Pharmacy resources Complete communications plan, evaluation and exit plan including transition into the primary care implementation plan. Finalise and implement action plans for the newer mental health work stream

Priority	Key Actions	Progress 2017/18	Target 2018/19
New Residential Care Unit Building good links and communication with new unit Orchard Grove. Building similar links for Leithland.	• Set up group to look at opportunities to improve service delivery • Share learning from Orchard Grove	Completed for Orchard Grove. Leithland Unit has been delayed; estimated date of completion Mar 19	Continue to build links between the unit and services and identify opportunities for service improvement.
Screening We will work with GPs to improve screening uptake rates for cervical screening and bowel screening	• Cervical and bowel screening sessions delivered within GP practices with low uptake by HI team	Included in Practice Activity Reports. Raised at locality meetings and PLT Learning from delivery within practices to inform a community based approach to screening promotion and awareness.	Focusing on GP practices with low uptake rates as well as those practices with high SIMD 1& 2 patients.
Improving Access	• Promote greater use of Community Pharmacy Minor Ailment service	Community Pharmacy information leaflets developed and translated into alternative languages commonly used within Govanhill	Review and monitor
	• Optometrist as first point of contact for eye problems being promoted.	Poster developed and distributed to all GP practices and pharmacies	Review and monitor
	• Promote use of other services before accessing GP	Know Who to Turn To Posters displayed in all practices, dentists and local libraries Peer learning event has taken place around redirection to the most appropriate service.	Redirection/signposting training to be delivered to reception staff, GPs and practice managers.
Support Sustainable General Practice	• Better use of all members of the primary care teams	Smaller, vulnerable practices identified, resilience sessions undertaken. Making the most of your practice leaflets distributed and displayed in practices	Build on work to support smaller practices.
Prescribing We will continue to work with Prescribers and local community Pharmacists to deliver the safe, cost effective patient centred use of medicines in Primary Care.	• Delivery of Prescribing action plan in conjunction with GP Clusters, the prescribing forum and individual GP practices	As of end November 2017 Glasgow South shows an overspend of 1.8%. This is being driven by price increase of specific medicines that have been subject to shortages or delayed patent expiry issues. For 17/18 a risk sharing agreement exists between GG&C HSPCs and HB to cover associated	Core themes to be progressed in 2018/19 as part of South Prescribing Action Plan are: • prescribing budget spend; • prescribing indicator improvement

Priority	Key Actions	Progress 2017/18	Target 2018/19
		overspend South continues to show overall progress with key prescribing indicators	
Prescribing Lead on the delivery of the GMS 2018 contract pharmacotherapy service as part of the Primary Care Improvement Plan	• Develop the prioritization schedule for implementation across practices in GS • Recruit and develop the workforce to deliver the service • Engage & communicate with all appropriate stakeholders regarding progress	By end of march 2018 GS will have pharmacotherapy service –like enhanced pharmacy input in 16 practices These are implemented under the Primary Care Investment funding for 16/17 and 17/18	Implementation of next phase of pharmacotherapy resources as allocated

Carers

Priority	Key Actions	Progress 2017/18	Target 2018/19
Continue to raise awareness of adult carers and promote the single point of access within the health and social care teams	• Identification of new Carers • Training and awareness raising to staff • Increase in carers referrals from primary care	All targets met, increase in referrals from primary care to 24% in 17/18. Test of change exercise currently underway at QEUH with surgery each Wednesday afternoon.	Continuation of implementation of different parts of carers act, monitor and evaluate compliance levels and effectiveness via locality reporting and operational quarterly and annual carers reporting structure via IJB
Continue to identify and support young carers through a family based approach	• Training around Young Carers • Links with Education partners • 300 new adult carers by March 2017 • Asset and outcome based training to be delivered by September 2016	All training targets for South HSCP staff met during 2017. South YC Education Worker has prepared an information/working pack for Education pathway.	Continue to review and monitor

	• Staff training and awareness raising on-going		

Children & Families

Priority	Key Actions	Progress 2017/18	Target 2018/19
Keeping Children Safe			
Children and young people living in the South of the city should be free from the risk of Child Sexual Exploitation (CSE).	CSE Community Engagement model to increase awareness of CSE amongst our communities and partner agencies.	To be reviewed bi-monthly at the South Child Protection Forum.	March 2019.
Healthy and Resilient Children			
Children's primary immunisations are delivered in a safe, efficient and effective way.	To develop a community immunisation model across the South locality	Phased approach to implementation, enabling a safe transition to complete locality cover.	March 2019
School nursing services are to be reviewed across the city.	South HSCP will contribute to and support review of service.	As per review recommendations.	March 2019
Teenage pregnancy rates across neighbourhoods in the South locality are to be explored.	Analysis of variance in teenage pregnancy rates across South neighbourhoods to be undertaken.	Progress reviewed bi-monthly at South Locality Planning group.	December 2018
Children under the age of 5 years will be offered additional assessments in line with the National Practice Model.	Implementation of the Universal Health Visiting Pathway.	Progress reviewed bi-monthly at South Locality Planning Group.	December 2018
Family Support and Early Intervention			
Early Years Joint Support Teams (EY-JST's) will	Validated self-evaluation exercise to be undertaken with	Progress to be reviewed bi-monthly at South Locality Planning Group.	March 2019.

Priority	Key Actions	Progress 2017/18	Target 2018/19
continue to provide co-ordinated early help for pre-school children living in the most deprived neighbourhoods in the South of the city.	the Pollok and Gorbals EY-JST's (Govan complete 2017).		
Families who do not require statutory support from social care, can access a range of preventative third sector services.	Financial investment to be secured which ensures that families living in the South of the city can access necessary third sector support which is proportionate with families living in other areas of the city.	Progress to be reviewed bi-monthly at South Locality Planning Group.	March 2019.
Services supporting children and families living in the South of the city can accurately signpost families to appropriate support services.	Mapping exercise to determine range of third sector support services both in specific neighbourhoods and across the South locality.	Progress to be reviewed bi-monthly at South Locality Planning Group.	October 2018.
Raise Attainment and Achievement for All			
Children and young people living in the South of the city are supported to overcome barriers which prevent them being able to learn.	Children's services in the South locality will ensure a co-ordinated and planned response to the delivery of supports achieved through the Pupil Equity Fund.	To be reviewed bi-monthly at the South Locality Planning Group.	March 2019
Care Experienced Children and Young People			
Children and young people from the South of the city who require to be looked after and accommodated by the local authority can expect to remain living in the city and maintain	We will further reduce the number of South children living out with the city by 10%.	To be reviewed monthly by Service Manager (Social Care).	March 2019.

Priority	Key Actions	Progress 2017/18	Target 2018/19
connections important to them.			
Transforming Glasgow – prevention through Early help			
Families living in the South of the city will receive services from the HSCP that are located within their communities.	A review of accommodation across the South HSCP will determine opportunities for co-location and effective delivery of HSCP Children's Services.	Progress will be regularly reviewed, with a staged approach to co-location.	December 2018
Families requiring support from social care can expect a service that is prompt, respectful and meets their needs.	Children's social care services in the South locality will replace the current Duty model with an Early Help service designed to work alongside families to meet their support needs.	Progress to be reviewed bi-monthly at the South Locality Planning Group.	Implementation March 2018 – progress update to be completed March 2019.
Families requiring support will receive a co-ordinated response that is tailored to meet their individual needs.	Neighbourhood HSCP will implement a "test of change" approach to community support – where all services pull together and attend "Early Help" meetings with a solution focused approach to helping families.	Test of change will commence after accommodation review and HSCP services are co-located in neighbourhoods.	Test of change not likely to commence until March 2019. Priority for 2019/2020.
Children and families living the in Govan area will receive a community-based Early Help approach to supporting them.	Govan SHIP is a multi-agency Early Help model which considers the needs of vulnerable families registered with 3 GP practices in the Govan area.	Review currently on-going.	October 2018
Children and families living in the Govan area will be meaningfully consulted in relation to disadvantage, and	NSPCC, in partnership with South HSCP will deliver the NSPCC "Together for Childhood" model of community	To be reviewed quarterly at NSPCC Together for Childhood forums chaired by HSCP South Head of Children's Services.	March 2022 – 5 year programme

Priority	Key Actions	Progress 2017/18	Target 2018/19
supports delivered accordingly.	partnership and sustainable change.		
Welcoming Diversity and Tackling Inequality			
Children residing in communities whom did not receive immunisations in their country of origin will be immunised up to the age of 12.	Community immunisation clinics focusing on incomplete childhood vaccinations will deliver a needs-led response.	Progress to be reviewed bi-monthly at the South Locality Planning Group.	December 2018
Children and their families can expect a service that is sensitive and responsive to cultural diversity.	"Cultural competence" training will be delivered to HSCP frontline workers.	Progress to be reviewed bi-monthly at the South Locality Planning Group.	March 2019

Adult Services including addictions, adult mental health and learning disability

Priority	Key Actions	Progress 2017/18	Target 2018/19
Focus on and develop service capacity particularly in relation to prevention and early intervention support Implement the changes to Learning Disability Out of Hours Service in line with GG&C strategy recommendations.	• Progress through the learning disability planning group. • Review changes and adherence to strategy recommendations	Implementation complete – CPN Out of Hours Service now providing this role. Reviewed no issues 345 contacts in 2017	
Review adult mental health	• Review pathway at locality	Updated pathway implemented;	Review the admission/discharge

Priority	Key Actions	Progress 2017/18	Target 2018/19
patient pathway between hospital and community with health and social work interventions to optimise admission and discharge planning, including improving delayed discharge performance for adult mental health and learning disability.	planning groups. • Scrutiny of delayed discharges at operational management level on weekly basis	feedback resulted in amendments (completed April 18) Discharge co-ordinator role created to focus on 3 month plus admissions; early indications are this role in conjunction with the bed manager and updated pathways are positive impact on reducing delays.	pathway to support the aim of ensuring that movement through the pathway is managed as efficiently as possible. Further develop the role of the Discharge co-ordinator to support the admission/discharge pathway work and to support more efficient discharge planning.
Complete a self-assessment against the Adult Mental Health Community Services Framework requirements for all community mental health services across South Glasgow.	• Benchmark against the Mental Health Community Services Framework and identify actions to achieve any unmet standards.	Framework implemented, focus now on monitoring of standards.	On-going and continue to monitor standards
Review links between Primary care Mental Health Teams and Community Mental Health Teams with GP practices	• On-going monitoring and review • Establish links with GP clusters	Initial work has been via Govan SHIP project. Agreement to identify a link CPNs to clusters.	Agreed Primary Care MH team point of contact for each cluster; support and information re referrals to MH network.
Access to psychological therapies	• Maintain patients seen within 18 weeks performance • Improve percentage of first referrals seen within 28 days.	Quarter 3 17/18 achieving 95.9% (target 90%)	Maintain psychological therapies 18 weeks performance, and improve percentage of first referrals seen within 28 days.
Update patient information systems	• EMIS implementation within In-patient Services.	New work for 18/19	As part of the system wide programme of work, commence the roll out of EMIS to in-patient areas.
Implement new alcohol and drug access team arrangements in line with the geographical realignment of	• Implement through addictions management team arrangements	Completed, new arrangements reviewed Jan 18.	Maintain strong links with Community Recovery Hub and South Community Recovery Network (SCRN)

Priority	Key Actions	Progress 2017/18	Target 2018/19
team locations across South Glasgow.			Support SCRN to develop and expand volunteer programme with assistance of Recovery Co-ordinator Continue to provide link worker to South Community Recovery Hub to ensure continued movement between services
Deliver services that are safe, efficient, effective and value for money Increase numbers of staff trained in adult support and protection and strengthen joint approach across health and social care staff.	• Progress through adult services management team meetings. • Review performance information re staff training	Mandatory Learn-pro module for all in-patient staff, good uptake of monthly training targeted at second worker training for NHS staff. Additional sessions developed as required.	On-going as 17/18
Implement the recommendations of the Community Addiction Team review across south Glasgow.	• Implementation taken forward by addictions management team	Staged delivery of the review recommendation, Access and Shared Care concluded and reviewed.	Complete
Participate in the work of the Learning Disability Tier 4 redesign process.	• Taken forward by city-wide learning disability planning group. • Work led by North East Glasgow	Review Group convened to develop options for supported living models and on-going work with local care providers to reduce delayed discharges.	On-going
Consider options for learning disability day care provision for the South.	• Taken forward by city-wide learning disability planning group. • Work led by North East Glasgow	Significant investment in the fabric of day service; business case developed to prioritise a new build in North Glasgow. South LD day services will continue as is for the forthcoming period Work commenced in relation to an integrated service model for CLDT; consultation is commencing 27th March 18.	Continue to link in with city-wide LD Planning Group. Follow up output of consultation
Work with third sector care	• Processed through the adult	Addictions New Community recovery	On-going

Priority	Key Actions	Progress 2017/18	Target 2018/19
providers, Commissioning and Finance to meet the challenges of rising costs of social care particularly in 24 hour services.	services management team	hubs established through commissioning with quarterly monitoring. About to undertake a re-commissioning of residential services	
Planning for the Future Ensure a shared understanding of the approach, process and inputs, delivery and outcomes of the roll out of personalisation within adult services, including increased numbers taking support in form of direct payment.	• Progressed through adult services management team meeting, locality planning groups and forums.	Work in relation to sleepovers due to the implementation the Scottish Living Wage is now complete. Direct payments continue to be consistently static around 15% in line with the rest of the City.	
Develop a contingency response procedure for replacement care if a Provider exits the social care market – all care groups	• Processed through service modernisation and commissioning	Contingency planning continually refreshed and updated as appropriate. This has not been required as the market has held stable and preventative actions have been successful.	On-going
Recovery programme Rebalanced relationship with alcohol and reduced drug use: Support the implementation of the Single Outcome Agreement for Alcohol and the Alcohol & Drug Partnership Strategy	• Contribute to community recovery within South Locality and further develop & deliver South Locality 'Recovery with Rangers' and 'Recovery with the Citizens' programmes. • Implementation of Single Outcome Agreement actions by March 2017	Delivery and evaluation of phase 1 of pilot programme integrating RWR, rowing, photography, cookery and swimming under the banner of South Health Addictions Recovery Programme (SHARP). SVQ3 Placement engaged with Portfolio 1 through Elevate Glasgow	Contribute to community recovery within South Locality, including ELEVATE- Glasgow and further develop & deliver South Health Addictions Recovery Programme (SHARP).
Roll out recovery training for all alcohol and drug service staff to ensure service is recovery orientated in line with review recommendations and ADP outcomes measures.	• Roll out to be overseen by locality addictions group.	South Recovery Matters training concluded. South Alcohol and Drug Service launched 2017, review identified development work with staff re recovery.	Take forward development work identified in review

Priority	Key Actions	Progress 2017/18	Target 2018/19
Improve mental wellbeing and resilience Implement the recommendations in the Mental Health Framework	• Delivery of community based stress service for adults and young people through the Lifelink Contracts.	Adult contract is on course to deliver against its annual targets	Delivery of community based stress service for adults and young people through the Lifelink Contracts.
	• Build capacity for Peer Mentoring approaches through local Mental Health Support networks.	platForum produced a research report on Peer Support. Further developments are dependent on on-going support to platForum and city-wide 5 year strategy	On-going
	• Build capacity of staff and third sector organisations through delivery of MH Training i.e. Seasons for Growth, Assist, Safe Talk and Suicide Prevention.	SMHFA training is planned for second half of financial year.	Continue to work with staff and third sector organisations. Develop Suicide Safer Communities Form for South Locality
	• Consider in depth training for contracted third sector organisations engaging with patients who have severe and enduring mental health issues.	Review outcome of activity and report on proposals for 2017/18	Implement proposals
Improve access to addiction treatment and care	• Introduce 'Access Teams' within existing alcohol and drugs community services to improve assessment and access to appropriate services.	Completed	N/A
	• Focus on more intensive, shorter-term interventions to maximise the opportunities for recovery.	Achieved 90% of clients commencing alcohol or drug treatment within 3 weeks of referral Recovery plans in place within 21 days of commencing treatment	Maintain performance
	• Establish presence of "lived experience" representation along with recovery hubs within Access Teams to support individuals not requiring/eligible for formal Care and Treatment provision.	Peer volunteers spend time within the teams every week	Continue to support peer volunteers

Priority	Key Actions	Progress 2017/18	Target 2018/19
	• Implement eligibility criteria consistently	Review September 2017	
	• Engage with service users and communities over proposals to locate NHSGGC addiction inpatient beds and 'Greater Glasgow' NHS day services at Gartnavel Royal Hospital, with enhanced outreach provision.	Day Services move to single site on hold due to issues with the fabric of the building	Complete review and move to implementation of new day service model. Undertake a suitability study of current premises in Kershaw Unit. Move to ensure single day programme running across both sites initially
	• Development of community based Recovery Clinics • Review of Clinics within Care and Treatment Services	Not commenced	Plan to introduce recovery clinics based within Community Recovery Hub (CRH) to offer safe detoxification from ORT in partnership with CRH

Older People, including older people's mental health

Priority	Key Actions	Progress 2017/18	Target 2018/19
Putting in place the architecture of Integration Establish an Integrated Management Team for OPPC ensuring that there is appropriate time and exposure of all components within OPPC agenda	• Agree TORs for schedule of meetings and arrangements for cascade of information to and from all staff	Integrated Management Team Established March 2017 4 locality engagement events taken place, involving OP teams and other agencies. Team building and understanding other services, relationship building.	Develop integrated teams (health and social work) built around the neighbourhood model. Build working relationships with GP clusters, contractors, third sector, RSLs and others.

Priority	Key Actions	Progress 2017/18	Target 2018/19
including physical disability and long term conditions			
Establish Locality Planning for older people and physical disability services that links to Community Planning and HSCP strategic planning arrangements.	• Implement the older peoples' system of care • Progress planning and implement integrated neighbourhood teams	Older People Locality Planning Group in place. Planning events taken place.	Review and monitor
Establish Locality Governance structures for OPPC that connect to wider HSCP, Health Board and Glasgow City Council arrangements.	• Ensure we have effective governance including for ASP, escalation of concerns, Datix reporting, complaints, outcomes of LMRs and Significant Clinical Incidents and audits. Encourage an increase in NHS input and presence at ASP meetings	Continue to review and evaluate to ensure effective governance arrangements in place. ASP Completed, Established processes in place	Review and monitor
	• Develop training and awareness arrangements for NHS staff on ASP	On-going roll out of training and awareness	Review and monitor
Match local service delivery against agreed priorities Test our service provision against • National priorities (e.g. the 9 Health and Wellbeing Outcomes and HEAT targets) • Outcomes and key actions described in the HSCP Strategic Plan 2016-19 (Strategy Maps).	• Specific local actions to deliver these to feature on the agenda of the OPPC planning group and management group. • Report on progress against agreed outcome measures/targets at the OPPC planning meetings and locality and HSCP management structures	On-going review of progress and performance through agreed action plan. On-going. citywide weekly operational delayed discharge meeting Home is Best Steering Group established working on draft operational procedures with development sessions	Continue to monitor performance against the action plan. On-going
	• Increase the number of people who receive supported living services at home	Progress made towards target including review of collection of performance data Supported living considered in all appropriate cases.	Continue to monitor performance against target
	• Increase in % of intermediate users transferred home (target	Continue to monitor through balance scorecard	Continue to monitor performance against target

Priority	Key Actions	Progress 2017/18	Target 2018/19
	30%)	Average % in previous 12 months is 27%	
	• Increase in % receiving re-ablement following referral for home care (target 75%)	Achieved on on-going basis, Cordia are working to improve enablement outcomes	Continue to monitor performance against target
	• Delayed discharges improve the number of patients over 65 breaching the 72 hour target	Target is a maximum of 20 delays per month. Continue to improve performance in this area to achieve set citywide targets	Continue to monitor performance against target
	• Contribute to a reduction in the percentage of people aged 65+ and 75+ dying in acute hospitals	40% target achieved in quarter 3 (44.2% 65+ & 43.9% 75+)	Continue to monitor performance against target
Focus on and develop service capacity particularly in relation to prevention and early support Develop services that are in line with the National Clinical Strategy (2015) http://www.gov.scot/Resource/0049/00494144.pdf and the NHSGGC Clinical Services Review.	• We will promote anticipatory care approaches throughout our services • We will focus on the prevention of falls across our services • Target residential and nursing care homes to support them to reduce falls	Anticipatory Care Completed for all intermediate care residents to support discharge home Citywide Strategic Group work-plan now concluded moving to locality groups. Work underway to improve falls awareness among staff. LA residential (Orchard Grove) and independent care homes have been engaged with the CAPA (Care about Physical Activity) programme.	Focus on the development of cross sector training, working with partners including the independent sector to remove barriers to accessing joint training. Continue to implement the CAPA programme to increase physical activity within the care home population, working with independent partners to share learning across the different care home settings.
	• Support early discharge from hospital, contributing to the on-going development of Intermediate Care and the accommodation based strategy • Maintain 90% occupancy rate • LOS target of 30 days	Intermediate care units established. Supporting staff to ensure that these areas are considered in the assessment process	On-going
	• Develop, test and evaluate effectiveness of level one and two	Key individuals at locality level are working to develop service based solutions to improve falls awareness.	Build on current work with Scottish Ambulance Service to reduce the number of uninjured

Priority	Key Actions	Progress 2017/18	Target 2018/19
	falls assessment tools	Focus is on increasing level 1 falls conversations and developing proxy measures.	fallers being transported to A&E by improving uptake of the SAS pathway into Community Rehab Services
Support residential and care homes to have easy and appropriate access to primary care services and routes for escalation - Focus on reducing the number of hospital admissions from care homes	• Develop a co-ordinated approach to District Nursing and treatment room services for residential care homes population	Work has not progressed to develop a residential treatment room service Focus on improving Level 1 Falls conversations and implementing the CAPA programme to increase physical activity. Focus on reducing unplanned admissions is progressing via Unscheduled Admissions Group led by Clinical Director	As above
Implement the Dementia Strategy locally	• Work with Acute and care homes re admissions and support provided to Care Homes	Dementia strategy service managers 2017/20 – national and local Glasgow – to be progressed in 2018.	On-going
Deliver on early intervention and person centred approaches to care for those with a mental health diagnosis	• Disseminate information re 8 pillars pilot and contribute to evaluation	All staff trained in person centred approach. 8 Pillars evaluation complete	Completed. Review and monitor
	• Raise awareness and understanding of dementia amongst our staff and the general public and to promote timely access to dementia diagnosis	Sessions carried out with OPMH staff as part of the 8 pillars pilot including key learning from 8 pillars evaluation rolled out across both teams Multi agency approach, RAG is now MDT, SW in attendance at OPMH ref meetings local approach to crisis intervention OPMH & SW	On-going
	• Evaluate the outcomes of the '8 Pillars' approach, centred on a Dementia Practice Co-ordinator role and implement good practise across all services.	On-going review agreed performance targets / progress at OP planning Group	On-going
	• Progress a consistent model of	Agreed measures for waiting times	Continue to monitor

Priority	Key Actions	Progress 2017/18	Target 2018/19
	Dementia Post Diagnosis support and progress to tender and implementation. Monitor and review waiting times	through dashboard measures. Waiting list for PDS Alzheimer's Scotland contracted to employ 2 additional 6 month fixed term contract to reduce waiting list citywide Developed a service pathway for referral to PDS as part of the new contract	performance and waiting times for access to PDS.
	• CMHT Framework to be implemented • Improve hospital environment to meet the needs of people with dementia as described in National Dementia Strategy, 10 Point National Action Plan.	CMHT Operational Framework action plan has been developed and strands on-going. Dementia Demonstrator Site on-gong until 2019 Met all 10 points; Single sex environment improved, access to appropriate garden space, reviewing and improving the furniture to reduce falls.	On-going
	• Glasgow City Dementia Strategy and Integrated Dementia Services Framework for Residential and Day care services and with Commitment 11 of the Strategy.	Commitment 11 action plan completed. Recruiting additional care home liaison nurse residential, stress and distress training is being rolled out in res homes	On-going
	• Deliver access to Psychological Therapies to meet HEAT target.	Continue to meet the target All inpatient staff completed stress and distress training; CBT training underway.	On-going
Palliative Care Take forward in South the HSCP palliative are strategy in South and support individuals with palliative care needs	• Support for individuals with Palliative Care needs • Continue to develop a South Locality Palliative Care plan in partnership with key stakeholders and partners taking account of key priorities outlined in the Palliative and End of life strategy	Continue to progress through the South Locality palliative care group.	On-going

Priority	Key Actions	Progress 2017/18	Target 2018/19
Continue to lead and implement on the polypharmacy / mindful prescribing agenda to ensure safe, effective and patient centred use of medicines in OP as per South Sector Prescribing action plan	• Reshape current prescribing support team commitment to focus on polypharmacy reviews	Prescribing support reviewed, on target to achieve 2017/18 action plan. Focus on continual improvement	On-going
Deliver services that are safe, efficient, effective and value for money Deliver services within budget; identify areas of further efficiency and areas requiring development, investment or disinvestment with reference to the Quality Strategy. Establish mechanisms for monitoring and reviewing performance against agreed KPIs across health and social care	• Ensure close budget monitoring to address any financial challenges • Included on the agenda of the OPPC planning group and Management Team agenda quarterly	On-going – OPMH ward/unit closed as part of the financial target achieved. Continue to identify opportunities for service reform and savings	Support the closure of Mearnskirk Hospital (led by acute) in March 2019 and agree a new model of provision to include a combination of beds and community supports. Link with the on-going review of Out of Hours Community Services to identifying opportunities for service reform and improve the model of OOH community nursing services across the city.
Planning for the Future Ensure that staff within OPPC are well informed about policy, strategy and emerging issues and are given opportunities to contribute to contribute to the shape of future services	• Locality events being planned May/June and autumn 2016 • Organise shared learning events, briefings and developmental opportunities throughout the year • Consider other models of service including for treatment room provision as part of the city wide review	4 engagement sessions and neighbourhood planning sessions targeted at Team Leader and Service Managers	On-going Recruit and train 11 phlebotomists. Ensure that the infrastructure is in place to support this service (IT etc.) Link with the on-going review of Out of Hours Community Services to identifying opportunities for service reform and improve the model of OOH community nursing services across the city.

Homelessness

Priority	Key Actions	Progress 2017/18	Target 2018/19
Putting in place the architecture of Integration Embed the community homeless service in the locality	• Improve the interface with all care groups. • Provide shadowing opportunities for Community Homeless Team	Regularly attend management meetings for all care groups Shadowing on-going	On-going
	• Increase access to preventive services	Housing Options implemented; review resulted in updated paperwork.	Review regularly
	• Undertake a review of the Housing Options approach to include referral numbers to preventative services and service user outcomes	Review report completed; quarterly reporting on-going	Review regularly
Match local service delivery against agreed priorities Homelessness prevention mediation service Improve provision for those leaving prison We are introducing this to the Prison Casework Team, this is a service that is currently available through housing options.	• Examine ways of reducing homelessness on leaving prison. • Work with SPS re measure outcomes. • Prison Casework Team to work more closely with Community Homeless Teams • Reduce the length of time that service users spend in bed and breakfast accommodation. • Aim to resettle people as quickly as possible following a period of homelessness	Prison homeless team are now dealing with all registered sex offenders the prison homeless team now cover duty in the South. Reviewed and no issues identified. Target has been increased from 24 to 30. Issue across the city with a lack of appropriate RSL lets (properties tend to be 2/3 bedroom which is unsuitable for large families or single people)	Work closely with SPS and Criminal Justice Social Work to improve outcomes for prisoners Continue to work to achieve target
Improve the quality of accommodation available to homeless service users.	• Agree a new service user involvement framework to ensure service users views are fed into planning and service delivery • Ensure services to refugees continue to be effective	HHL to carry out 2017/18 Service User Survey and submit to Executive Group	On-going
Improve our arrangements for service user involvement	• Continue to ensure access to cost effective interpreting services	HHL to carry out 2017/18 Service User Survey and submit to Executive	On-going

Priority	Key Actions	Progress 2017/18	Target 2018/19
	• Carry out annual survey on access to health and social care services	Group	
Support the development of services to refugees and new communities	• Ensure staff have access to up to date guidance for homeless applicants with no recourse to public funds • Community Homeless Team to work closely with Children and Families Roma Team to support Roma families • Continue to examine opportunities to develop access to private rented sector.	On-going	Review and monitor
Focus on and develop service capacity particularly in relation to prevention and early support Strengthen the focus on homelessness prevention Mitigate the effects of welfare reform	• Continue to support the Housing Options approach, to prevent homelessness. • Improve links with the private rented service in conjunction with DRS to improve private rented accommodation. • Improve joint work with law centres • Support delivery of the single outcome agreement Housing and Homelessness work stream • Continue to monitor the impact of welfare reform • Continue to ensure staff can signpost	The HSCP continues to support the 18 Housing Options' sites in South Glasgow. Named contacts in every care group; regularly reviewed. Health and Homeless Lead acts as a single point of contact to Housing Options' sites for access to HSCP and other services	On-going
Deliver services that are safe, efficient, effective and value for money Strengthen tenancy sustainment activity Improve outcomes for multiply	• Improve pathways into services • Develop innovative approaches to accessing housing support services • Improve access to homeless prevention services to tenants in	Turning Point Scotland contracted to provide homelessness housing support; this includes prevention of homelessness work	Co-locate both in Council buildings and Turning Point Scotland buildings to improve outcomes for homeless service users in relation to securing a permanent tenancy

Priority	Key Actions	Progress 2017/18	Target 2018/19
excluded homeless service users Ensure effective service pathways for vulnerable people	private rented sector • Review and develop pathways for vulnerable adults and children		
Planning for the future Ensure commissioned services continue to be strategically relevant, meet the needs of service users and the wider community. Access to employment, health and education	• Work with GCC Commissioning Team on a review of commissioned services, including housing support and Bed and Breakfast accommodation.	Continue to work closely with the commissioning team	Work closely with Social Work Services Commissioning Team in relation to the implementation of the homeless alliance.

6. Health Improvement and Inequalities

Priority	Key Actions	Progress 2017/18	Target 2018/19
Less difference in healthy life expectancy between neighbourhoods and groups Thriving Places: Contribute to the development of a place based approach to community capacity building and neighbourhood regeneration through partnership working in Gorbals, Priesthill/Househillwood and Govan.	• Support the Gorbals Regeneration Group develop the Thriving Places agenda, including development of a communications strategy • Community engagement 'creating conversations' activities undertaken in Gorbals and Priesthill/Househillwood thriving places. • Support the selection process to ensure the appointment of anchor organisation for Priesthill/ Househillwood • Continue to work with	Community Events including Community Market, Gorbals Fun, Spirit of the Gorbals, St Francis Com Garden, Community Breakfast, School Holiday Programme, Arts Strategy Group & Community Renewal Continue the development of neighbourhood forum and thematic groups. Anchor organisation &Community connecter appointed Consortium of local organisations	Support the Gorbals Regeneration Group in its delivery of a thriving places agenda, including the development of an engagement strategy which will link to the Gorbals Locality Plan. Build on existing relationships within the Priesthill/Househillwood area, continue to enhance established community resources.

Priority	Key Actions	Progress 2017/18	Target 2018/19
	partners to develop the Thriving Places approach in Govan. • Support the wider community planning agenda and requirements for the development and delivery of Local Outcome Plans.	(Galgael, Plantation Productions & Govan Community Project) are progressing the Community Engagement aspect of Govan Thriving Places; report to be produced by end of financial year Assisted in the development of the 4 CPP Locality Plans (3 thriving places and Govanhill)	Govan: Continue to work with partners to develop thriving places approach.
Govanhill Neighbourhood: Responding to the diverse needs of Govanhill community	• Recruitment of additional peer educators for Roma Peer Education Programme • Implementation of capacity building and training programme for peer educators.	Training needs identified. Update sessions taken place, focus on oral health & GP registration; Antenatal care and pharmacy update session planned. Pilot developed in conjunction with EU Health Visiting Team, Health Improvement, OHD and Childsmile move to whole family approach for newly transferring in families. Staff input delivered Govanhill ESOL classes around specific health themes.	Support current Peer Educators in their delivery of Peer Education sessions and development of their role within a wider context.
Reduced exposure and use of tobacco Smoke: Support the Implementation of the Glasgow Tobacco strategy	• Target our smoke free services to patients in SIMD 1 & 2 to ensure new HEAT Target is reached. • Make use of data to target new partnerships with pharmacies • Improve marketing to support update of services (Govan & Gorbals) • Target BME Groups within Govanhill	83 clients set quit dates at these 2 new services. Data is being used to inform discussions with local community pharmacies; 28 staff attending training session to improve outcomes, data recording and partnership working. Facebook marketing targeted within local areas of high deprivation to promote local stop smoking services, sharing good news stories, etc.	Continue to target our smoke free services to patients in SIMD 1&2 to ensure new LDP target is reached.

Priority	Key Actions	Progress 2017/18	Target 2018/19
		Smoking cessation information and support available at the EU drop in clinic held in Govanhill.	
Rebalanced relationship with alcohol and reduced drug use: Support the implementation of the Single Outcome Agreement for Alcohol and the Alcohol & Drug Partnership Strategy	• Train local partners in Alcohol Brief Intervention. • Community Alcohol campaigns • Increase the number of people participating in 'Recovery with Rangers' and other recovery programmes.	ADP, P & E Contracts Started July 2017: ABI training & delivery. Workforce Development Alcohol & Drug Training. October 2017: Children & Families Multiple Risk Contact, 1:1 service and Prevention & Education programme Community Alcohol Campaigns in Govan and Ibrox delivered 32 people involved over 2 courses. Recovery with Rangers integrated into SHARP	Train staff & partners in Alcohol Brief Intervention's (ABI) and monitor delivery towards the LDP target. Deliver & evaluate the delivery of CRAFFT screening and brief interventions for young people. Develop referral guidelines for youth workers in South Locality and within a wider context. On-going work to support Increase the number of people participating in SHARP and other recovery programmes
Reduce Poverty and Build Aspirations Deliver financial inclusion services including income maximisation, financial capability and debt management.	• Increased referrals to financial inclusion services. • Peer support group established.	Resources secured to deliver the service in 2017/18; on track for referrals and uptake of service. Attendance allowance flyers were produced and distributed to staff and third sector organisations. Continuing to support Money Matters in delivery of the project.	Increased referrals to financial inclusion services.
Employability	• Deliver employability services through the Bridging Service. • Promote the service to improve referral rates	Joint presentation with Momentum at management development group and links made with HI team. Occupational Therapist now operating in South within Pollok Civic Realm.	Continue to deliver employability services through the Bridging Service.
Deliver actions to address	• Deliver food and nutrition	Food for Thought contract awarded to	Continue to deliver food and

Priority	Key Actions	Progress 2017/18	Target 2018/19
poverty including food poverty and the stigma of living in poverty for our patients and communities.	programmes.	Urban Roots to deliver community/family meals in the Thriving Places areas. Cookery courses continue part funded by HI and IGF. HI funding to Urban Roots to pilot a Food Co-op style initiative in the Priesthill/ Househillwood Thriving Place.	nutrition programmes. Implementation, monitoring and evaluating of Food For Thought Contract.
Creating a Culture for health in the city (alcohol drugs smoking and obesity) Promote breast feeding and healthy early years (NHWO 1,2,3,5,7,9) Deliver Oral health Improvement Programmes based on local Population needs targeting BME and Vulnerable communities within Budget; Identify areas for further efficiency and	• Maintain UNICEF baby accreditation awarded. • Welcome award and BFFN to be targeted in localities with lowest breastfeeding rates and highest BME communities • Support exclusive breastfeeding among BME communities. • Support the Child healthy Weight programme.	Unicef Baby Friendly accreditation maintenance programme continues. Annual audit submitted Sept 17. Sector will look to progress to Unicef Achieving Sustainability Gold award in next two years BFFN award on-going. Improved links with education to support uptake of outstanding nurseries Roll out of Welcome Award to Glasgow Life (and other large orgs) in 2018. New breastfeeding Group Launched Pollok Nov 17 to target areas with low breastfeeding rates. Scottish Gov funding up to March 18 for Govanhill Baby Café run by National Childbirth trust (NCT) with HV teams /Health Improvement. Child Healthy Weight programmes continue in Govan and Priesthill/ Househillwood. 30 Starting Solids Sessions delivered across 7 venues in 2017 (Ave 4 per venue).Sessions being reviewed and	Maintain Unicef Baby friendly Standards and progress towards achieving the Unicef BFI Achieving Sustainability (Gold) award Continue breastfeeding public acceptability work (breastfeeding Nursery and breastfeeding welcome awards) in the locality with a focus on manager cascade training to increase roll out. Continue to provide support to baby cafe in Govanhill and new breastfeeding support at Pollok. Look at options to develop further breastfeeding support 2018/19 Delivery of 32 starting solids sessions per year. Number of targeted establishments and age range

Priority	Key Actions	Progress 2017/18	Target 2018/19
areas requiring development, investment or disinvestment with reference to the SHANARI indicators(NHWO 1,2,3,5,7,9)	• Number of programmes/ local residents involved in early years programme	targeted to areas with most need. Fluoride Varnish Programme consent process reviewed, increase in consents noted. Oral Health Training delivered to EYS and key partners. Daisy Chain pilot programme to improve the oral health of local children particularly Roma continues. Working in partnership with Early Years Scotland, Bookbug, Jeely Piece Club and Home-Start Glasgow South. Partners encouraged to offer services in local neighbourhood areas.	of children consented for Fluoride varnish to Increase during 2018/19 Reduce incidence of dental caries in pre fives: On-going delivery of oral health prevention programme in early years establishments. . Method of updating staff training via managers updates being rolled out.
Early intervention, prevention and harm reduction. **Public protection including keeping vulnerable people safe from harm.**	• Child and young people's mental health and wellbeing framework		Implementation of the board child and young people's mental health and wellbeing framework.
Providing greater self-determination and choice Young Parents Programme	• Young Parents Programme		Develop a tailored programme to meet the expressed needs of young parents to provide opportunities for personal and social development.
Providing greater self-determination and choice Health Issues in the Community (HIIC)	• Increase community capacity and participation and supports community development approaches to tackling inequalities in health.		Continue to identify groups of young people to participate in the Health Issues in the Community programme.
Early intervention, prevention and harm	• Weigh to Go - healthy, sustainable and successful weight		Co-ordinate the Weigh to Go programme in the South,

Priority	Key Actions	Progress 2017/18	Target 2018/19
reduction. Weigh to Go	loss for young people who are overweight and want to lose/manage their weight.		refer/sign post young people to the service and continue to raise awareness (with young people and relevant partners) of the supports available.
Focus on and develop service capacity particularly in relation to prevention and early support	• Early notification of dates of generic training for all staff		Wide communication of objectives and benefits of GBV specific Training opportunities to be targeted at Health Visiting staff

7. PROMOTING EQUALITY

The South Locality will contribute to the delivery and actions and priorities set out within Glasgow City HSCP's Equality Plan 2016-18. Key actions and priorities for the South include:

- roll out of ' Checking It Out' Toolkit across services;

- staff awareness raising sessions to improve uptake and referrals to interpreting services and use of accessible information for patients;
- maintaining accessibility audits and Equality Impact Assessments for new buildings;
- participation in Equality Impact Assessments of cost savings, service redesigns, service developments and policies;
- hate crime awareness and reporting;
- routine enquiry money worries, gender based violence (GBV), employability and appropriate onward referral;
- responding to findings of the Fairer NHS staff survey alongside staff training priorities (Asylum seekers & Refugees, Poverty e-learning module, key care groups including Roma and GBV;
- meeting the requirements of the HSCP's participation and engagement strategy including equalities monitoring of community engagement;
- analysing performance monitoring and patient experience by protected characteristics as required; and,
- provision of a programme of equality and diversity training for South staff and local organisations.

Gender Based Violence

Priority	Key Actions	Progress 2017/18	Target 2018/19
Putting in place the architecture of Integration Embed the work of the South GBV Implementation Group in the locality	• Improve liaison with HSCP care groups	Locality Groups including South GBV Implementation Group to be reviewed in March 2018 as part of a citywide cross locality approach. HSCP staff offered multi-agency GBV training on an on-going basis.	On-going training programme
Match local service delivery against agreed priorities	• Concentrate effort in 'hot spots'	Daisy project continues to cover the whole of the South. Police have been active members of both the South Implementation Group and Events Sub Group. A programme of events for 16 days took place; 6 events in the Govan hot spot.	Work with partners such as the Police to target activity where required
Focus on and develop service capacity particularly in relation to prevention and early support	• Early notification of dates • Wide communication of	Training timetable shared with HSCP staff and partner organisations Tailored sessions delivered to housing	Continue to raise awareness of GBV training and the benefits

Priority	Key Actions	Progress 2017/18	Target 2018/19
Promote attendance at multi-agency, multi-disciplinary awareness raising training	objectives and benefits	staff 4 lunchtime drop-in sessions for HSCP and acute sector staff held during 16 days FGM Awareness session took place with a mix of partner Youth staff and HSCP staff.	of training GBV specific training opportunities to be targeted at Health Visiting Staff
Deliver services that are safe, efficient, effective and value for money	• Advertise availability of local and city-wide services • Annual diary of events, particularly 16 Days of Action • Continue to deliver annual programme with £6k IGF and 'in kind' input • Locality staff continue to participate in MARAC	Women Where to Go leaflet shared widely during 16 Days of Action GBV stall at Mental Health Awareness community session Full 16 Days' programme delivered in 2016 Locality staff took part in the review of MARAC and participate	On-going
Planning for the future	• Ensure services in the South are strategically relevant • Work with Community Planning Partners	South GBV Implementation Group and other locality groups to be reviewed in March 2018 as part of a citywide cross locality approach. Hotspots and equity of service for GBV to continue to be discussed with partners; hot spot areas have received extra support during 16 days and International Women's Day events.	On-going
Public Protection – including keeping vulnerable people safe from harm	• Ensure local communities and those who access our services are safe from harm	Offer a range of supports e.g. Youth worker guidelines Providing GBV training Coordination of the Schools Health Relationships drama programme	

8. RESOURCES

Accommodation

Services are delivered across a wide range of locations in the South locality. Our vision is that we will focus our health and social care services around our four main centres in Gorbals, Castlemilk, Govan and Pollok supported by other smaller centres across the south. We will take forward a programme to improve our accommodation and support the delivery of integrated health and social care services to the people of South Glasgow. We have begun a major project to assess the scope for increasing clinical space, making better use of our non-clinical areas through the introduction of agile working, and improving facilities for staff and patients.

Work has commenced on a new health and care centre in the Gorbals to replace the existing Gorbals Health Centre, the Two Max building and the South Bank Centre for Specialist Children's services. This is due to be operational in early 2019. We have also begin to make significant moves in Rowanpark so that this becomes a hub for children's and families services serving the South West, and remodel Govan health centre and Elder Park Clinic as one of four bases in the South for our new integrated teams for older people. We are currently assessing space in both Castlemilk health centre and Castlemilk social work office to better support integration. During 2018/19 we will also be exploring options for a new HQ.

Human Resources

We have a total of 1,841 staff working in the South – 1,288 NHS staff and 553 social work staff. We have undertaken a programme of staff engagement to raise awareness about integration and what it means for staff and teams, and the challenges facing the HSCP. Each care group has also undertaken staff engagement sessions to explore specific issues of relevance to them. Supporting staff through training and other personal development opportunities will be a priority for us going forward. We are also conscious of the current sickness absence rates for NHS and social work staff, are currently above target.

Finance

The indicative budget for the locality in terms of net expenditure for 2018/19 is approximately £236.9m as shown below by care group.

South Locality Budget by care group 2018/19

GCHSCP – South	**2018/19**
Children and Families	15,709,000
Prisons Healthcare and Criminal Justice	2,428,000
Older People	35,641,000
Addictions	3,990,000
Carers	575,000
Elderly Mental Health	7,349,000
Learning Disability	20,780,000
Physical Disability	5,525,000
Mental Health	24,719,000
Homelessness	1,295,000
Prescribing	47,106,000
Family Health Services	61,160,000
Hosted Services	3,951,000
Other Services	6,700,000
Total	**236,928,000**