Glasgow City
Glasgow City
Integration Joint Board

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GLASGOW CITY HSCP WORKFORCE PLAN

Purpose of Report:	To provide Glasgow City Integration Joint Board with the first completed Workforce Plan for the Health and Social Care Partnership.

Recommendations:	The Integration Joint Board is asked to: a) note the work done to date and further refined versions will be brought to the IJB in due course; and b) note and approve the workforce plan.

Relevance to Integration Joint Board Strategic Plan:

The relevance of the workforce plan is to support the HSCP to deliver the priorities in the strategic plan and ensure appropriate staffing arrangements are in place across the HSCP

Implications for Health and Social Care Partnership:

Reference to National Health & Wellbeing Outcome:	Outcome 9 – Resources are used effectively and efficiently in the provision of health and social care services.

Personnel:	The document describes the transformational agenda for the HSCP and the impact on our workforce going forward.

Carers:	None

Provider Organisations:	None

Equalities:	The document describes equalities challenges for the population of Glasgow City and also confirms the organisational requirements of equality duties and outcomes as detailed in the Equalities Act (2010)

Financial:	The document describes the service transformational agenda for the HSCP and the programmes of redesign underway to meet our financial requirements.

Legal:	None at this time

Economic Impact:	None at this time

Sustainability:	None at this time

Sustainable Procurement and Article 19:	None at this time

Risk Implications:	Service changes described will potentially impact on staff within the HSCP and these processes will have to be managed via appropriate H R processes.

Implications for Glasgow City Council:	Changes to structures and staffing arrangements

Implications for NHS Greater Glasgow & Clyde:	Changes to structures and staffing arrangements

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.   Introduction

1.1   Glasgow City HSCP is required by Scottish Government to develop and publish a workforce plan which sets out the strategic direction for workforce development, service redesign and the resulting changes to our workforce.

1.2   This document presents the first workforce plan for the HSCP. This plan will be revisited on a regular basis, to ensure that further versions contain accurate and up-to–date details of the current workforce and any planned changes to that workforce moving forward.

2.   Context

2.1   In December 2016, the Scottish Government published the Health and Social Care delivery plan.

2.2   This plan set out an aspiration for high quality health and social care services in Scotland which are focussed on prevention, early intervention and supported self-management.

2.3   The HSCP needs to ensure that everyone receives the right help at the right time, not just now, but in the years to come as our society continues to change. Our approach to primary and community care on the one hand, and acute and hospital services on the other, should support the critical health challenges our society faces, not least with respect to an ageing population.

2.4   For community based services, this will mean everyone should be able to see a wider range of professionals more quickly, working in teams if we are to ensure people receive high-quality, timely and sustainable support for their needs throughout their lives.

2.5   Through our workforce planning processes the HSCP need to redesign those services around communities and ensure that they have the right capacity, resources and workforce.

2.6   At the time of completion of this version of the plan, specific guidance for the structure of workforce plans within integrated health and social care policy has not yet been formalised by the Scottish Government. In the absence of formal guidance this Workforce Plan has been developed using the Skills for Health 'six steps methodology for integrated workforce planning'. This methodology is a workforce model which provides a framework which can be applied across both health and social care services and, as such, allows the HSCP to take a coherent view of the workforce across all job families and sub-groups.

2.7   A National Workforce Plan is under development and publication is anticipated at the end of May. It should be noted, however, that following representation from Chief Officers and Local Authority representatives across Scotland, the Cabinet Secretary has agreed to delay the publication of the social care element of the National Workforce Plan. This is to allow more time to consider how to address workforce planning challenges for the social care workforce, including those working within Integration Joint Boards, local authorities and third and independent sectors.

2.8   The workforce implications of service change and redesign are set out in the HSCP financial and service plans. It is recognised by all stakeholders that the redesign and service change plans set out in this document are at varying stages of development and implementation. In addition a number of the projects are still the subject of continuing discussion with staff side and therefore outcomes may change as consultations are completed. The flexibility is reflected in the narrative of the plan. Some of these plans will change in response to external influences and events and this may affect projected workforce change.

2.9   The current iteration of the workforce plan, which is appended to this report, has been circulated and discussed with the NHS Staff Partnership Forum membership. The size and complexity of the level of detail in the document has been recognised by all those involved in the discussion. Trade Union colleagues have asked that we confirm that this document is recognised as a work in progress as is detailed in the narrative above. From a management perspective, we have been clear in discussion with trade union colleagues that whilst the document does describe a direction of travel in relation to areas of redesign which are detailed in the action plans included in the document, this does not preclude further and appropriate engagement with staff and trade unions in relation to any proposed service change.

2.10   Regular updates on progress against the aims and targets set out in the plan will be provided to the IJB, Senior Management Team, Staff Partnership Forum and other stakeholder forums. The detail of the workforce plan will be subject to further scrutiny and refinement on a continuing basis via the Core Leadership Groups and will include regular discussions with staff side

3.   Recommendations

3.1   The Integration Joint Board is asked to:

a) note the work done to date and further refined versions will be brought to the IJB in due course; and
b) note and approve the Workforce Plan.

DIRECTION FROM THE GLASGOW CITY INTEGRATION JOINT BOARD

1	Reference number	210617-13-a
2	Date direction issued by Integration Joint Board	21st June 2017
3	Date from which direction takes effect	21st June 2017
4	Direction to:	Glasgow City Council and NHS Greater Glasgow and Clyde jointly
5	Does this direction supersede, amend or cancel a previous direction – if yes, include the reference number(s)	No
6	Functions covered by direction	All care groups within Glasgow City HSCP as described within the appended document
7	Full text of direction	To note the service redesign and staffing implications for both NHS Greater Glasgow and Clyde and Glasgow City Council staff which will be managed locally through agreed HR processes and policy for both organisations
8	Budget allocated by Integration Joint Board to carry out direction	Existing care group budget allocations
9	Performance monitoring arrangements	In line with the agreed Performance Management Framework of the Glasgow City Integration Joint Board and the Glasgow City Health and Social Care Partnership.
10	Date direction will be reviewed	June 2018

Workforce Plan

2017 to 2020

Contents

1 Section One

Background to the Glasgow City Health and Social Care Partnership Workforce Plan

1.1 Introduction to the Workforce Plan

1.1.1 In December 2016 the Scottish Government published the Health and Social Care Delivery Plan[1]

1.1.2 The plan set out an aspiration for high quality health and social care services in Scotland which are focussed on prevention, early intervention and supported self-management. The plan set out our programme to further enhance health and social care services. Working so the people of Scotland can live longer, healthier lives at home or in a homely setting and we have a health and social care system that:

- is integrated;
- focuses on prevention, anticipation and supported self-management;
- will make day-case treatment the norm, where hospital treatment is required and cannot be provided in a community setting;
- focuses on care being provided to the highest standards of quality and safety, whatever the setting;
- ensures people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.

1.1.3 The National Health and Social Care Delivery Plan is designed to support an evolution of the health and social care system building on the excellence of NHS Scotland, recognising the critical role that services beyond the health sector must play. It prioritises the actions which will have the greatest impact in support of this and outlines a focus on three areas "The Triple Aim":

- **Better Care** - improving the quality of care for people by targeting investment at improving services, which will be organised and delivered to provide the best, most effective support for all;

- **Better Health** - improving everyone's health and wellbeing by promoting and supporting healthier lives from the earliest years, reducing health inequalities and adopting an approach based on anticipation, prevention and self-management;

- **Better Value** - increasing the value from, and financial sustainability of, care by making the most effective use of the resources available to us and the most efficient and consistent delivery.

1.2 How will the HSCP support the delivery of "Better Care"

1.2.1 The HSCP needs to ensure that everyone receives the right help at the right time, not just now, but in the years to come as our society continues to change. That requires a change in our approach to how and where the services that support our health and social care are delivered. First, we need to move away from services 'doing things' to people to working with them on all aspects of their care and support. People should be regularly involved in, and responsible for, their own health and wellbeing.

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[1] The National Health and Social Care Delivery Plan
http://www.gov.scot/Publications/2016/12/4275/downloads

1.2.2 Care planning should anticipate individuals' health and care needs both by helping those with chronic and other complex conditions to manage their needs more proactively, and by focusing on a prevention and early intervention approach to supporting health throughout people's lives. This is not always a question of 'more' medicine, but making sure that support fits with, and is informed by, individual needs.

1.2.3 The HSCP needs to support a service that has the capacity, focus and workforce to continue to address the increasing pressures of a changing society. Our approach to primary and community care on the one hand, and acute and hospital services on the other, should support the critical health challenges our society faces, not least with respect to an ageing population.

1.2.4 For community based services, that will mean everyone should be able to see a wider range of professionals more quickly, working in teams if we are to ensure people receive high-quality, timely and sustainable support for their needs throughout their lives.

1.3 How will the HSCP support the delivery of "Better Health"

1.3.1 The National Health and Social Care Delivery Plan suggests that to improve the health of Scotland, there needs to be a fundamental move away from a 'fix and treat' approach to our health and care to one based on anticipation, prevention and self-management.

1.3.2 The plan notes that the key causes of preventable ill health should be tackled at an early stage. There must be a more comprehensive, cross-sector approach to create a culture in which healthy behaviours are the norm, starting from the earliest years and persisting throughout our lives. The approach must acknowledge the equal importance of physical and mental health as well as the need to address the underlying conditions that affect health.

1.3.3 All services must be sensitive to individual health and care needs, with a clear focus on early intervention. Moreover, it will not just be what services can provide, but what individuals themselves want and what those around them – not least families and carers – can provide with support. Services need to be designed around how best to support individuals, families and their communities and promote and maintain health and healthy living.

1.3.4 The HSCP will deliver this by working closely with our key partners such as social care, primary care, education, housing and the third and voluntary care sector.

1.4 How will the HSCP support the delivery of "Better Value"

1.4.1 For the HSCP "Better Value" means improving outcomes by delivering value from all our resources, not just increasing the efficiency of what we currently do, but doing the right things in different ways.

1.4.2 Achieving this will require integrated approach to the components of our strategic plan so that the whole approach and its constituent parts are understood work seamlessly for patients and service users.

1.4.3 For better integrated care to become a reality, the Health and Social Care Partnership must plan and deliver well-coordinated care that is timely and appropriate to people's needs. We are integrating health and social care in Renfrewshire to ensure people get the right care, at the right time and in the right place, and are supported to live well and as independently as possible.

1.4.4 An important aspect of this will be ensuring that people's care needs are better anticipated, so that fewer people are inappropriately admitted to hospital or long-term care. The HSCP along with its partner organisations are focussing on actions around three key areas:

- reducing inappropriate use of hospital services;
- shifting resources to primary and community care;
- supporting capacity of community care

1.4.5 Key to achieving these aims will be shifting the balance of where care and support is delivered from hospital to community care settings, and to individual homes when that is the best thing to do. Good quality community care should mean less unscheduled care in hospitals, and people staying in hospitals only for as long as they need specific treatment.

1.4.6 Through our workforce planning processes the HSCP need to redesign those services around communities and ensure that they have the right capacity, resources and workforce.

1.4.7 Optimising and joining up balanced health and care services, whether provided by NHS, local government or the third and independent sectors, is critical to realising our ambitions.

1.4.8 Integration of health and social care has been introduced to change the way key services are delivered, with greater emphasis on supporting people in their own homes and communities and less inappropriate use of hospitals and care homes.

1.4.9 The HSCPs service redesign activities must also be must support a culture of improvement. Sustainable improvements in care, health and value will only be achieved by a strong and continued focus on innovation, improvement and accountability across the whole health and social care workforce.

1.4.10 The Health and Social Care Partnership is required by the Scottish Government to develop and publish a workforce plan for approval by the Integrated Joint Board, which sets out the strategic direction for workforce development and the resulting changes to our workforce.

1.4.11 Specific guidance for the structure of workforce plans within integrated health and social care policy has not yet been formalised by The Scottish Government. In the absence of formal guidance this Workforce Plan has been developed using the Skills for Health "Six Steps Methodology for Integrated Workforce Planning"[2].

1.4.12 The Six Steps Methodology is a workforce model which enables provides a framework which can be applied across both health and social care services and, as such, allows the HSCP to take a coherent view of the workforce across all job families and sub-groups.

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[2]http://www.skillsforhealth.org.uk/resources/guidance-documents/120-six-steps-methodology-to-integrated-workforce-planning

1.4.13 The workforce implications of service change and redesign are set out in Glasgow City HSCPs financial and service plans. These workforce implications highlight any planned recruitment activity and are further analysed in the project implementation documents (PIDs) which are prepared to support any significant service change and which set out the financial, workforce and equality impacts of any proposed changes.

1.4.14 It is critical therefore that all workforce plans whether stand alone documents or part of wider service planning documents are signed off by a wide range of stakeholders including local management teams, service managers and planners, financial managers and local staff side representatives and partnership forums.

1.4.15 It is recognised by all stakeholders that the redesign and service change plans set out in this workforce plan are at varying stages of development and implementation. In addition a number of the projects are still the subject of continuing discussion with staff side and therefore outcomes may change as consultations are completed. This flexibility is reflected in the narrative of the plan. Some of these plans will change in response to external influences and events and this may affect projected workforce change.

1.4.16 **Actions arising from this Workforce Plan**

1.4.17 The 2017/20 workforce actions are noted within this workforce plan under each relevant heading/topic.

1.4.18 These actions are summarised in an action plan in Chapter 5 of this document

1.4.19 Regular updates on progress against the aims and targets set out in the Workforce Plan will be provided to the IJB, Senior Management Team (SMT), Staff Partnership Forum (SPF) and other stakeholder forums e.g. the Glasgow City HSCP Workforce Board.

1.5 An overview of Glasgow City Health and Social Care Partnership

1.5.1 The Public Bodies (Joint Working)(Scotland) Act 2014[3] requires local authorities and health boards to integrate the strategic planning of most social care functions, and a substantial number of health functions. As a minimum these functions must be integrated where they apply to services delivered to adults. This can be done by one party delegating to the other (also known as a 'lead agency' model) or by establishment of a new body to oversee this strategic planning and delivery of health and social care services (known as the 'body corporate' or 'integration joint board' model).

1.5.2 Glasgow City Council and NHS Greater Glasgow and Clyde have agreed to adopt the integration joint board model of integration, and also to integrate children and families, criminal justice and homelessness services as well as those functions required by the Act. The functions delegated from Glasgow City Council to the Integration Joint Board represent almost all of the current Social Care functions of the Council, along with the budget for these functions. A similar range of health functions, along with the budget for these, are also delegated to the Integration Joint Board by NHS Greater Glasgow and Clyde.

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[3] The Public Bodies (Joint Working)(Scotland) Act 2014

1.5.3 The Glasgow City Integration Joint Board is a distinct legal entity created by the Scottish Ministers upon approval of the Integration Scheme.

1.5.4 As a separate legal entity, the Integration Joint Board is fully able to act on its own behalf and to make decisions about the exercise of its functions and responsibilities as it sees fit, without any need to refer to, seek the approval of, or take direction from, the Council or Health Board. The Council and Health Board may not change, ignore or veto any direction from the Integration Joint Board, and may not use delegated resources for any purpose apart from carrying out a direction from the Integration Joint Board. The Glasgow City Integration Joint Board is therefore the primary body through which integrated health and social care services are strategically planned and monitored within Glasgow.

1.5.5 The Glasgow City Integration Joint Board is made up of 16 voting members (8 Councillors appointed by Glasgow City Council and 8 Non-Executive Directors or other appropriate persons nominated by NHS Greater Glasgow and Clyde). There are also a number of non-voting members on the Integration Joint Board, including the Chief Officer, clinical leads, the Chief Social Work Officer and stakeholder members representing the interests of staff, service users, patients, carers and the third and independent sectors.

1.5.6 The stakeholders which make up the voting and non-voting membership of the Integration Joint Board represent the 'partnership' within the title Glasgow City Health and Social Care Partnership.

1.5.7 Some of the functions and services delegated by Glasgow City Council and NHS Greater Glasgow and Clyde to the Integration Joint Board are:

- The strategic planning for Accident and Emergency services provided in a hospital
- The strategic planning for inpatient hospital services relating to the following branches of medicine:
    o general medicine;
    o geriatric medicine;
    o rehabilitation medicine;
    o respiratory medicine.
- Palliative care services
- District nursing services
- Services provided by allied health professionals such as dieticians and occupational therapists
- Dental services
- Primary medical services (including out of hours)
- Ophthalmic services
- Pharmaceutical services
- Sexual Health Services
- Mental Health Services
- Alcohol and Drug Services
- Services to promote public health and improvement
- School Nursing and Health Visiting Services
- Social Care Services for adults and older people
- Carers support services
- Social Care Services provided to Children and Families, including:
    o Fostering and Adoption Services
    o Child Protection
- Homelessness Services

- Criminal Justice Services

1.5.8 A full list of the functions delegated to the Integration Joint Board by the Council and Health Board is available in the Integration Scheme which is published on the Glasgow City Health and Social Care Partnership website.

1.5.9 This plan is a strategic document which sets out the vision and future direction of health and social care services in Glasgow. It is not a list of actions outlining everything that the Glasgow City Health and Social Care Partnership are doing or plan to do over the coming years. The plan shows the objectives that we want and need to achieve in order to improve the health and wellbeing of the citizens of Glasgow, making best use of all the resources available to us. The detail about how we achieve those things will be developed through our local and city-wide engagement structures in collaboration with all partners in the public, independent and voluntary sectors, and in local communities, over the lifetime of the plan. This will be how we ensure the joint commissioning of services.

1.6 Our Aspirations and Ambitions

1.6.1 The Glasgow City Integration Joint Board is committed to ensuring that the people of Glasgow will get the health and social care services they need at the right time, the right place and from the right person.

1.6.2 We want to improve outcomes and reduce inequalities by providing easily accessible, relevant, effective and efficient services in local communities where possible and with a focus on anticipatory care, prevention and early intervention. We need to become less of a dependency based (and dependency creating) service, to one that delivers outcomes and is focussed on achieving the best possible outcomes for our population, service users and carers.

1.6.3 We believe that services should be person centred and enabling, should be evidence based and acknowledge risk. We want our population to feel able to not only access and use health and social care services, but to participate fully as a key partner in the planning, review and design of services which support and enable people to lead the lives they want.

1.6.4 When we have achieved our ambitions, patients, service users and carers will see an improvement in the quality and continuity of our services, and have smoother transitions between services and partner agencies. There will be clear points of access to health and social care services and clear routes through the system, and far less of a need to give the same information to multiple health and care professionals. People will live longer, healthier lives in their own homes and communities, with access to and use of health and social care services seen as a means to an end, rather than an end in itself.

1.7 Vision

1.7.1 Glasgow City Health and Social Care Partnership believes "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".

1.7.2 Our Principles

1. Focussing on being responsive to Glasgow's population and where health is poorest
2. Supporting vulnerable people and promoting social well being
3. Working with others to improve health
4. Services designed and delivered around the needs of individuals carers and communities
5. Transparency, equity and fairness in the allocation of resources
6. Competent, confident and valued workforce
7. Strive for innovation
8. Develop a strong identity
9. Focus on continuous improvement

1.8 Glasgow City HSCP Draft Organisational Development Strategy 2017/2020

1.8.1 The draft OD Strategy has been designed to support the vision and principles for the HSCP as outlined in the strategic plan as well as to deliver the various elements of the workforce plan through the strands of:

- Culture;
- Service improvement and change;
- Establishing integrated teams;
- Leadership development.

1.8.2 Annual implementation plans will describe the activity that delivers this change

1.8.3 The draft action plan is noted across the next pages.

Organisational Development Strand 1 - HSCP Culture

Our Principles as measures of success	Desired Outcomes	Required Processes	Requirements for Change
8. Develop a strong identity 3. Working with others to improve health 5. Transparency, equity and fairness in the allocation of resources	People can describe the values and behaviours to support the vision There are plans for ongoing review and reflection to meet the vision Healthy, engaged and empowered workforce	Staff engagement and communication Core Leadership Groups committed to service change engagement Locality engagement Integrated Joint Board development	To develop the values, attitudes and behaviours that supports a healthy organisational culture To develop the activities which support our workforce to feel valued and able to engage with the 2020 workforce vision and to be able to deliver the national health and wellbeing outcomes

Organisational Development Strand 2 - Service Improvement and Change

Our Principles as measures of success	Desired Outcomes	Required Processes	Requirements for Change
6. Competent, confident and valued workforce, 7. Strive for innovation, 8. Focus on continuous improvement	Quality and Service Improvement culture of learning, innovation and improvement Workforce Development Plan which includes OD Strategy for Team Development A Service Improvement approach that describes an ongoing commitment to deliver quality services – change redesign and improvement activity at the heart of service review, supported by qualified practitioners	Model for Improvement embedded in everyday practice through skills development and ongoing review of improvement approach Support to managers to deliver change including the human dimensions of change Apply iMatter –ensuring ongoing action plans for teams	Ensure consistent change management applied across HSCP with principles of ➢ Partnership working ➢ Value for money ➢ Quality approach ➢ Improvement and sustainability ➢ Leadership developed to embed and sustain change

Organisational Development Strand 3 - Establishing Integrated Teams

Our Principles as measures of success	Desired Outcomes	Required Processes	Requirements for Change
3. Working with others to improve health 4. Services designed and delivered around the needs of individuals carers and communities 5. Transparency, equity and fairness in the allocation of resources 6. Competent, confident and valued workforce	Skilled change agents Effective teams and cross functional working – emphasis on Person centeredness A set of Team Development plans which holds teams accountable for delivering in an integrated way with further development to support this process	Effective team development process to support team development and measure impact of team leader's involvement Shared individual, team and organisational objectives reviewed and reported Conversations to enable the review and development required- agreed coaching style ROI approach	organizational design that describes decision making and communication processes and the teams that support the organizational structure Focus on the behaviours required to develop leadership model the approach to sustainable delivery of service ensure congruence between espoused and visible behaviours Staff are equalities aware through training and support Performance is routinely reported by age, gender and ethnicity and other equalities characteristics where possible We use equalities sensitive conversations - caring conversations, in all our care and treatment services

Organisational Development Strand 4 - Leadership development

Our Principles as measures of success	Desired Outcomes	Required Processes	Requirements for Change
1.Focussing on being responsive to Glasgow's population and where health is poorest 2.Supporting vulnerable people and promoting social well-being	Leaders can describe the Adaptive Leadership style and behaviours required to deliver an integrated approach - and the ways that staff will be supported to develop this style.	Embed a leadership style that has a coaching approach to conversations either solutions or behavioural focus and building on organisational knowledge and learning	Fostering Good relations and removing discrimination Equality Proof our strategies and services and act on the results Champion Cultural change

3.Working with others to improve health
4.Services designed and delivered around the needs of individuals carers and communities
5.Transparency, equity and fairness in the allocation of resources
6.Competent, confident and valued workforce
7.Strive for innovation
8.Develop a strong identity
9.Focus on continuous improvement

Strategic leaders with knowledge of multi-organisational service delivery

Collaborative leaders Leading change Adaptive and distributed approach to leadership

Ongoing development of strategic leadership through professional coaching

Empower those using our services and staff to challenge discrimination
Work towards IJB membership that reflects the characteristics of Glasgow, starting with gender and ethnicity

1.9 Key Priorities for the Partnership

1.9.1 The biggest priority for the Glasgow City Health and Social Care Partnership is delivering transformational change in the way health and social care services are planned, delivered 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** We are committed to working with a broad spectrum of city partners to improve the overall health and well-being of the population of Glasgow. We will continue our efforts to promote positive health and well-being, early intervention, prevention and harm reduction. This includes promoting physical activity, acting to reduce exposure to adverse childhood experiences as part of our commitment to 'Getting it Right for Every Child'[4], and improving the physical health of people who live with severe and enduring mental illness. We will seek to ensure that people get the right level of advice and support to maintain independence and minimise the occasions when people engage with services at a point of crisis in their life.

- **Providing greater self-determination and choice** We are committed to ensuring that service users and their carers are given the opportunity to make their own choices about how they will live their lives and what outcomes they wish to achieve.

- **Shifting the balance of care** Services have transformed over recent years to shift the balance of care away from institutional, hospital-led services towards services better able to support people in the community and promote recovery and greater independence wherever possible. Glasgow has made significant progress in this area in recent years, and we aim to continue to build on our successes in future years.

- **Enabling independent living for longer** Work will take place across our all Care Groups to assist people to continue to live healthy, meaningful lives as active members of their community for as long as possible.

- **Public Protection** We will work to ensure that people, particularly the most vulnerable, are kept safe from harm and that risks to individuals or groups are identified and managed appropriately.

1.10 Engaging Stakeholders

1.10.1 The Glasgow City Integration Joint Board and Health and Social Care Partnership is committed to engagement with the people who use our services. We recognise that services cannot be shaped around the needs of individuals if individuals do not have the opportunity to contribute their views on the services they receive.

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[4] http://www.gov.scot/Topics/People/Young-People/gettingitright

1.10.2 The primary method of engagement with service users, patients, and carers is on an individual and personal basis, through for example co-produced assessment and care planning activity with social workers or within primary care through GPs and health visitors. We aim to improve by building on feedback gathered through these interactions, to support service users, patients and carers to shape the future development of our services.

1.10.3 Our staff are fundamental in the development of our services, particularly front line staff who are very much the public face of the Partnership. We aim to build on the wealth of experience, knowledge and insights which we have across the Partnership and use this to shape our delivery of high-quality, effective services.

1.10.4 Glasgow already has an extensive network of engagement forums, including - but by no means limited to - service user and carer representation on the Integration Joint Board and Strategic Planning Groups, and will build on these networks in our development of a Participation and Engagement Strategy which will clearly articulate how individuals and groups can interact with the Partnership and the Integration Joint Board, and how these interactions can influence the direction of the Partnership.

2 Demand Drivers

2.1 Glasgow City

2.1.1 Glasgow is a vibrant, cosmopolitan, award-winning city known throughout the world as a tourist destination and renowned location for international events. The city has been transformed in recent years, becoming one of Europe's top financial centres and developed remarkable business and tourism sectors, whilst the physical enhancement of our city has been dramatic. However, our challenges in addressing deprivation, ill health and inequality are significant and well documented.

2.1.2 While much progress has been made in addressing these issues, but there is more to be done to ensure that there are opportunities for everyone in the city to live longer, healthier, more independent lives.

2.2 The Glasgow City Population Profile

2.2.1 Glasgow has a population of 593,245, based on the 2011 census, which is 11.2% of the total population of Scotland. Although the population fell sharply towards the end of the 20th Century, it has been increasing again since 2004. This growth is expected to continue over the next few years.

2.2.2 Estimates of Glasgow's population increase until 2022 indicate:

- An overall population increase of 2.5%
- The number of children increasing by 6.2%
- The population of older people aged 75+ rising by 14%

Figure 2.1

Glasgow City HSCP		
% Population Change to 2022 by Age Group		
Age Group	Glasgow City	All NHSGGC
0 to 14	15.4	6.2
15 to 29	-14.3	-12.3
30 to 44	21.5	8.8
45 to 59	-1.2	-6
60 to 74	20.8	18.3
75 plus	2.5	14
All Ages	0.8	2.5

Figure 2.2

Glasgow City HSCP
Projected % Population Change by 2022
(By Age Group)
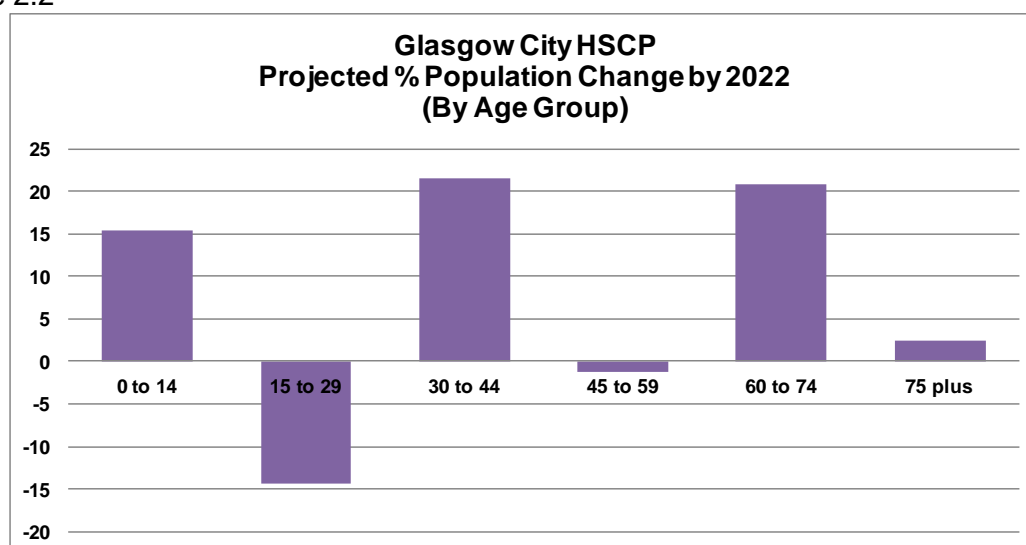
2.2.3 **Dependency Ratios**

2.2.4 Dependency ratios are a useful indicator of the potential social support required as a result of changing population age structures. The larger the dependency ratio, the greater the burden on the average adult as the needs of the dependents must be met by the rest of the adult population.

2.2.5 As shown in Figure 2.2 the NHSGGC population is getting older which will have an effect on dependency ratios.

Figure 2.3

Glasgow City HSCP
Dependency Ratio Trends
2006 to 2022
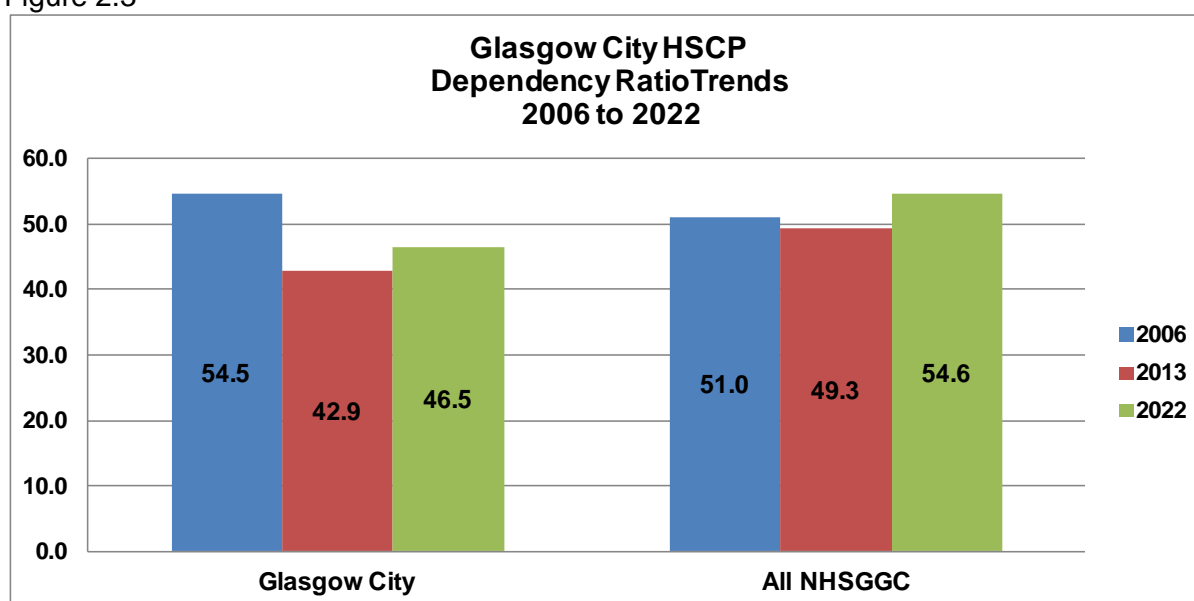
2.2.6 The NHSGGC dependency ratio has remained relatively flat since 2006 but is predicted to rise to 55 by 2022. There are, however, marked variations in the dependency ratios for each of the HSCPs within NHSGGC.

2.2.7   Glasgow City has the lowest ratio in 2013 and has fallen since 2006 (43 and 55 respectively) however it is projected to rise to 47 by 2022.

2.2.8   This means that on average, there will be almost 5 dependent people for every 10 working-age people by 2022.

2.3   Glasgow City HSCP - Locality Profile

2.3.1   Glasgow is divided into three areas, known as localities, to support service delivery. To ensure consistency in local service delivery, the Glasgow City Health and Social Care Partnership has adopted the same strategic areas as the Glasgow Community Planning Partnership. .

2.3.2   There are three localities areas:

- North East Glasgow;
- North West Glasgow;
- South Glasgow.

2.3.3   The localities continue the current organisation structure of social work, primary care and community health services, and also correspond to the three Community Planning Sector Partnership Board areas, that are recognised by all the public sector agencies as appropriate for service delivery.

2.3.4   Each of the localities includes:

- a management team responsible for service delivery and co-ordination and ensuring implementation of the Partnership's policies and plans at a local level;

- management teams for adult services, children's services, older people's services and health improvement;
- a range of service user and carer networks and groups;
- primary care locality groups for GPs, a Primary Care Strategy Group and GP Forum;
- locality children's planning and implementation group; and,
- care group planning groups.

2.4 Health as a driver of demand

2.4.1 Glasgow City contains 3 in 10 of the 15% most deprived data zones[5] in Scotland. This is the highest proportion for a local authority. 116 of these data zones are in the North East of the city, while the North West has 83 and South has 89.

2.4.2 Around two fifths of Glasgow's entire population live in one of these 288 data zones, with around 54% of these people living in the North East of the City.

2.4.3 Key Health and Social Care Indicators

- Although increasing, life expectancy at birth in Glasgow is currently 72.6 years for males and 78.5 years for females (compared to the Scottish averages of 76.6 and 80.8).
- Around 8.7% of the Glasgow population live in 'bad' or 'very bad' health, with 31% of Glasgow's population, around 184,000 people, suffering with one or more long term health conditions.
- According to national estimates, around one in 25 people will be experiencing dementia by the age of 70, rising to almost one in five by the age of 80. Up to 4,500 people aged over 80 in Glasgow currently may be experiencing dementia.
- Just under a quarter (22.7%) of people in Glasgow believe that their day-to-day activities are limited in some way by a long term health problem or disability.
- Almost 2.7% of the population have some form of learning disability or learning difficulty.
- 7.8% of the population have a physical disability.
- Almost 6.9% of the population were recorded as having a hearing impairment and almost 2.5% of the population were recorded as having a visual impairment.
- It is estimated that up to 7,000 people in Glasgow have a form of autism.
- Around 9.3% of people in the City carry out unpaid caring duties.
- It is estimated that up to 75,000 people in Glasgow experience common mental health problems such as depression or anxiety, with around 6,000 people experiencing a more severe and enduring mental illness.
- Glasgow has over 69,000 residents estimated to be problem alcohol drinkers, and has the highest rate of alcohol related hospital admissions in Scotland.

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[5] Data zones are a common, stable and consistent, small-area geography produced by the Scottish Government. To produce data zones, groups of 2001 Census output areas with between 500 and 1,000 household residents are identified. Where possible, data zones respect physical boundaries and natural communities. They have a regular shape and, as far as possible, contain households with similar social characteristics.

- Glasgow has an estimated 13,000 problem drug users, most of whom also consume alcohol on a daily basis.

2.4.4 Each of the HSCPs localities has unique populations and consequently differing health and social care needs.

2.4.5 **North East Locality**

2.4.6 North East locality covers the following Local Area Partnerships:

- Calton;
- Springburn;
- East Centre;
- Shettleston;
- Baillieston; and,
- North East.

2.4.7 The total population of North East Glasgow is 167,518 people. A breakdown of the population by age is shown in the table below:

Figure 2.4

Age Bands	No. of people	% of population	% of this age band in Glasgow City
0-17 years	32,595	19.5	18.2
18-64 years	110,141	65.7	67.9
65 years plus	24,782	14.8	13.8

2.4.8 The health rating of general population in the North East shows 10.7% have 'bad' or 'very bad' health. This is higher than the city average of 8.7%

2.4.9 There are a number of factors affecting the health of the people living in North East Glasgow. Male and female life expectancy is significantly lower than the Scottish average, although it has been rising over time. Mortality rates from coronary heart disease, cerebrovascular disease and cancer (all under 75s) are all higher than the Scottish average, as are deaths from alcohol conditions in the last five years which is one of the highest death rates in Scotland. The proportions of the population hospitalised with alcohol conditions and with drug related conditions are also higher than the Scottish average.

2.4.10 Drug prescribing for mental health problems is significantly higher than average. Suicide death rate (23.4 per 100,000 population) is also significantly higher than the Scottish average (15.1 per 100,000).

2.4.11 North East Glasgow has a significantly higher percentage of adults claiming incapacity benefit/severe disability allowance than the Scottish average. Levels of income and employment deprivation, the percentage of working age population claiming Job Seeker's Allowance, dependence on out of work benefits or child tax credit, and people claiming pension tax credits are all significantly higher than the Scottish average.

2.4.12 The crime rate (76.4 per 1,000 population) is higher than the Scotland average (49.5 per 1,000 population). Rates of referrals to the Children's Reporter for violence-related offences, and rates of patients hospitalised following an assault are also high.

2.4.13 Breast screening uptake is lower than the Scottish average. The prevalence of pregnant mothers who smoke, and the rate of teenage pregnancies (under 18s) are both higher than average, while the percentage of babies exclusively breastfed at 6-8 weeks is lower than the Scottish average. Child dental health in primary 1 is worse than the Scottish average, although we have seen improvements in recent years as a result of concerted efforts to promote tooth brushing in schools and nurseries.

2.4.14 Initial Priorities for North East Locality

- Development of a Health and Social Care Centre on the Parkhead Health Centre and Hospital site;
- Working with families, especially through early intervention, to improve the life chances for children, with a specific focus on reducing the number of children who need to be looked after by the Council;
- Development of new adult mental health wards on the Stobhill Hospital site;
- Continuing to improve waiting times to access primary care mental health teams;
- Re-design of Older People's Mental Health Services to make sure that we deliver services in line with the most up to date care pathway;
- Focus on improving the uptake of cancer screening by local residents as these are below the Health Board average; and,
- Supporting the development of the Thriving Places agenda in Parkhead/Dalmarnock and Easterhouse.

2.4.15 **North West Locality**

2.4.16 North West locality covers the Local Community Area Partnership areas of:

- Anderston / City
- Hillhead
- Partick West
- Garscadden / Scotstounhill
- Drumchapel / Anniesland
- Maryhill / Kelvin
- Canal

2.4.17 The total population of North West Glasgow is 206,483 people. A breakdown of the population by age is shown in the table below:

Figure 2.5

Age Bands	No. of people	% of population	% of this age band in Glasgow City
0-17 years	32,501	15.7	18.2
18 -64 years	147,528	71.4	67.9
65 years +	25,454	12.8	13.8

2.4.18 There is a large proportion of people of working age, however this is due to the very high numbers of young people aged 16- 24 years (with students representing 13.5% of the total population in North West).

2.4.19 The minority ethnic population, including black or minority ethnic (BME 11.9%) and other white non UK/non Irish (4.9%) is higher than the overall Glasgow level (BME 11.6% and other white non UK/non Irish 3.9%). The percentage of the minority ethnic population varies significantly across the North West locality from 8% in Drumchapel/Anniesland to 32% in Anderston/City.

2.4.20 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, therefore an overview of statistics relating to the entire North West can mask stark inequalities within the locality.

2.4.21 There are a number of factors affecting the health of the people living in North West Glasgow. Male and female life expectancy (71 and 77.2) is lower than the Scottish average (74.5 and 79.5) However there is a gap of 16 years between average male life expectancy in Possilpark (64.1) and Kelvinside (80.1) and 12.3 year gap in female life expectancy between Drumry East (72.2) and Victoria Park (84.5) .

2.4.22 Mortality rates from coronary heart disease, cerebrovascular disease and cancer (all under 75s) are all significantly higher than the Scottish average, as are deaths from alcohol conditions over the last five years.   The proportions of the population hospitalised with alcohol conditions and with drug related conditions are also higher than the Scottish average.

2.4.23 Drug prescribing for mental health problems is significantly higher than average in North West. Suicide death rate (21.6 per 100,000 population) is also higher than the Scottish average (15.1 per 100,000).

2.4.24 North West Glasgow has a lower level of out of work benefit claimants than the level for the rest of Glasgow. The level however is not uniform across North West, ranging from 8.7% in Hillhead to 24.1% in Canal.

2.4.25 The crime rate in North West Glasgow (81.4 per 1000) is significantly higher than the Scotland average (49.5 per 1000) and the highest of all Glasgow localities areas; this is likely due to Glasgow city centre being part of North West locality.   Rates of referrals to the Children's Reporter for violence-related offences and rates of patients hospitalised following an assault are also significantly high.

2.4.26 Breast screening uptake is lower than the Scottish average. The prevalence of pregnant mothers who smoke is lower than the Scottish average whilst the rate of teenage pregnancies (under 18s) is higher than average. The percentage of babies exclusively breastfed at 6-8 weeks at 29.4% is higher than the Scotland average. Child dental health in primary 1 is worse than the Scottish average with 49% of children with no obvious signs of decay.

2.4.27 **Initial Priorities for North West**

- Delivering the new Woodside Health and Care Centre (completion due late summer 2017) to support integrated working and improve access to primary care, community health and social care services;
- Working with partners to reduce the impact of health inequalities evident across North West, with a particular focus on the Thriving Places programme in Ruchill/Possilpark, Drumchapel and Milton/Lambhill;
- Improving the life chances for children, through implementation of 'Getting It Right For Every Child' and the new Children and Young People's Act;
- Working with GPs and the wider primary care team to develop 'locality clusters' to support service integration and partnership working;
- Achieve waiting time and access targets for services, including improving access to psychological therapies and reducing delayed discharges;
- Implement findings of community addiction team review to place a greater emphasis on Recovery;
- Progress redesign of mental health and older people's inpatient services;

2.4.28 **South Locality**

2.4.29 The South locality covers the Local Community Planning Area Partnerships of:

- Greater Pollok;
- Newlands / Auldburn;
- Southside Central;
- Pollokshields;
- Govan;
- Langside;
- Craigton; and,
- Linn.

2.4.30 The total population of South Glasgow is 220,489 people. A breakdown of the population is shown in the table below.

Figure 2.6

Age Bands	No. of people	% of population	% of this age band in Scotland
0-15 years	38,743	17.6	17.6
16 -64 years	151,602	68.8	65.7
65-74 years	15,622	7.1	9.0
75+ years	14,522	6.6	7.7

2.4.31 A particular feature of the locality is that a large number of people from an ethnic minority live in the South locality, and make up 14.2% of the total population. In addition, there is also a lower percentage of people aged 65 and over as compared to the Scottish average (significantly different in the age 75 plus age group).

2.4.32 There are a number of factors affecting the health of the people living in South Glasgow. Male and female life expectancy is significantly lower than the Scottish average, although it has been rising over time.

2.4.33 Mortality rates from coronary heart disease, cerebrovascular disease and cancer (all under 75s) are all significantly higher than the Scottish average, as are deaths from alcohol conditions in the last five years. The proportions of the population hospitalised with alcohol conditions and with drug related conditions are also higher than the Scottish average.

2.4.34 Drug prescribing for mental health problems is significantly higher than average. Suicide death rate (19.5 per 100,000 population) is also higher than the Scottish average (15.1 per 100,000).

2.4.35 South Glasgow has a significantly higher percentage of adults claiming Incapacity Benefit/Severe Disability Allowance than the Scottish average. Levels of income and employment deprivation, the percentage of working age population claiming Job Seeker's Allowance, dependence on out of work benefits or child tax credit, and people claiming pension tax credits are all significantly higher than the Scottish average.

2.4.36 The crime rate (63.9 per 1,000 population) is significantly higher than the Scotland average (49.5 per 1,000 population). Rates of referrals to the Children's Reporter for violence-related offences, and rates of patients hospitalised following an assault are also high

2.4.37 Breast screening uptake is lower than the Scottish average. The prevalence of pregnant mothers who smoke is lower than the Scottish average whilst the rate of teenage pregnancies (under 18s) is higher than average. Although an increasing figure in the South Locality, the percentage of babies exclusively breastfed at 6-8 weeks at 22% is lower than the Scotland average. Child dental health in primary 1 is worse than the Scottish average with 49% of children with no obvious signs of decay.

2.4.38 **Initial Priorities for South Glasgow**

- Delivering New Gorbals Health & Care Centre to support integrated working and improve access to primary care, community health and social care services;
- Responding with partner agencies to the specific needs in the Govanhill area including housing and the significant Roma population;
- Taking forward the Thriving Places agenda in Gorbals, Govan and Priesthill Househillwood;
- Supporting the development of new residential care and day care facilities in Toryglen and Castlemilk;
- Completion of the redesign of mental health services at Leverndale;
- Taking forward the Govan integrated care project with four GP practices testing new forms of integrated service delivery with community health, social care and the third sector to support and prolong independent living in the community harnessing all available resources;

- Supporting implementation of the 415 Project with Glasgow Housing Association and other partners to test an early warning system to enable earlier intervention to support frail older people and their carers before crisis happens;
- Developing Housing Options with four housing associations to prevent and avoid homelessness through a committed earlier cross agency response;
- Extension of Food for Thought through network of community gardens with housing associations and local communities;
- Incorporating the new asylum seeker/refugee reception facility in Kinning Park;
- Ongoing delivery of health improvement programmes for older people, encouraging older people to improve their health; and,
- Continue to deliver smoking cessation work with the local BME population.

2.5 Equalities

2.5.1 Glasgow has a very diverse population, with interpreting services providing support for over 80 regularly used languages in the city. One in every six residents (15.4%) identified themselves in the last Census (2011) as non-British White. Our non-British White population has more than doubled in the last decade, with growth across most ethnic groups, but most significantly in Polish and Roma communities. We welcome and support around 3000 people seeking asylum per year.

2.5.2 We understand that around one in every fourteen residents are Lesbian, Gay, Bisexual or Transgender (LGBT), although we have further progress to make in enabling service users and patients to routinely disclose equalities information.

2.5.3 We will work to establish strong working arrangements with equalities networks within and beyond the city. This will include continuing to support the Community Planning Partnership's equalities work in particular, to work with partners to support the Single Outcome Agreement, which sets out the planned improvements for local areas' thematic and place based priorities.

2.5.4 We aim to remove discrimination in accessing all of our services; ensure that our services are provided in an equalities sensitive way; contribute to reducing the health gap generated by discrimination; and, work in partnership, to make Glasgow a fairer city.

2.5.5 Both the NHS Board and Council routinely publish Equalities progress reports which highlight the significant progress that is already being made. We will continue this journey to improve the health and care outcomes for equalities groups, recognising the additional challenges experienced by equalities groups living in poverty.

2.5.6 The Equalities Act (2010) requires public sector bodies to comply with general equalities duties. Integration Joint Boards have been added to the list of public sector organisations relevant to the Act and are therefore required to develop Equalities Outcomes by the 30th April 2016 and report on these outcomes by 1st April 2018.

2.6   Care Groups/Core Leadership Groups

2.6.1   The following text sets out the drivers which will influence the Glasgow City HSCP workforce within each of our main Care Groupings and are described under the following headings:

- Older People's Services
- Children's and Families Services
- Adult Services
- Business Support

2.6.2   Details of the identified actions for the workforce are described for each of the care groupings in Chapter 3 of this document.

2.7   Older People's Services

2.7.1   There are currently a number of service arrangements in place within Glasgow City to deliver older people and physical disability health and social care services across the city. These range from:

- Area based social work teams;
- Hospital interface social work teams;
- Social work occupational therapy teams;
- GP cluster based district nursing teams;
- Locality based rehab teams;
- Locality based older people's mental health teams;
- Locality based specialist nursing teams;
- Citywide specialist nursing resources;
- Professional nursing support;
- Citywide residential and day-care services.

2.7.2   These services are not all co-terminous and cross cover in terms of location and service provision. There are also a number of direct access points and duty systems for each of these services which do not relate to each other.

2.7.3   Some but not all of the teams have direct connections to GPs and there are a varied set of arrangements in place in relation to the interface with acute.

2.7.4   **Proposals for the development of Older People's Services**

2.7.5   As noted previously within this document Glasgow city is currently divided into to 3 localities all with a network of health and social care services, partner agency services and community and third sector services.

2.7.6   It is proposed that the new arrangements for delivery of older people and physical disability services adopt a community/neighbourhood model which will reflect the development of the GP cluster arrangements and link to natural communities.

2.7.7 The proposal to create neighbourhood teams to deliver Health and Social Care services for older people and those with long term conditions is based on the principle of supporting people with increasing levels of frailty and complex needs to live longer at home. It is our ambition to provide an older people's system of care across the City that ensures that services users/patients get access to the service at the right time and can live well for longer within their own community. There are a number of principles that we aim to deliver. These include:

- To reshape the design and delivery of care for older people across the city ensuring there is a clear focus on maintaining their independence; health and wellbeing.

- Ensuring that older people have access to the right service at the right time.

- Working with our communities; partners and staff to deliver initiatives that prevent ill health; intervene early and avoid escalation of need.

2.7.8 The model will consist of 20 GP clusters' across the City

- 7 in South,
- 7 North West
- 6 North East

2.7.9 In broad terms these clusters are geographically based although a number of cross boundary issues still exist with GP patient lists. It is proposed that there will be 10 neighbourhood teams in the new arrangements

- 4 covering South Glasgow;
- 2 covering North West Glasgow
- 3 covering North East Glasgow

2.7.10 These neighbourhood teams will link to the broad geographical area that the clusters cover.

2.7.11 Rationale for Change

2.7.12 The challenge facing Glasgow City HSCP is how to maximise the opportunities of Health and Social Care integration to deliver effective and efficient services. Current drivers include:

- Glasgow's high use of care home places
- New GP contract and cluster arrangements
- Agreed shift in resources to support home based care
- Financial pressures across Health and Social Work

2.7.13 Evidence suggests that joint approaches between Health and Social Care that result in a multi-component approach are likely to achieve better results than those that rely on a single or limited set of strategies (King's Fund 2011). The establishment of Neighbourhood Teams will allow for:

- Community-based multi-professional teams based around general practices that include generalists working alongside specialists

- Joint care planning and co-ordinated assessments of care needs
- Clinical records that are shared across the multi-professional team
- Streamlined access and response for service users/patients
- Earlier intervention and prevention approach.

2.7.14 We expect the integrated models of service delivery to:

- Increased patient satisfaction
- Increased staff satisfaction
- Increased access to services
- Reduce the number of professionals involved in delivery of care
- Utilise neighbourhood capacity
- Enhance trust between services

2.7.15 Much of the research into integrated teams recommends that we have a sustainable approach to the delivery of health and social care services for older people. The Care Quality Commission (Building Bridges Breaking Barriers July 2016)[6] identified that:

- Across the UK there were examples of joint working in delivering health and social care, but these were often inconsistent, short-term and reliant on partial or temporary funding and goodwill between different providers. They were not a mainstream part of the way in which services were planned or delivered around older people.
- The lack of connection between services often resulted in older people and their families or carers needing to take responsibility for navigating complex local services. This could result in people 'falling through the gaps' and only being identified in response to a crisis.
- Older people often had multiple care plans because professionals did not routinely link together and share information.
- There were still many organisational barriers that made it difficult for services to identify older people who were at risk of deterioration or an unplanned emergency admission to hospital.
- Monitoring and evaluation was often not carried out locally or was insufficient.
- Older people were not routinely involved in decision making about their needs and preferences.
- Older people and their families or carers did not routinely receive clear information about how their health and social care would be coordinated, in particular if there were changes in their circumstances or if there was an unplanned or emergency admission to hospital.

2.7.16 **Vision for integrated Teams**

2.7.17 We expect Neighbourhood Teams to be formed on some key principles:

- Neighbourhoods within Localities will reflect local population profiles and will be inclusive of emerging Clusters of GPs (in some cases, Clusters might span Neighbourhoods)
- A Service Manager will lead each Neighbourhood team to ensure health & social care activity is connected to that of key partners and will work closely with primary care services to support people with complex presentations.

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[6] https://www.cqc.org.uk/sites/default/files/20160712b_buildingbridges_report.pdf

- The team will include directly employed health & social work leads as well as senior practitioners from 3rd sector organisations operating in the neighbourhood.
- The team will work to a system of cross-discipline referral & information sharing that enables effective MDT input to complex cases.

2.7.18 The team will:

- Manage access for both Health and Social Care services but build on existing access routes while considering opportunities for more integrated systems
- Better joint working with GPs and other contractors
- Joint assessment focussed on agreed outcomes
- Person centred joint anticipatory care planning
- Joint monitoring and review
- Shift in culture towards home based care including enablement/ re-ablement
- Prevention of unnecessary admissions to hospital and prompt discharge home
- Support structured community management of high risk individuals
- High quality palliative and end of life care delivered in place of choice
- Supporting people to manage their own illness
- Flexible and responsive team approach to care, delivered at home across 24/7
- Ensure best use of resources such as day care and residential/nursing care

2.7.19 We also will develop a new Home is Best Service which will be a key component of the City's HSCP's response to unscheduled care and delayed discharge. The service will assist in:

- Reshaping the design and delivery of care for older people across the City ensuring there is a clear focus on maintaining their independence; health and wellbeing.
- Ensuring that older people have access to the right service at the right time.
- Establishing close working relationships with Acute Hospital Staff and Glasgow HSCP staff.
- Redirecting patients who may have unplanned admission to community based Health and Social Care Services.
- Improving patient flow through the acute system, ensuring that patients can return home at the earliest opportunity.
- Facilitating early supported discharge in patients who when assessed may not require admission but could be supported in the community.

2.7.20 The drivers for developing this proposal are:

- Increasing older population
- Reduction in hospital beds
- Glasgow's high use of care home placements
- Shift in culture towards home based care including enablement/ re-ablement
- Financial challenges in Health and Social Care
- National Target - patients who are defined as medically fit for discharge to be discharged home within 72 hours.
- Government aspiration that discharges should be earlier in the day and be the same 7 days per week
- Focus on improving outcomes, not services

2.7.21 At the present time patients can be delayed in an acute bed due to multiple reasons.

2.7.22 An important root factor identified is a lack of timely information to connect the person at the earliest possible time in their hospital journey. The opportunity to engage and connect with people is happening too late in the person's assessment/ admission and is impacting on potential discharge outcomes. Information sharing between the acute and community teams is inconsistent and patchy. There is a lack of a co-ordinated response to admission avoidance and community alternatives to prevent admission are often not available.

2.7.23 The Home is Best Service will be developed on key principles which will include:

- Avoid preventable admissions from front door where appropriate , 'whole system' approach -or patients/service users following assessment/screening
- Plan discharge direct from admission involving patients and carers , explore a named person , responsible for all aspects of the patients journey based on most relevant MDT professional
- Staff will work within a framework of integrated multi-disciplinary and multi-agency team working to manage all aspects of discharge.
- Person centred approach - everyday problem, move away from focus on census point.
- Good communication with patient, carers and ward staff to head off future difficult conversations/ decisions
- Discharge to assess. Long term care assessment / decision should not take place in an acute hospital setting.
- Robust interface between the hospital based integrated teams and the emerging neighbourhood teams.

2.7.24 **Management and Professional Leadership**

2.7.25 It is proposed that we move to a flat management structure across older people and physical disability services and move to a ratio of Service Manager to Team Leader of 1:5 and Team Leader to frontline staff of 1:10 (N.B. - There will be a different proposals for the configuration of the acute interface team).

2.7.26 In implementing this new structure, efficiencies can be achieved as a number of posts will not be required or can be re-aligned to different grades to reflect new roles and responsibilities.

2.7.27 It is also proposed that the HSCP centralise the professional nursing structure for the service and reduce the number of staff delivering on this agenda.

2.7.28 **Health and Social Care Direct Access Hub**

2.7.29 Across the HSCP there are a number of access routes to health and social care services for older people. Initiatives and service developments such as SPOA for DN services, Social Care Direct and Single Point of Access for Rehab Services and Social Work duty systems have all realised efficiencies in relation to service access and service user experience.

2.7.30 **Residential and Daycare Management Arrangements**

2.7.31 The Head of Residential and Daycare Services are currently reviewing the external management arrangements for the service to improve performance; capacity and linkages to the broader system.   A proposal will be developed and linked to the broader system of care identifying any efficiencies that can be realized from this piece of work.

2.7.32 **District Nursing**

2.7.33 District nursing services play an important role in helping people to maintain their independence by supporting them to manage long term conditions and treating acute illness. These services are key to policies that aim to provide care closer to home such as the Scottish Governments 2020 vision. They deliver an ideal model of person - centred, preventative, and co-ordinated care which can reduce hospital admissions and help people stay in their own homes.

2.7.34 District nurses are leaders in community nursing teams and co-ordinate increasingly complex care for people at home and in the community. They operate within the current, rapidly evolving policy landscape, working within the context of integrated health and social care, and the evolving models of community care.

2.7.35 District nurses are instrumental to the delivery of care which is integrated from the point of view of service users by ensuring high quality person centred care, care co-ordination and joint working across health and care agencies. Their skills are essential in helping transform the multi –disciplinary future for primary care.

2.7.36 The new GP contract will see a significant shift in work away from general practitioners to the wider health care team. In order to meet the growing demand it is essential that the district nursing workforce is adequately resourced to meet the challenge. Despite the acknowledgement that these services are key to future models there remains a dichotomy between the frequently stated policy ambition to offer care closer to home and the continued focus on acute hospitals in terms of resources.

2.7.37 In order to ensure that services are fit for the future NHSGGC carried out a review of district nursing services in 2012 which set out the workforce model going forward. In addition the service uses the national workforce tool to plan the workforce, assess workload and to ensure maximum efficiency and productivity.

2.7.38 The District Nursing Workload Tool is a national tool which enables teams to demonstrate the wide range of activity in which they are regularly involved. It also helps to reflect on the range of knowledge and skills that are required for district nursing practice within a skill mixed team:

- Application of the national workload tool is mandatory as prescribed in CEL 13 (April 2014). It must be applied on an annual basis as a minimum;
- District nurses complete the workload tool for 10 days over a 15 day period;
- The tool collects information on all aspects of the district nursing workload including face to face contact, non face to face contact, associated workload, planned home visits, clinic hours, travel and exceptions;
- Measures workload based on intensity of work and time taken;
- There are four levels of interventions ranging from level one, straightforward, to level four, complex. Each patient intervention is given a level of complexity;

- This is a workload tool, not a caseload profiling tool, which would capture workload on given days and more accurately reflects the complexity of care;
- The most recent completed application of the national workload tool across District Nursing Services in NHSGGC was completed by staff in October/November 2016 and the final results which are recorded on SSTS platform were made available in January 2017.
- The 2016 application ran from 31st October to 21st November across all teams.

2.7.39 It was recognised from previous runs of the workload tool that despite running awareness sessions there was some inconsistency in how the tool was completed resulting in the potential for in-accurate reports. This is in keeping with other areas of practice that have demonstrated that the tool should be used on several occasions before any meaningful data is obtained. The original supporting documentation was seen as open to interpretation therefore further information and training was developed locally to support staff in the use of the tool. This preparation was worthwhile as data collection was demonstrated to be more robust than previous runs. Further awareness sessions were held prior to the October/November 2016 run

2.7.40 The results demonstrate a positive change in the proportion of time spent in patient facing activity and associated clinical management. It is not clear whether this is related to more accurate recording compared with previous runs of the tool or whether this is a result of increased productivity. When triangulated with CNIS data and professional judgement it is likely to be a combination of both

2.8 Children's and Families Services

2.8.1 The transformation programme for children's services is based on a series of inter-related reviews and re-designs projects to substantially shift the balance of care from acute, crisis driven activity towards prevention and early intervention.

2.8.2 This is a system-wide programme of work which requires strong partnership working with colleagues in Education Services and the third sector.

2.8.3 The key workstreams are:

2.8.4 **Improving the care pathway**

- an early focus on improving assessment and care planning for looked after children.
- Specific outcomes of this project will be a reduction in children moving into formal care, more appropriate placements made available for young people and
- a reduction in the use of high cost placements/ secure placements.
- To identify and develop a commissioning strategy for young people with complex care needs who will be in need of support into adulthood.

2.8.5 **Audit and review of funding in children's services**

- to ensure that we are making best use of our resources and to support the reduction in high cost placements and the shift in investment from acute-focused care to family support and early intervention.

2.8.6 **Implementation of the Council's Corporate Transformation Programme in relation to Children and Family's Workforce:**

- Review of the management and staffing structure and profile of social work
- All posts audited in terms of the sustainability and reference to a range of agreed criteria; Review of the skill mix within social work teams;
- Review of the core service activity in light of "reclaiming" frontline Social Work**.**

2.8.7 **The development and implementation of a family support strategy**

- which will ensure that we have an agreed definition of family support, a consensus amongst the multiple funding agencies on the priorities for investment,
- development of a commissioning framework,
- improved sustainability for third sector providers,
- increased investment in family support and improved pathways of care for children and families.
- Increased recruitment drive in family based respite and shared care.

2.8.8 **Develop and modernise the continuing care arrangements**

- capacity within formal care arrangements is currently been overseen by the Continuing Care group. The outcomes of this work will be to improve the outcomes for young people (e.g. education, training, employment and housing) and enhance capacity in responding to the increasing number of young people who will require longer term services by being accommodated for a longer period

2.8.9 **Kinship Care**

- To ensure the correct balance of care is afforded to kinship families, in order to promote stability of placements and to ensure kinship care remains the primary consideration when children are no longer able to remain in the care of birth families
- Extend family network searching through models of life long links services and ensure every opportunity to enhance kinship placements are made available.

2.8.10 **Social Work Services Residential Services**

2.8.11 A review of residential care services is underway with the following workstreams:

- Continue the building modernisation programme through investment in new build residential units.
- Re-design of services to reflect changing profile of looked after children, such as the increasing number of younger children (under 12) and older young people who are staying in care longer but are not ready to move on to supported accommodation
- Creating capacity and re-designing services to enable young people who are in high cost placements to reside in our own provided units.
- Residential Unit Managers will chair the reviews of care plans for looked after children reviews

- Responding to the Scottish Government's requirement all residential workers to have Level 9, degree level qualification

2.8.12 In reflecting on the progress have made so far the Children's Services Core Leadership Group has agreed a number of changes which we will need to make to our current arrangements for governance, accountability, performance monitoring and communication and engagement. In particular, we need to ensure that the HSCP achieves the 2017/18 savings

2.8.13 **Health Visiting**

2.8.14 Ring fenced funding has been made available to Health Boards across Scotland to deliver the new Universal Pathway for children under the age of five.

2.8.15 The underlying assumption is that health visitors will assess and make plans to meet all under 5s children's health and wellbeing needs utilising both their clinical knowledge and the Getting it Right for every Child national practice model. NHSGGC has undertaken significant work to develop an appropriate workforce model for this service.

2.8.16 NHSGGC have created a workforce modelling group to implement the new universal pathway using a resource allocation model the model relies on Band 5 nurses completing the Public Health nursing course.

2.8.17 Upon successful completion there will be a phased deployment of newly trained staff to localities until the projected resource is fulfilled.

2.8.18 It is anticipated that by the end of January 2019 Glasgow City HSCP will have an additional 123 health visitors in the workforce

2.8.19 Within this envelope of increased health visiting resource there will be opportunities for the HSCP to redesign services and maximise efficiencies in service delivery models. These options include

- The centralisation of immunisations (efficiency saving) which would free up some clinical time through corporate clinics in 'community hubs'.

- A redistribution of the centralised parenting team to core functions associated within the pathway

- The removal of practice development nurse posts, with practice teachers assuming this role although this represent only a small wte resource and is not equitably distributed across all areas at present.

- Consider revising the current arrangements of health visitors in specialist posts (e.g. Infant feeding advisors and in Health Improvement Teams) to incorporate these staff into locality teams.

2.8.20 **School Nursing**

2.8.21 NHSGGC is undertaking a review of School Nursing and a framework describing the service redesign envisaged is currently under development at a board wide level. Glasgow City HSCP will subsequently develop local service plans for school nursing to reflect any necessary service redesign required.

2.8.22 Existing saving requirements for this service have been achieved through workforce redesign as a proportion of current Band 5s currently going through the SCPHN qualification subsequently secure the additional Health Visitors posts paid for by the monies ring fenced by the Scottish Government.

2.8.23 **Family Nurse Partnership (FNP)**

2.8.24 Family Nurse Partnership (FNP) is a voluntary programme for first time mothers aged 19 and under. It is an intensive, structured home visiting programme which is delivered by specially trained nurses to pregnant women from under 28 weeks gestation through to their child's second birthday. Family Nurses carry caseloads of no more than 25 clients.

2.8.25 The programme aims are:

- To improve maternal health and pregnancy outcomes
- To improve child health and development and
- To improve parents' economic self-sufficiency

2.8.26 There are currently have two sites in NHSGGC. One of these sites is based in the North East Sector of Glasgow City HSCP (but covering Glasgow City, East Dunbartonshire and West Dunbartonshire). The second is based in Renfrewshire and covers East Renfrewshire, Renfrewshire and Inverclyde. (this site is currently full and is about to begin to graduate their first cohort of clients. They are likely to begin recruiting again in September 2017.

2.8.27 The first site, based in the North East Sector of Glasgow City CHP (but covering Glasgow City, East Dunbartonshire and West Dunbartonshire) has graduated their first cohort of 167 clients who have completed the programme and have now recruited its second cohort of 202 clients who will stay with the programme until their oldest child is 2.

2.8.28 The Scottish Government are committed to the further expansion of the FNP programme and are keen to examine where FNP can add specific value to the current early years landscape. NHSGGC are currently in the process of signing off an SLA for the next three years. This SLA includes current service provision for team A and B and is fully funded by Scottish Government. The funding however will still be subject to the annual spending review.

2.8.29 **Social Work Services**

2.8.30 The Children and Families Core Leadership team have agreed critical and substantial areas of future activity for Children's Social Work staff. These are:

- Child Protection;
- Looked After Children;
- Looked After and Accommodated Children;

- Reports to SCRA;
- Kinship Care Placements.

2.8.31 As part of our workforce planning process a excessive to project required need using a time weighting for each task associated with these priorities was conducted (using baseline staffing figures for Qualified Social Workers as at August 2016).

2.8.32 Assuming these figures remain at the same level until April 2017 it is projected that there will be a deficit in the workforce required to deliver these services.

2.8.33 This being the case the service delivery model for the areas identified above requires to be reviewed with consideration given to the associated risks and mitigating factors.

2.8.34 It is important o note that client contact is a significant driver of workforce demand within social care and it is estimated the HSCP, if efficiently resourced could complete around 60,000 hours of supervised contact per annum. The HSCP should consider a greater skill mix to allow us to more efficiently manage the considerable demands on staff time for supervising contact which may mean a requirement for an increase of the workforce at social care grade 6.

2.9 Adult Services

2.9.1 Within the HSCP Adult Services includes mental health, learning disabilities, alcohol and drugs, homelessness, sexual health, prison health care and police custody.

2.9.2 The main common drivers which will influence workforce planning for Adult Services include

- Rising demand
- Ageing workforce with forecast increase in retirals
- Impact of poverty, welfare reform and job insecurity on people's mental resilience
- National strategies e.g. mental health, alcohol and drugs , learning disabilities
- National professional workforce models and benchmarking projects
- National inspections and audit reports e.g. MWC, Housing Regulator
- Local transformation programmes.

2.9.3 **Mental Health**

2.9.4 Glasgow City leads on whole system planning and clinical leadership for mental health services and workforce across all 6 HSCP areas, 2 of which (East Dunbartonshire & East Renfrewshire HSCPs) are non-bed holding.

2.9.5 There are 10 inpatient sites across NHSGGC which provide 936 beds (599 beds in Glasgow City HSCP) and 40 Community Adult and Older Peoples Mental Health Service Teams (22 teams in Glasgow City HSCP)

2.9.6 In the past three decades two major themes have impacted on the configuration of the mental health workforce

- The closure/downsizing of the large psychiatric hospitals (mainly the continuing care beds);
- The development of the community based teams to support the care in the community programmes.

2.9.7 Within NHSGGC mental health services, community developments have also expanded beyond generic Community Mental Health Teams (CMHTs) to create specialist community services.

2.9.8 The mental health workforce also faces specific issues which will impact on the workforce, these are:

- An ageing workforce
- Mental Health Officer Status
- Changes to NHS pension provision
- Application of the national workforce and workload planning tool
- Nursing staffing standards.
- 5 year forward view

2.9.9 **Ageing Workforce**

2.9.10 The MHS nursing workforce exhibits an older profile

2.9.11 Of the 2500 wte staff in post, 1150 are aged between 50 and 60 years old with a further 160 aged over 60. This represents an increase of 30% in staff aged over 50 years old in the past 5 years.

2.9.12 **MHO Status**

2.9.13 As at November 2016 620 staff (or 21%) of the workforce retained Mental Health Officer (MHO) pension status which allows some staff members to retire at age 55 years with full pension benefits.

2.9.14 MHO status applies to certain groups of staff who were members of the pension scheme prior to 1st April 1995 and is given in recognition of the nature of the difficult work undertaken by the staff member.

2.9.15 MHO status affords NHS employed staff an earlier Normal Pension Age (NPA) of 55 rather than the age 60 NPA for other members and all completed years service beyond 20 years are doubled for pensionable purposes meaning staff can reach 40 years pensionable service after 30 years reckonable NHS employment with MHO status.

2.9.16 As noted this ageing profile is further exacerbated by recent changes to the NHS Pension Scheme.

2.9.17 **NHS Pension Changes**

2.9.18 Under the new 2015 Pension Scheme normal retiral age will increase in line with the state pension age for most NHS staff.

2.9.19 This means that most staff will see an increase in pension age from 66 years old as from October 2020 rising to 68 years old. However, those NHS staff within 10 years of current normal pension age are included in a protection scheme (which covers staff aged 45 years or over who have Mental Health Officer status).

2.9.20 Recent changes to the NHS Pension Scheme have introduced a protected period of 10 years for staff affected by these changes which will end in 2022. This effectively means that existing MHO staff within 10 years of their normal retiral age of 55 will continue to accrue pension benefits as normal until 2022.

2.9.21 Staff with MHO status remaining in the workforce beyond this will be required to comply with the retirement arrangements under the new scheme (including retiral age) and would potentially suffer detriment in relation to the age they are able to retire (i.e. they would lose the ability to retire at 55 and require to work until 67 years of age).

2.9.22 **Workforce and Workload Planning Tool**

2.9.23 NHS Boards are mandated by SGHD to use the validated Nursing and Midwifery Workforce and Workload Planning (NMWWP) tools to assist with workforce planning and to ensure safe and effective staffing levels. At the present time a tool exists for in-patient services which is used in conjunction with a formal professional judgement tool and a number of quality measures. It is expected that as of April 2018 use of the NMWWP tools will become a statutory requirement under the proposed legislation on safe staffing levels within the NHS

2.9.24 A recent system wide review of ward funded establishments demonstrated the need for this work to be completed to ensure budgetary spend for each ward is aligned to the funded establishment for each ward. The current establishments are historical and were reviewed in light of changes mental health service ward sizes have been standardised and reduced to or around 20 beds:

- Ward designs reflect single room accommodation and additional communal and therapy areas with the associated need to ensure safe supervision of patients;
- The introduction of community and specialist services has resulted in a corresponding increase in the acuity and dependency of those patients requiring inpatient care;
- Supplementary staffing used has increased incrementally to meet patient needs most significantly to provide enhanced observation support.

2.9.25 Between October and November 2016 62 of the 63 eligible wards conducted a 2 week run period of the mandatory specialist Mental Health and Learning Disability NMWWP tools.

2.9.26 **Nursing Staffing Standards**

2.9.27 The Royal College of Nursing (RCN) recommends a % skill mix of registered to unregistered nurses at a ratio of 65:35. This is based on a body of evidence that reports safer and improved outcomes for patients where there are more registered staff working on the wards.

2.9.28 The 2013 Nurse Director's review paper supported this position however acknowledged that services required additional investment to achieve this and suggested that a safe working model was a ratio of 60:40 for Acute Admission/IPCU and 50:50 for Continuing Care wards as an interim position, with the aim being to work towards the RCN recommendation. It is recognised that it is difficult to predict an absolute skill mix ratio and that this needs to be assessed dependant on the clinical needs of the patients at that time.

2.9.29 **5 Year Forward View**

2.9.30 Implementing conventional efficiencies and seeking modest incremental change is unlikely be sufficient to meet financial targets while maintaining safe and effective services. The HSCP proposes a five-year "forward view" that takes account of the strategy developed for mental health (MH) by the Department of Health in England,[7] and other UK strategic planning documents in MH.[8,9] to make sure that short-term measures to manage financial challenges are consistent with viable service configurations in the medium to long term.

2.9.31 It is predicated on achieving four fundamental changes to the current system:

- A redesigned "unscheduled care" system coordinated GG&C-wide, and incorporating acute admission beds as well as liaison, OOH and home treatment services.
- A "scheduled care" system (using LEAN methodology) managing community and specialist teams, and including all "non-acute" beds and supported accommodation.
- A clearer distinction will be made between "clinical treatment" and "recovery and support" services in longer-term care settings.

    o Clinical services will use the principle of "easy in, easy out" to optimise access and effectiveness according to careful care planning and outcome measurement.
    o Recovery-based support services will emphasise long-term stability and emotional and social care, making greater use of peer support. The system will acknowledge and respect the adversity and trauma that underlies many mental health problems.

- Investment in prevention, early detection and intervention with a particular emphasis on under-18s and people exposed to childhood adversity.

2.9.32 Given that inpatient costs represent the majority of MH expenditure, unless a reduction in beds is achieved, there is limited scope to reinvest in alternative provision, and there would be a correspondingly adverse impact on community services. The aspiration is to provide alternatives to inpatient care, which would aspire to sustain bed occupancy levels of 85-90%, and release significant resources to fund the development of community alternatives to inpatient care.

2.9.33 A reduction in inpatient mental health bed numbers is proposed, beginning from a baseline in the 18/19 financial year, and achieved over the five subsequent years. The rationale for this proposal is that the reduction takes account of:

- 30% of "acute" beds are currently occupied by patients staying for more than 1 month, whose needs would better be met elsewhere
- the average length of stay is about 32 days, it should be possible to reduce this significantly, especially with an emphasis on longer-stay patients

[7] https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf
[8] https://www.centreformentalhealth.org.uk/priorities-for-mental-health-economic-report
[9] http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/mental-health-under-pressure-nov15_0.pdf

2.9.34 In summary, to address the current and projected financial climate, major re-modelling of inpatient and community mental health services will be required in order to cut the costs of NHS mental health services.

2.9.35 Any reduction in inpatient beds will require reinvestment in the in the community including for new models of delivery for community health and social care alternatives. Major work will be required on developing options for such alternatives and on the service user requirements and volumes of need. The balancing reinvestment in the community would be dependent on new in-patient and community pathways and thresholds.

2.9.36 A similar 5 Year Forward view is being applied to

- Learning Disability
- Alcohol and Drugs

2.9.37 All of the 5 Year Forward Views will have implication for future workforce planning

2.9.38 **Psychology**

2.9.39 NHSGGC has an excellent track record of recruiting and retaining across Psychology staff and supporting skill mix in our Primary Care Mental Health teams (PCMHTs).

2.9.40 We receive NES funded Trainee Clinical Psychologists which are a financially free resource for NHS GGC although they require support in services. In areas such as LD and Older Adults it is becoming difficult to provide this support and there is a risk that we lose this valuable resource. NHSGGC also receives similar NES funded MSc Psychologists both in Adult and in CAMHS.

2.9.41 Currently our workforce data for Psychology staffing (part of the Other Therapeutic job family) is currently being reviewed as part of an exercise to improve data quality. However the following trends have been noted.

2.9.42 NHSGGC has seen a modest increase in wte Psychology staffing (using a 2011 baseline when data was first gathered with ISD at Scottish Government) this varies across care group with some specialties showing a reduced workforce e.g.:

- a decrease in Psychology in MH of 6%
- a decrease in Psychology in LD of 24%
- a decrease in Psychology in Alcohol and Drugs of 8%

2.9.43 Staffing has increased marginally in CAMHs, Forensic and within Acute Clinical Psychology. Forensic and acute clinical psychology sit with Acute and not within the HSCP.

2.9.44 The main challenges which are faced in terms of the Clinical Psychology workforce include:

- The small critical mass of Psychology staff in certain care groups such as LD, Alcohol and Drugs and Older Adults, In-patients and some specialist services mean service wide vulnerability across NHSGGC;
- A significant number of staff have MHO status and can retire at 55;

- Analysis of gender and part time working profile suggests that the Psychology workforce is a largely female profession so many who join the profession will reduce working hours within 3 years post training;
- Services have small numbers of clinical psychologists and other psychological therapists meaning they are vulnerable to not being able to provide care as expected when vacancies and forms of leave occur.

2.9.45 **Social Care – Mental Health Officers**

2.9.46 During 2016 analysis of Glasgow Mental Health Officer's range and scope of work, deployment across the city was conducted to confirm MHO's compliance with requirements to maintain their registration and to ensure that MHO's have access to appropriate support and opportunities for development.

2.9.47 A survey was undertaken which formed a key part of this work and was a mandatory and anonymous questionnaire to all MHO's while trainees and workers applying for training were requested to complete only the profile related questions.

2.9.48 The survey also included a

- trend analysis in terms of the current workforce
- proportion of time spent of MHO activity
- practice development and learning and education needs

2.9.49 This analysis was been undertaken to determine the definitive number of MHO staff within Glasgow. Following consultation with Mental Health Service Managers, and reference to existing staff lists it can reasonably established that Glasgow City Council currently employs 86 staff city-wide who have MHO status.

2.9.50 This figure will always fluctuate given that some staff are not always practicing (e.g. Service Manager grade while others have requested a temporary respite) or are on long term leave.

2.9.51 The number of practicing MHO's and trainees have remained consistent over the last two years but there is a 15% increase in MHO Practitioners over this time period. Larger numbers of MHO's work within non-mental health specialist teams, the majority within Community Care Teams.

2.9.52 Historically, funding to enable Mental Health Officers to access learning and practice development opportunities was drawn from the Mental Health budget, held centrally under the responsibility of the Head of Mental Health services. This approach was discontinued and funding for continuous professional development opportunities for Mental Health Officers is now required to be approved annually, and report submitted to Governance.

2.9.53 Recommendations for Social Care Mental Health Officer arising from the work undertaken are noted below:

- Review process of budget allocation for recurring training costs and resources i.e. courses, learning materials and venue costs via Steering Group
- Identify individuals who require a practice letter to be put in place, ensure all MHO's have provided a copy of this letter to their manager.

- Develop a template to record all MHO's details going forward.
- Review the effectiveness of mentoring systems in place across the city

2.9.54 **Occupational Therapy**

2.9.55 The National Delivery Plan (NDP) for the Allied Health Professions in Scotland (2012)[10] identified AHPs as experts in rehabilitation at the point of registration, bringing a different perspective to the planning and delivery of services, it stated that AHPs are uniquely placed to exploit their expertise in enabling approaches through providing rehabilitation and re-ablement approaches across health and social care as well as driving integrated approaches at the point of care.

2.9.56 The national active and Independent Living and Improvement Programme (AILIP), (launch date April 2017), builds on the work of the NDP and will focus on the contribution of AHPs throughout the life curve and emphasise their contribution in early intervention, rehabilitation and enablement.

2.9.57 A key message within the AILIP will be the importance of integrated working. Occupational Therapists are currently employed across health and social care structures. They traditionally function separately with separate management and professional leadership arrangements, and different working practices.

2.9.58 The establishment of Health and Social Care Partnerships (HSCPs) provides the opportunity to consider the current systems and how these can be improved to enhance service delivery. Discussions around this are already being facilitated within all of the HSCPs in NHSGGC.

2.9.59 There has never been a standard workforce model developed and applied for Occupational Therapy and the review is the first step in being able to develop such a model.

2.9.60 This review aims to provide:

- The service background to workforce and workload planning within the broader strategic context
- A position statement regarding the Partnership Occupational Therapy profile
- Information on the demographics of the Occupational Therapy workforce which can be used for succession planning
- The professional context and evidence base with regards to Occupational Therapy staffing levels and skill mix

2.9.61 The scope will cover all clinical areas within NHSGGC Partnership services associated with Occupational Therapy in both inpatient and community settings. The report provides an overview of Occupational Therapy services across partnerships as a collective and then for ease of clarity and structure, It provides specific data and narrative in a separate format across the 4 care group areas listed below:

- Mental Health
- Learning Disability

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[10] www.scotland.gov.uk/Publications/2010/06/15133341/0

- Specialist Children Services
- Community Rehabilitation

2.9.62 Workforce planning in Occupational Therapy will necessitate a drive towards integration, challenging the traditional health and social care pathways and streamlining services to minimise duplication.

2.9.63 The emphasis in the strategic plan around early intervention and prevention could suggest that more Occupational Therapists should work in Primary Care. The majority of the current NHSGGC workforce are deployed in secondary care services. Similarly given their skills within rehabilitation, the focus on "home is best"/organising discharge as early as possible, could recommend that a high proportion of the Occupational Therapy resource should be in the community to facilitate early discharge and provide re-ablement and rehabilitation.

2.9.64 The emphasis in the AILIP is also around prevention and early intervention and would support this shift in the workforce. A national piece of research will be undertaken as part of AILIP in April 2017. This will provide useful information in relation to where Allied Health Professionals, including Occupational Therapy interventions are best placed for maximum outcome.

2.9.65 Integration has provided the opportunity to examine the role of Occupational Therapists in traditional Health and Social Work roles and to consider how these currently distinct services can become more connected.

2.9.66 A valuable support staff resource exists within Occupational Therapy, both within health and social care however roles are different. Integration also provides the opportunity to consider a performance management system across the OT service.

2.9.67 **Homelessness Services**

2.9.68 Adults with Multiple and Complex Needs – this group is an adult population who are highly vulnerable and who are characterised by the following:

- Chronic homelessness/rooflessness and rough sleeping;
- Mental Health/drugs/alcohol dependence and variable level of engagement with treatment services;
- Repeat offending, frequent and custodial sentences plus higher than average use of A&E services

2.9.69 Quantification of numbers/needs is complicated by the variable information systems within HSCP and those being used by our external partners. However the homelessness and health data merge will be a helpful development for the HSCP moving forward with its potential to improve our understanding of patient/client needs.

2.9.70 There are significant financial implications for HSCP arising with demand on criminal justice, accident and emergency and in bed and in breakfast costs. In addition there are other costs to the public sector hence the need for multi-agency input within the coordinated plan. Police Scotland, Community Safety Glasgow and the RSL sector are critical partners as is the wider voluntary sector.

2.9.71 247 staff are directly employed by the HSCP to provide homeless services engaged in a wide range of activities including hostel support, homeless addiction team, community care workers and specialist health service working in city-wide or locality teams.

2.9.72 **Sexual Health Services**

2.9.73 Sandyford Sexual Health Service is a service for the whole of NHS Greater Glasgow and Clyde, hosted by Glasgow City HSCP. The service provides universal sexual health services for the population provided for by NHS Greater Glasgow and Clyde as well as specialist services for complex procedures and specific population groups. Many of the specialist services are provided on a regional or national basis.

2.9.74 The service provides a core universal service which includes:

- Testing and treatment for sexually transmitted infections and blood borne viruses including HIV;
- Comprehensive reproductive health care;
- Provision of contraception including long acting reversible methods;
- Termination of Pregnancy Services.

2.9.75 Specialist Services include:

- The Archway service for people who have been raped or sexually assaulted;
- The Steve Retson Project for gay and bisexual men;
- Young People's Services;
- Counselling and Support services;
- Complex gynaecology including for women with long term conditions;
- Sexual Problems service;
- The Gender Identity Service.

2.9.76 Sandyford is also a significant training centre for new consultants in genito-urinary medicine and gynaecology and receives significant funding from NES (NHS Education for Scotland) to facilitate this.

2.9.77 The service is managed through the North West Locality and has planning structures in place for each of the Health & Social Care Partnerships across the Board area. It delivers services across 15 sites.

2.9.78 The core services are delivered by a workforce of 21. These include genitourinary physicians, consultant gynaecologists, specialty doctors, nursing and, over recent years, four advanced nurse practitioners have been introduced to the service. The gender service is provided by psychiatry, psychology and specialty physicians.

2.9.79 Increasingly the service has faced problems with the shortage of specialty medical cover (this is a problem nationally for sexual health services) which has resulted in the service carrying some medical vacancies. This problem, combined with the current service model, has resulted in the service finding it increasingly difficult to deliver the existing service.

2.9.80 **Alcohol and Drugs**

2.9.81 Recovery Services

2.9.82 Alcohol & Drug Recovery Services in Glasgow City cover 3 sectors by means of Care and Treatment Teams (CAT's). They deliver integrated health and social care for individuals affected by drug and alcohol misuse.

2.9.83 Core objectives in terms of service delivery are;

- To ensure individuals in the greatest need are prioritised in terms of access to co-ordinated services.
- To improve efficiency and effectiveness of addiction related intervention by effective multidisciplinary working.
- To ensure that services users and the wider community can benefit from the full range of care and treatment options available.
- To ensure that individual needs are assessed by competent staff with a wide range of specialist skills and knowledge.
- To ensure that service users have a robust recovery plan ensuring that the service and services users have a clear focus on outcomes
- To ensure that there is a joint approach to the planning and development of new services, which meet local unmet need.

2.9.84 Composition of Teams

2.9.85 The composition of care and treatments teams is

- Operational Management Team – Change Managers
- Community Medical staff – comprising of Senior Medical Officers, Medical Officers
- Nursing teams - comprising of Nurse Team Leaders, addiction nurses (80% RMN's and 20% RGN's) and Healthcare Support Workers.
- Psychologists
- Social care team - comprising of Team Leaders, who manage the Senior Practitioners
- Pharmacists with links to community and Tier 4 services
- Occupational Therapists link to community and Tier 4 services

2.9.86 Day and Inpatient services

2.9.87 The composition of Day and Inpatient services is

- Addiction Psychiatrists with links to community
- Nursing Team – comprising of Senior Charge Nurse, Charge Nurses, Staff Nurses and HCSW
- Advanced Nurse Practitioner
- Dieticians

2.9.88 Psychology

2.9.89 The psychological therapies stepped care model is in line with the recommendations set out in 'The Delivery of Psychological Interventions in Substance Misuse Services in Scotland' as well as 'The matrix: a guide to delivering evidence based therapies in Scotland' (In Press, 2017; Matrix, 2015;). It is based on a tiered approach to service provision, whereby psychological therapies are provided at differing levels of intensity by a range of staff of differing skill mix.

2.9.90 Medical Staffing

2.9.91 Medical staff work either in the community (Medical Officer/Senior Medical Officers supporting community addiction teams) or in Tier 4 addiction services.

2.9.92 General Practitioners (and practices) are also contracted through the NES Drug Misuse Contract to deliver Opiate Replacement Treatment in partnership with the community services.

2.9.93 **Learning Disability**

2.9.94 In light of the Learning Disability Change Programme 'A Strategy for the Future'[11] there has been a significant focus on future sustainability of the learning disability nursing profession within NHSGGC which faces significant challenges due to an ageing learning disability workforce and a need to address succession planning.

2.9.95 Historically, large scale redesign of NHSGGC's learning disability services (such as the closure of the Long Stay Lennox Castle and Merchiston Hospitals) had resulted in a redeployment legacy.

2.9.96 Due to the projected increase in staff leavers associated with the existing cohort of staff reaching retirement age NHSGGC will, in future, be able to address and establish a workforce profile which includes greater opportunity for recruitment; a clearer future career framework which links to national approaches for the profession; and a workforce profile which is line with the role and function of specialist teams and their relationships with other NHS and Partnership services.

2.9.97 A revised workforce profile is being implemented across all HSCPs. A workforce implementation group is supporting all HSCP partners in this process and providing system wide governance. Practice development and Professional Leadership roles are now in place, alongside revised local leadership arrangements.

2.9.98 In line with the national career framework for Learning Disability Nursing and our 'Strategy for the future,' NHSGGC is reshaping its nursing workforce to better reflect the range and different levels of health provision we deliver to people with learning disabilities and their spectrum of evolving care needs.

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[11] http://www.nhsggc.org.uk/your-health/health-services/learning-disability-change-programme/

2.9.99 We are introducing band five nursing staff to our community services in order to better support the quality of care we deliver to our patients and their families; to develop competencies and enhance skills' acquisition in this area of professional practice; to facilitate shared learning between newly qualified and experienced practitioner levels and form the basis for clear succession planning. This will develop a flexible, sustainable nursing workforce capable of meeting the current and future needs of the service.

2.9.100 **Health Improvement**

2.9.101 The majority of the Health Improvement workforce in Glasgow city is organised in three locality based teams, with additional capacity from a small number of city wide posts(all led by the Head of Health Improvement)   and significant input from Board wide specialist teams in sexual health, addictions and mental health.

2.9.102 Health Improvement forms part of the wider Public Health workforce and liaises closely with Public Health colleagues within the GGC NHS Board.

2.9.103 Workforce Planning and development is driven through the Board wide Health Improvement workforce development group, chaired by one of the city health improvement managers.

2.9.104 Glasgow City HSCP services have been part of the NHSGGC Public Health review which concludes in the spring of 2017. The review will advocate a refresh of the functional domains for staff (based on Scottish Review of Public Health published in February 2016). This identifies 12 critical and core functional areas for health improvement staff, the challenge is to develop and maintain levels of competence of the workforce across these domains.

2.9.105 Live issues for the health improvement workforce include:

- Respond to the workforce implications that may emerge via the national Public Health Review and Public Health Strategic Statement from the Scottish Government (expected later in 2017)
- Implement the Practitioner registration scheme led by NHS Health Scotland. (NHSGGC currently have a small number of staff working to achieve registration via the pilot scheme).
- Ensure that the workforce is appropriately trained, supported and developed to fulfil the full range of competencies set out in the refreshed UKPHR Skills and Competency framework[12]) and the public health functions as set out by GGC in its suite of work on the Public Health Review

2.9.106 Overall within Health Improvement there is an ongoing collaborative effort to ensure that a workforce development plan is co-ordinated for the city for health improvement, achieving efficiencies and economies of scale in responding to the training and development needs of the staff, with a clear fit and link into the Board wide Workforce Development Plan for health improvement

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[12] http://www.ukphr.org/wp-content/uploads/2014/08/UKPHR-Practitioner-Standards-14.pdf

2.9.107 Key priorities for the workforce will be developing transferable skills and key functions in partnership working, influencing and creating partnerships to drive forward the health improvement strategic direction for Glasgow city within the workforce.

2.9.108 In practical terms, there is an ongoing collaborative effort to ensure that a workforce development plan is co-ordinated for the city for health improvement, achieving efficiencies and economies of scale in responding to the training and development needs of the staff, with a clear fit and link into the Board wide Workforce Development Plan for health improvement

2.9.109 Transferable skills and key functions in partnership working, influencing and creating partnerships to drive forward the health improvement strategic direction for Glasgow city within the workforce, via distributed leadership, are some of the key priorities in moving forward

2.9.110 **Prison Healthcare Services**

2.9.111 Glasgow City HSCP has hosted Prison Healthcare Services on behalf of NHSGGC since responsibility for the provision of health care to prisoners was transferred from SPS to the National Health Service (NHS) in November 2011.

2.9.112 Prior to this date health care services in Scottish prisons were provided by the Scottish Prisons Service (SPS). The aim of the transfer was to ensure that prisoners received the same standard of care and range of services as offered to the general population according to need.

2.9.113 There are three publically owned prisons in the NHSGGC geographical area all of which are closed prisons. These are:

- HMP Barlinnie;
- HMP Greenock;
- HMP Low Moss.

2.9.114 Scotland has one of the highest rates of imprisonment in Western Europe and the prison population is rising. The burden of physical and mental illness in the prison population is disproportionately high when compared to the general population.

2.9.115 Imprisonment may contribute to poor physical and mental health and well-being and exacerbate social exclusion. Many prisoners experience mental illness (predominantly anxiety and depression) following incarceration, lose contact with their families during their sentence and are homeless, unemployed and socially isolated on liberation.

2.9.116 The health and social care needs of the prison population are complex. Prior to incarceration prisoners rarely engage with health care services in the community; during imprisonment demand for health care services is high. The guiding principle is that of 'equivalence' of care, as outlined in 'Equally Well' the Ministerial Taskforce Report on Health Inequalities (2008)[13].

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[13] http://www.scotland.gov.uk/Publications/2008/06/25104032/16

2.9.117 Equally Well brought aims to tackle the root causes and social determinants that underpin the wellbeing and health of individuals and communities. It makes a number of recommendations related to access to services in order to help address health inequalities, particularly in vulnerable groups, such as prisoners. The report specifically recommends services addressing the following areas for offenders:

- dental health
- general access to health and other public services, with women having priority based on needs
- addictions
- learning disabilities
- mental health and wellbeing

2.9.118 It is recognised that Glasgow City Health and Social Care Partnerships will have a key role in addressing both causes and consequences of health inequalities and that no agency on its own can reduce these inequalities.

2.9.119 Imprisonment provides a opportunity to engage this marginalize population, improve physical and mental health and well-being and address the wider social determinants of health.

2.9.120 Beyond the benefits experienced by the individual, improving physical and mental health and well-being in the prison population may lead to wider societal gains through a reduction in rates of re-offending and by breaking the cycle of inter-generational socioeconomic disadvantage and criminality.

2.9.121 Providing health care in the prison setting is an opportunity for the NHS to engage a hard to reach population and reduce health inequalities, it also presents a number of unique challenges for healthcare professionals:

- Planning and delivering services for a dynamic population is challenging as the number of new admissions or 'receptions' is high and prisoners can be transferred or liberated with little or no notice;

- Poor communication links between prison health care staff and community service providers is a barrier to timely information sharing and effective inter-agency working which impacts on quality of care;

- Within the prison setting security is prioritised over health care. The prison regime may be disempowering and reduce personal autonomy, a barrier to health promotion, self-care and self-management;

- Although demand for health care services in prison is high reflecting need, resources are limited and unmet need is significant;

- Difficulties recruiting, training and retaining health care staff to work in the prison setting have been documented;

- A lack of skilled staff impacts on the range and quality of health care services available, as does limited use of information technology (IT) and inadequate health care facilities;

- Models of delivering health care in the prison setting have traditionally been biomedical with a focus on triage and crisis intervention rather than prevention;

- The development of alternative models of care has been hindered by a genuine paucity of evidence on the effectiveness of interventions to improve physical and mental health and well being in the prison setting;

- It cannot safely be assumed that interventions that are efficacious in clinical trials or indeed effective in routine clinical practice in the community will work in the prison setting;

- The prison population are a multiply disadvantaged group with complex needs and as such the provision of services equivalent to those in the community is unlikely to have a significant impact on health outcomes or reduce population level health inequalities.

2.9.122 To achieve the required improvement it is likely that healthcare services will need to be enhanced and developed to meet need, with a focus on equivalence of outcome rather than equivalence of services

2.9.123 **Police Custody Healthcare Service**

2.9.124 Glasgow City HSCP currently hosts Police Custody Healthcare Services on behalf of NHSGGC .Responsibility for the provision of health care to People in Police Custody was transferred from Police Scotland to the National Health Service (NHS) in April 2014.

2.9.125 The NHSGGC Police Custody Healthcare Service model is a nurse led service with nursing staff on duty 24 hours a day, 7 days a week, supported by an on call rota of Forensic Physicians, (FPs).The nursing staff are based at an NHS healthcare hub located in a Police Office (currently at Govan Police Station) and work peripatetically from there. All calls are triaged and allocate cases to the most appropriate clinician on duty. This model brings mutual professional advantages from specialisation in respective areas of expertise, nurses focusing on delivering healthcare in custody and Forensic Physicians (FPs) expanding their forensic expertise, whilst supporting the nursing team in their healthcare role.

2.9.126 NHSGGC has seven police custody suites where healthcare and forensic services are provided

2.9.127 Service provision also includes responding to the Scottish Terrorist Detention Centre, as set out in the Service Specification. Each of the Police Custody areas has an NHS clinical area equipped to NHS standards and specifications.

2.9.128 The current staffing compliment is**:**

- 1 Service Manager
- 0.5 Professional Nurse Advisor
- 1 Senior Charge Nurse
- 18 Nurse Practitioners
- 1 Senior Business Support Assistant

2.9.129 The medical input to service, is provided on behalf of the NHS by a private group of doctors, who provide FP and CFP input.

2.10 Pharmacy and Prescribing Support

2.10.1 Glasgow City HSCP is supported by the Pharmacy Prescribing & Support Unit (PPSU) to develop the service in line with Scottish Government (SG) health directives including 'Prescription for Excellence' (PfE), local NHSGGC priorities including the Clinical Services Strategy and changing patient pharmaceutical care needs.

2.10.2 PfE is a ten year vision and action plan for pharmacy in Scotland with the ambition that "all patients will receive high quality pharmaceutical care from clinical pharmacist independent prescribers". "This will be delivered through collaborative partnerships with the patient, carer, GP, social care and the independent sector so every patient gets the best possible outcomes from their medicines, avoiding waste and harm." PPSU has developed several early actions to progress this plan.

2.10.3 In summer 2015 the Scottish Government announced details of Primary Care Investment Funding to support the primary care workforce across Scotland and improve patient access to service www.sehd.scot.nhs.uk/pca/PCA2015(P)16.pdf. The circular detailed funding allocation for Pharmacists in GP Practices including additional Prescription for Excellence Funding to March 2018.

2.10.4 The expectation was to recruit pharmacists to work directly with GP practices to support the delivery of care to patients with long-term conditions and free up GP time to spend with other patients. The 2017/18 Primary Care Funding Allocation for Pharmacists in GP Practices allocation (PCA (P) (2016) 2) www.sehd.scot.nhs.uk/pca/PCA2016(P)2.pdf.

2.10.5 Across the HSCP, PPSU has supported the development of Prescribing Support Teams which are delivering cost efficiencies and improved quality of primary care prescribing practice. Skill mix review is also a feature of this development with increasing responsibility being assigned to community pharmacists and to specialist pharmacy technicians who support the GPs and the Prescribing Support Pharmacists. Investment in this activity can demonstrate both cost and quality improvements.

2.10.6 The HSCPs Lead Clinical Pharmacist continues to operate clinics to manage caseloads of patients with long term conditions reducing pressure on GP appointments. This is in line with the PfE vision of "General Practice Clinical Pharmacists" and has the potential to reduce demand on GP's and offering a part solution to GP workforce shortages.

2.10.7 The need for ongoing efficiencies will clearly influence all aspects of service provision, with concerns about cost effectiveness and affordability in prescribing practice, driven by the ageing population, increasing prevalence of long term conditions and the emergence of innovative therapies from the pharmaceutical industry.

2.10.8 The Scottish Government (SG) has indicated that NHS Board Pharmaceutical Care Services Plans should be subject to wide ranging review and redesign with the aim of enhancing the role of the pharmacist and encouraging closer working with GPs and other community based services. This will examine the pharmaceutical needs of patients and the arrangements for providing NHS Pharmaceutical Services to ensure safe and effective care to patients in the community

2.10.9 The PPSU Community Pharmacy Development Team is facilitating a significant programme of change in professional roles in community pharmacy through the Chronic Medication Service (CMS) which is a partnership between the GP, pharmacist and patient to improve the safe, effective and cost effective use of medicines used in long term conditions.

2.10.10 This links directly to the vision in PfE that pharmacists working in community locations are independent prescribers, working in close partnership with the medical profession. The aim is that post diagnosis patient caseloads will be selectively allocated by GPs to the local prescribing pharmacists who will manage the patient's medicines by conducting regular consultations to review progress, monitor outcomes and prescribe the appropriate medicines.

2.11 Business Support

2.11.1 The Integration Scheme agreed between the Council and Health Board (The Parties) indicates that:

2.11.2 "The Parties agree to make available to the Integration Joint Board such professional, technical or administrative resources as are required to support the development of the Strategic Plan and the carrying out of delegated functions.

- *The existing planning, performance, quality assurance and development support arrangements and resources of the Parties will be used as a model for the future strategic support arrangements to the Integration Joint Board.*

- *The Parties will reach an agreement on how this will be integrated within the annual budget setting and review processes for the Integration Joint Board.*

- *Collaboratively, the Health Board, Council and Integration Joint Board will conduct an in-year review within the first year of the Integration Joint Board being established, to ensure the Parties are providing the level of support required."*

2.11.3 Following the establishment of the Glasgow City Integration Joint Board (IJB) and the Glasgow City Health and Social Care Partnership (HSCP), it is considered that there is scope to improve the provision of the Business Support function through an integrated approach, as opposed to the largely separate Council and Health Board systems currently in place.

2.11.4 The scale of the Glasgow HSCP, and the significant amount of transformational change and integration of previously separate functions which will take place over the next few years is such that continuing to apply previous models of support to these functions is very unlikely to be the most effective, efficient or appropriate way forward.

2.11.5 It is necessary therefore to review our Business Support arrangements in the context of this change, and the expected future needs of the Integration Joint Board and the Partnership.

2.11.6 At present, the Business Support function is largely delivered within two separate Council and Health Board systems. Full scoping will be carried out as an early action of this review. This will include a series of workshops with business support staff of the Health Board and the Council (including staff employed by Customer and Business Services) to map current arrangement, identify strengths and opportunities for potential improvement

2.11.7 The main objectives of the review will be:

- Develop a clear understanding of existing business support arrangements within the Health and Social Care Partnership
- Consideration of how effectively these arrangements support the aims, objectives and future direction of the Partnership
- Development of options / proposals for how business support could be delivered in future

2.11.8 The following business support functions will be considered within the scope of this review:

- Admin support in localities
- Admin support at centre, in city-wide functions and hosted services
- Support to the HSCP senior management team
- Governance & support to IJB and committees
- Communications
- Research
- Resilience / Business Continuity
- Information Systems
- Performance (Corporate level reporting)
- Complaints
- Rights and Enquiries
- Freedom of Information
- Claims and litigation (NHS)

2.11.9 The nature of the impact on the workforce cannot be quantified until completion of review activity. The impact on the workforce will be analysed and considered in the identification of recommended options.

2.11.10 Early discussions with Staff side representatives and Trade Unions will be held to ensure an appropriate level of representation and engagement within this project.

2.11.11 Glasgow City Council and NHS Scotland is at present committed to a policy of no compulsory redundancies among its staff, and it is further considered that no proposals will be brought forward which involve any element of compulsory redundancy for health board employees.

2.12 The Financial Environment

2.12.1 Figure 2.7 shows the 2017/18 budget for Glasgow City HSCP by the various service delivery areas.

2.12.2 Glasgow, in common with all public services in Scotland, has faced significant financial challenges in recent years, with further pressures anticipated in future years.

Figure 2.7

Glasgow City HSCP	
2017/18 Budget by Service Area	
Service Area	**Budget (£,000s)**
Children and Families	151,949
Prison Healthcare & Criminal Justice	4,936
Older people	212,110
Addictions	47,604
Carers	1,781
Elderly Mental Health	23,656
Learning Disability	53,394
Physical Disability	27,277
Mental Health	92,313
Homelessness	41,134
Prescribing	129,452
Family Health Service	169,273
Hosted Services	10,122
Other Services	61,307
Total	**1,026,308**

2.12.3 The Partnership's first Annual Finance Statement was published in April 2016, and will continue to be published in April of each year thereafter. This statement will outline the total resources available to the Integration Joint Board for delivery of the overall Strategic Plan.

2.12.4 Financial pressures on health and social care services include:

- Reduced levels of funding from central government
- Increasing costs of medications and purchased care services
- An ageing population with a corresponding increase in multi-morbidities and individuals with complex needs
- Increasing rates of dementia
- Increases in hospital admissions, bed days and delayed discharges
- Increases in National Insurance contributions for employers
- The increasing minimum wage and move to a living wage, leading to increased employer costs and requests for uplifts from contractors
- Superannuation increases and the impacts of automatic pension enrolment

2.12.5 Some of the measures we will take to address the financial changes facing the partnership are:

- Through our Service Reform programme, develop more efficient methods of service delivery which focus on outcomes and the needs of patients and service users
- Develop innovative new models of service which support people to live longer in their own homes and communities, with less reliance on hospital and residential care
- Continue the successful programme of work already underway to reduce and ultimately eliminate delayed discharges
- Develop a service model which is focussed on prevention and early intervention, promoting community based supports over residential settings
- Develop a Property Strategy which ensures that our use of property supports the aims of the Integration Joint Board of delivering high-quality, effective services to people in their own communities

3 Future Workforce

3.1 The future Older Peoples Services Workforce

3.1.1 As describe in Chapter 2 of this plan work is underway to reshape the design and delivery of care for older people across the city ensuring there is a clear focus on maintaining their independence; health and wellbeing.

3.1.2 The workforce implications include a move to a flat management structure across older people and physical disability services and in implementing the new structure it is likely that efficiencies can be achieved across the service reflecting new roles and responsibilities

Workforce Actions – Older People's Services
- Development of work streams to consider the management structure and makeup of the Neighbourhood Teams and the Home is Best Team.   - Review the workforce implications of RAM for Social Work older people's services based on service demand and future pressures.   - Development of a work stream to consider the Governance and support structure for adult community nursing.   - Development of a work stream to consider the future role and management arrangements of the specialist nursing workforce.   - Development of a work to consider the integrated single point of access for older people and physical disability services across the city.   - Undertake a review of the external management arrangements of residential and day care services.

3.1.3 **District Nursing**

3.1.4 The average age of the Band 6 Nursing Workforce is 53 years with 70% of the workforce over the age of 50 years.

3.1.5 Staff over 60 years could opt to leave the service at any time and the number of staff that have the option to leave in the next 24 months is 68.11 wte or 13% of the current workforce

3.1.6 The District Nursing Review Programme Board identified a future workforce model for the service of 1 Band 6 WTE per 9000 registered population supported by a wider skill mix team of staff nurses and health care assistants. This was based on an analysis of workforce and workload including a benchmarking exercise with other health boards / authorities across the UK. Achievement of the redesigned workforce model was predicted to be completed by March 2017 through natural turnover. This was agreed in 2013 by the then CH(C)P Directors, and the health board in partnership with staff side colleagues.

3.1.7 Since that time services have moved towards the agreed model as opportunities have arisen to redesign the workforce. The new model saw a reduction in the number of band 6 posts across the system with an increase in band 5 and band 3 support workers.

3.1.8 There has been an increase in the past 2 years in the number of experienced district nurses retiring and moving to other areas to work which has resulted in recruitment and retention difficulties within the service. This has resulted in a number of vacancies across the system with services required to develop risk management plans to ensure safe and effective service provision.

3.1.9 In a bid to ensure the supply of adequately qualified district nurses Glasgow City HSCP committed to recruit to and train staff for in the Post Graduate Diploma Advanced Practice in District Nursing on a part time and full time training programme at Glasgow Caledonian University 2013/15. Both cohorts of students from these programmes will graduate in September 2016.

3.1.10 A paper was submitted to the Area Partnership Forum in January 2016 proposing that these students be offered a vacant Band 6 post which they would take up on successful completion of the course. Vacancies actual and predicted to September 2016 were identified by service managers. Students were asked to indicate a first, second and third choice of vacancies where they would prefer to work. This was supported by Human Resources who advised that graduates should be able to select a preference for any area within the board not just the HSCP that initially funded the place.

3.1.11 A paper to Chief Officers in 2015 resulted in a decision that each HSCP would make local arrangements to ensure a sufficient supply of staff through investment in training as each partnership had different needs at that time.

3.1.12 There was no agreement on risk sharing across partnerships with a preference to manage the issue locally as oppose to a system wide approach to recruitment and retention.

3.1.13 Within NHSGGC a further 17 students have commenced the programme in 2016.The identified training requirements for entry year 2016/17 noted that Glasgow City required 14 of these placements.

NHS Greater Glasgow and Clyde	
District Nursing Workforce Student Training Allocation 2016/17	
HSCP	DN Students
Glasgow City	14

3.1.14 In future there is a need to consider the potential increase in demand for community nursing services as a result of new ways of working for GPs which will place additional pressures on the existing workforce.

3.1.15 It is anticipated that the national review of District Nursing due to report findings in 2017 will promote a more flexible method of educational preparation for the band six role in order to ensure a fit for purpose workforce.

3.1.16 The district nursing workforce is key to the emerging models of community care and the provision of high quality care at home which will be essential in supporting the increase in demand for complex care. NHSGGC committed to a workforce model in 2012 to ensure that the right number of staff were in place at the right time to deliver this service.

3.1.17 There have been challenges in ensuring that sufficient numbers of qualified district nurses are in place due to the demographics of the workforce which is ageing in line with the wider population. A continued commitment to the on-going education has resulted in the HSCP's being in a better position than some other parts of the country. However there is a real risk that the current financial challenges may see a shift from the agreed workforce model. Incorporated within this is the risk that individual HSCP's may have differing priorities therefore a range of models could potentially exist across the health board area.

Workforce Actions – District Nursing

- Align graduating DN student to existing HSCP DN team vacancies
- Monitor DN Workforce Trends and assess required student training numbers for induction onto 2017/18 training cohort;
- Assess the impact of recommendations of the national review of District Nursing
- Monitor the results of future applications of the workload tool to the DN workforce
- Explore the opportunities available to widen access to the Post Graduate Diploma Advanced Practice in District Nursing through flexible education and training routes

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3.2 The future Children's and Families Services Workforce

3.2.1 Health Visiting

3.2.2 The Scottish Government guidance stipulated that each Board must run the Caseload Weighting Tool during May 2015 to "identify any gap in resources needed to deliver the future vision".

3.2.3 NHSGGC completed The Caseload Weighting Tool exercise, and Scottish Government subsequently confirmed, in June 2015, resource to fund a projected need of 200 WTE Health Visitors required supporting additional activity.

3.2.4 As part of this additional input it was identified that Glasgow City HSCP required an extra 123 wte Health Visitors.

3.2.5 NHSGGC has prioritised the development of community children and family services, based on the national policy directives such as **Health for All Children**[14], the **Early Years' Framework**[15] and **Getting it Right for Every Child** and most recently CEL13(2013) Publiic Health Nursing Service Future Focus our own local policy paper **Mind the Gaps**[16].   Key deliverables from this work have included:

- Enhancing the capacity and infrastructure of our children and family teams to support delivery particularly to vulnerable children;
- Developing Leadership and Increasing Management Capacity;
- Introducing an NHSGGC GIRFEC framework.

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[14] Health for all children: http://www.gov.scot/Resource/Doc/37432/0011167.pdf
[15] Early years framework: http://www.gov.scot/resource/doc/257007/0076309.pdf
[16] Mind the gaps: http://www.gov.scot/Publications/2003/10/18358/28082
Scottish Government (2013) Public Health Nursing Service Future Focus. Chief Executive Letter Edinburgh, Scottish Government.

3.2.6   A recruitment plan has been put in place to support students through the Specialist Community Public Health Nursing (SCPHN) Health Visiting Programme in order to increase our Health Visiting capacity by 200 wte across NHSGGC (123 WTE for Glasgow City HSCP) posts in line with the SG Health Visitor Investment Programme.

3.2.7   The table below splits out into historic and projected future graduates per financial year:

NHS Greater Glasgow and Clyde				
Health Visiting Workforce Allocation 2015/19				
Graduating Year	2015	2016	2017	2018
Students Graduating	10	54	80	56

3.2.8   By 2019 the HSCP expect to deliver:

- A cap on caseloads to 350 children;
- A reduction in caseloads to 100 children for those health visitors who have the largest proportions of deprived children;
- Capacity to undertake targeted interventions for vulnerable children;
- Leadership/Supervisory ratios maintained at 1:10.

3.2.9   In preparation for the implementation of the Named Person and the introduction of the revised 0-5 Health Visiting Universal Pathway Health Visitors, Practice Development Nurses, Practice Teachers and Team Leaders require continuing professional education with focus on the four nationally agreed priority areas below. Three of the priority CPDs sessions have been delivered and the final CPD will commence in April 2017. The CPS is being delivered by Glasgow Caledonian University colleagues.

- Named Person;
- Leadership and Management;
- Strength/Asset Based approaches;
- Child Development, Illness and Assessment Tools.

3.2.10 In addition to the Continuous Professional Development (CPD) requirement there are other key areas for training as part of the GIRFEC NPM including:

- Outcome Analysis Training;
- Graded Care Profile/Neglect Tool;
- New Universal Pathway Training;

3.2.11 To support the workforce the GIRFEC group has developed training based around the relevant topics outlined below:

- Named Person; Lead Professional; Single Childs Plan; Request for assistance;
- Information management, sharing and transfer;
- Communication Strategy; Complaints process;
- Links with colleagues in the wider Community Services, Acute Services and Women & Children Service.

Workforce Actions – Children and Families Services
- Continue to monitor the level of Health Visitor vacancies to mitigate risk to service provision   - Continue to monitor the additional Health visiting posts in line with recent investment from SG   - Ensure future retiral projection numbers are returned on a regular basis to SGHD in order to inform future recruitment requirements   - Continue engagement with staff in the work programmes   - Review and audit of expenditure on children's services is in progress   - Undertake an evaluation of the Includem activity to measure its effectiveness and ability to reduce expenditure   - Re-design the Placement Team.

3.3   The Future Adult Services Workforce

3.3.1   Mental Health Services

3.3.2   The Adult Mental Health workforce is made up predominantly of psychiatrists, psychologists, nursing and occupational therapist staff with 75% of the total made up of nurses.

3.3.3   Workforce trends over the last 5 years have seen a drop in the overall workforce commensurate with the reduction in the number of hospital beds from 4199 to 4009 with most of the impact being felt within nursing.

3.3.4   In comparison to 2010 staffing levels in 2016 were

- AHPs   104%
- Medical   102%
- Psychologists   100%
- Nursing   94%

3.3.5   Though unavailable to new entrants the current workforce of **medical consultants** is able to retire at 55 on account of MHO status. Projected potential retirals over the next two years amongst consultants are shown below with impact varying across care groups.

- Mental Health - 19 representing 20% of the total
- Learning Disability - 2 representing 15% of the total
- Alcohol and drugs - 4 representing 33% of the total

3.3.6   In addition some specialist services could be disproportionately affected by retirals.

3.3.7 While we have little current difficulty in recruitment within the city it is estimated that if even 50% of the potential total retires that this will pose a serious challenge with competition from other health boards. This will leave us more dependent on reaching arrangements with returning consultants (those recently retired) or through increased use of locums. However in terms of consultant trainees the medium term looks more promising.

<table>
<tr><td>Workforce Actions – Mental Health Medical</td></tr>
<tr><td>

- Monitor levels of Consultant retirals in specialist service to assess impact on service delivery

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3.3.8 Nurses comprise 55% of the total mental health workforce with 1900 working in Glasgow city. 88% are full time with an average age of 49 but with a significant proportion (either 40 or 60% aged 50-60). Average turnover is now 15% double its previous norm. 21% have MHO status with 380 eligible to retire within the next 2 years. Some services could be particularly badly affected in the coming years by retirals exceeding 30% in some cases.

3.3.9 The Workforce Planning Group's view that the majority of staff with MHO status who can retire prior to 2022 are highly likely to do so.

3.3.10 There are a number of care group areas with staff profiles which could potentially lead to retirements in excess of 12% per annum are:

- Acute adult inpatients 16%
- Inpatient Rehabilitation/Continuing Care 28%
- MH Inpatient support 44%
- IPCU 21%
- Inpatient older adult 19%
- Inpatient older adult complex/continuing care 36%

3.3.11 All inpatient wards are overspent against funded establishment. An analysis of current staffing ratios across the 63 inpatient wards reveals current deficits in terms of the levels of registered staff. While most wards are at around a 60:40 ratio and some recent action has been agreed to address the position of the four worst affected wards the national recommended safe staffing level of 65:35 is expected to be enshrined in legislation from 2019. At present more than half our wards are below this level. To reach the recommended level of staffing will need 140 additional registered staff.

3.3.12 There is an imbalance between those who may leave and those may enter the profession. Currently there are 116 pre-registration mental health students in training with only a small increase planned. Some additional funding of £3M has been provided nationally to recruit advanced nurse practitioners but this is across all nursing groups.

3.3.13 In light of these factors it is recommended that a review of current ward establishment budgets is undertaken to reflect this in the context of meeting the recommended registered to unregistered nurse skill mix ratio and ensuring the nursing profile model detailed in the table below is met.

NHSGGC Mental Health Services	
Possible Staffing Profile for 20-24 Bedded Ward*	
Band	**WTE**
Senior Charge Nurse (Band 7)	1.00
Charge Nurse (Band 6)	2.00
Band 5	13 – 17 WTE (depending on bed numbers)
Unregistered staff	10 – 14 WTE (depending on bed numbers)

3.3.14 Currently inpatient wards have an indicative "funded establishment" aligned to budget. The only expected variation to this budget is the additional monies to support pay awards and/or incremental appreciation.

3.3.15 At present every ward requires supplementary additional staffing to meet clinical need the main reasons relate to enhanced observation, sickness and vacancy cover.

3.3.16 In total, this supplementary staffing approximates to over 300 WTE per week (i.e. 20%) of the current inpatient nursing workforce. The additional resources are made up from Agency, Bank, Overtime and Extra to Contracted hours. Mental Health has always relied upon additional hours to supplement services.

3.3.17 The results of the NMWWT suggest that the current ward funded establishments are not sufficient to meet the increasing complexity and acuity of patient need. The current funded establishment staff figures were established circa thirty years ago in response to the perceived population need at that point.

3.3.18 The result of the recent NMWWT tool showed that in excess of 50% of the supplementary staff was used to provide enhanced observations, it is further evidence that the nature of the severity of condition for mental health patients on admission has changed. Amongst other factors, improved access to Community Services and the work of the Crisis teams are enabling patients to be maintained in the community for longer, but experiencing greater severity in their symptoms at the point of admission.

3.3.19 It was also noted that out of the 62 participating wards, 10 had skill mixes lower than 50:50. The lowest skill mix was 38% registered WTE to 62% unregistered WTE. Many of these skill mixes are historical in nature and do not meet the recommended RCN 65:35 % skill mix for registered to unregistered nursing staff.

3.3.20 The current skill mix for inpatient wards is 56:44% (730 wte to 580 wte). In order to meet a 65:35% skill mix the service would require to recruit an additional 140 wte (note that this does not take into account the replacement requirements generated by retirals and other leavers).

3.3.21 The high numbers of potential retirees not only creates gaps in workforce capacity, but also represents a significant diminution in organisational knowledge, skills and experience which cannot be remedied solely by the appointment of newly qualified registrants. It would be prudent to consider how the experience and quality relationships with service users and their families can most effectively be "handed over" to the next generation of nurses.

3.3.22 Within NHSGGC Nursing and Midwifery leavers rates are, on average around 8%.The figure for mental health nursing is now averaging around 15% (with retirement accounting for up to 40% of MHS leavers and rising). There are almost 400 staff who will be able to retire under MHO criteria during financial years 2017-19.

3.3.23 It is estimated that the replacement need for the service to compensate for retirals is circa 190 wte during 2017/18 alone.

3.3.24 Within NHSGGC, Mental Health Services have not encountered difficulty in recruiting registered staff. This picture varies across HSCP areas and in order to ensure ongoing successful recruitment we require to ensure equitable access to vacancies for this staff group.

3.3.25 The Nursing and Midwifery Student Intake Reference Group recommendations to Ministers resulted in confirmation of a 4.7% increase in the intakes to pre-registration nursing and midwifery programmes in the 2017/18 Academic Year. Local Higher Education Institutions (HEIs) in the West of Scotland (WoS) will recruit to a total of 123 pre-registration mental health nurse training places (note that this pool of graduate staff will be available for recruitment in 2020 to all WoS NHS Boards.

3.3.26 Return to Practice - Over the next three years the Scottish Government will provide an additional £450,000 (nationally/) for a Return to Practice scheme to encourage former nurses and midwives back into the profession. This will enable around 75 former nurse and midwives to retrain each year and re-enter employment. This is hoped to address short term recruitment challenges, while at the same time helping address a more cost- effective way to meet projected requirements for more qualified staff in the medium term.

Workforce Actions – Mental Health Nursing

Complete the review of current ward establishment budgets
 	
Implement Nurse Director recommended registered to unregistered skill mix of 65:35% for all wards
 	
Better use of resources
 	
    • Improved Rostering through running more "Master classes"
    • Application of 25% Predicted Absence Allowance when rostering
 	
Advance Nurse Practitioners training/recruitment
 	
Recruitment Actions to mitigate the impact of ageing workforce and increased MHO retirals
    • Focus on ward areas with potential high levels of retirals
    • Progress recruitment of Newly Qualified Recruits (e.g.123 places at WoS HEIs)

3.3.27 **Occupational Therapy**

Workforce Actions – Occupational Therapy
Consider creative ways of developing OT posts at an early stage within the care pathway to evidence the impact they can make Review the OT support staff role and consider where they are best placed within the care pathway Develop a performance management system for OT

3.3.28 **Addictions**

3.3.29 Following the conclusion of the Community Addiction Team Review, the community based medical workforce and non-medical prescribers will become more aligned to the functions of the recommended sub-teams as they come into effect. It is also anticipated that more capacity will be required in GP shared care services. With the increasing complexity and psychiatric co-morbidity of the community caseload and to ease patient pathways to access mental health supports, recent progress has seen some addiction psychiatry services being delivered within the community addiction team. Work is on-going to release psychiatry capacity for community work and to reduce the number of consultant teams working into the in-patient units.

3.3.30 Non-medical prescribers have been employed to take on prescribing roles previously held by medical officers and an advanced nurse pilot is being tested in an addiction in-patient unit.

3.3.31 Following the conclusions of the Alcohol and Drugs CSR, day services are being re-designed from April 2018, and the Glasgow ARBD services will undergo review. Both will have implications for medical roles in these settings.

3.3.32 It is anticipated that medical staffing changes can be made to meet the priorities identified above through utilisation of opportunities anticipated through retirements and the regular turnover of community based medical staff.

Workforce Actions – Alcohol and Drugs
• Review the results of the advanced nurse pilot • Monitor workforce alignment with continuing implementation of CAT review • Review implications for medical role with day service redesign and ARSD review • Monitor Staff turnover and workforce balance

3.3.33 Learning Disability

Workforce Actions – Learning Disability Nursing
- Develop a 5 Year plan to ensure stability of services within projected financial parameters and produce a workforce plan to support planned changes.   - Implementation of a NHSGGC-wide resource allocation model (RAM) and associated workforce changes   - Continue to review the registered nursing skill mix within Learning Disabilities   3.5 wte vacant posts be removed from the NHS learning disability budget from 2017/18 onwards and RAM implementation will require to be managed.

3.3.34 Homelessness Services

3.3.35 The HSCP is currently active in a number of areas with a view to improving responsiveness and outcomes for this vulnerable group.

- The ADP has funded an assertive outreach service which has been focused on public injectors. This has informed a contemporary health needs assessment and the current business case on safe consumption room and heroin assisted treatment – which will be reported to the IJB in October.

- Homelessness Services is under a voluntary intervention from the Scottish Housing Regulator on its occasional statutory failure to accommodate individuals at the point of need. There is a high correlation between adults with multiple and complex needs and failure to accommodate – often linked to actual and perceptions of challenging behaviour.

- Homelessness Services has undertaken a strategic review and has set a policy direction which is focused on a housing first model, a reshaping of responses to individuals seeking emergency accommodation and a collaborative partnership with the voluntary sector in response to the target group. The CAN initiative is currently being up-scaled to continue its intervention with this vulnerable group.

- Criminal Justice Services has range of initiatives developed with partners to improve service responsiveness and reduce reoffending. Important in this context are 'Tomorrows Women' working directly with vulnerable women known to the criminal justice system and the 'Persistent Offenders Project' a multi-agency outreach approach focused on individuals who are engaged in acquisitive crimes within city centre – often linked to drug misuse.

3.3.36 As noted adults with multiple and complex needs are a highly vulnerable group whose health and social care needs transcend individual care group boundaries. Consequently responses can be fragmented with clients/patients falling through the 'net'. This can be compounded by a range of additional factors including the reluctance of individuals to engage with statutory services.

3.3.37 Recent analysis on public injectors coupled with findings from homelessness and criminal justice work reinforce the importance for the HSCP in reviewing and recommending service delivery arrangements. This has the potential for transformational change and for financial efficiencies assuming both a more rational redeployment of directly provided/purchased resources and a more defined role for the voluntary sector.

Workforce Actions – Homelessness
• Using existing core group of clinicians and managers supported by the HSCP OD Lead working across the care groups, establish project team to develop a project plan and to formalise recommendations for more effective cross care service delivery

3.3.38 **Sexual Health Services**

3.3.39 In the newly established operating environment that is the integration of health and social care, there is an opportunity to conduct a review of services which will:

- Improve the use of existing resources and release efficiencies through service redesign which will consider team structures, skill mix, localities and patient pathways;
- Encourage those who could be self-managing to be supported differently;
- Ensure that Sandyford services are accessible and targeting the most vulnerable groups.

3.3.40 It is imperative that this review and reform involves key stakeholders from HSCP services, acute services, education and the third sector utilizing joint commissioning approaches recently approved by the IJB.

3.3.41 There is a need to look at how the core Sandyford service is structured particularly in relation to:

- team structure;
- skill mix;
- localities;
- opening hours;
- accessibility.

3.3.42 Reduced numbers of young people attending clinics requires the service to re-think its model in relation to opening times, locations and what outreach services could be developed and delivered.

3.3.43 In an attempt to target resources to the most vulnerable, there is a need to look at more innovative ways of enabling those who can self-manage their sexual health to do so, thus freeing up more clinic time for the most needy.

3.3.44 There is a clear need to engage with GP and pharmacy services regarding the relationships and pathways between services and if it would be beneficial to direct some of Sandyford's routine activity towards them, consideration is required regarding the nature of that activity and how it should be resourced.

3.3.45 Improved partnership working perhaps with innovative and very different future arrangements with addiction services, homelessness, criminal justice and the third sector will also deliver better sexual health outcomes through staff training and the development of outreach and will be considered as part of the review.

3.3.46 With the improvements in HIV management and care which means that for most people it is now a long term manageable condition, there is a requirement to look at how outpatient care for this patient group is provided and whether this should continue to be delivered from the Acute outpatient based Brownlee Centre in Gartnavel. There is a need therefore to engage with colleagues in acute services on this review and reform programme.

3.3.47 The proposed review and reform of these services are likely to have an impact on the current workforce and Staff side partners will be involved as appropriate through the process.

Workforce Actions – Sexual Health Services
- Conduct a review of Sexual Health Services to be concluded by the mid-point in the financial year with the subsequent transformation taking effect from the beginning of 2018.   - Ensure programme of change delivers sustainability to the service during 2017/18 and beyond

3.3.48 **Prison Healthcare**

3.3.49 Historically retention of staff in Prison Healthcare is poor – the 15 – 18% turnover levels are considered indicative of an underlying retention problem, using standard workforce planning methodology. Additionally information gathered indicate that over 60% of Prison Healthcare staff who left did so within the first two years of service.

3.3.50 The Prison Healthcare Management Team is working closely with Workforce Planning Lead, HR, Staff Side and OH to ensure that staff retention is a key operational issue.

3.3.51 Promotion of Prison Healthcare in a variety of clinical environments and Higher Education Institutions is also hoped to assist in the recruitment of staff to the service.

3.3.52 Due to some changes in processes the way patients are admitted into prisons has altered. This has allowed a review of the role of nurses in this activity and the provision of healthcare within a prison environment.

3.3.53 By developing staff in key areas such as Non Medical Prescribing, Advanced Assessment and Advance Nurse Practice, the workforce model for nursing can move to a Nurse Led Clinic format, providing professional advantages for both nursing and medical staff in Prison Healthcare.

3.3.54 Following a review of the Prison Healthcare Drug, Alcohol & Tobacco Strategy the integration of addiction workers with addiction nurses and other professionals will allow greater emphasis on the holistic care of patients with complex addiction needs.

3.3.55 As a result of the Mental Health Innovation fund Prison Healthcare has developed better ways of delivering services, particularly psychological therapies. Greater focus will be made on distress and trauma work with improved quality of work through training and development of the existing staff group.

Workforce Actions – Prison Health Care
- Retention of existing workforce and recruitment to vacant posts   - Review of Nursing Workforce Model in relation to Nurse Led clinics and Admissions   - Development of Nursing staff in key areas : Non Medical Prescribing, Advanced Nurse Practitioners, Advanced Assessment   - Redesign of Addiction Strategy and provision   - Enhance of psychological and mental health input

3.3.56 **Police Custody**

3.3.57 The service will continue to invest in retention, and development of existing staff group, including training in unscheduled care assessment and non medical Prescribing. This will enhance staffs skill profile and add value to service, through reduced need for forensic medical input.

3.3.58 Service Managers are currently drafting a proposal for consideration by Head of Service around a review of staffing profile. This proposal will include moving from flat line structure to address areas such as succession planning, flexibility and cost effectiveness of service.

3.3.59 It is proposed that this could be achieved by creating band 5 and band 3 roles, to support the band 6 practitioners in their practice and let them focus on the value aspects of role discussed above. The broadening of pool of staff this would provide would also benefit contingency planning and sustainability of service provision at times of challenge.

3.3.60 In the shorter term we are looking at the extension and development of nurse bank capability for this service. This is challenging in relation to police Scotland vetting requirements for staff to work on their premises and In relation to level of induction required to fulfil the specialised nature of the role.

Workforce Actions – Police Custody
- Review current service model.   - Improve retention of existing workforce.   - Additional training/ development of existing workforce, Unscheduled care, NMP qualifications, Role of Forensic Nurses.   - Explore the development of specialist nurse bank.   - Review of nursing workforce model in relation to service development

3.3.61 **Business Support**

3.3.62 As noted in Chapter 2 the development of the new HSCP structure introduces scope to improve the provision of the Business Support function through an integrated approach.

3.3.63 This has the potential to improve efficiency to the largely separate Council and Health Board systems currently in place.

3.3.64 The full workforce implications of this will emerge following a review our Business Support arrangements, and the expected future needs of the Integration Joint Board and the Partnership.

Workforce Actions – Business Support
- Complete information gathering on NHS admin staffing arrangements   - Undertake a series of workshops with Partnership business support staff (including staff employed by Council Customer and Business Services)   - Complete mapping of current business support arrangements across the HSCP   - Identify and appraise possible alternative models of business support provision using SWOT or similar methodology

4 The Glasgow City HSCP Workforce

4.1 Staffing Resource

4.1.1 Figure 4.1 shows the WTE workforce for the HSCP across the last three full financial years. These figures have been sourced using data from the payroll systems of both NHS Greater Glasgow and Clyde and Glasgow City Council. The figures represent the inpost workforces as at 31st March each year (end of the financial year) and do not include any vacant posts.

Figure 4.1

Glasgow City HSCP			
WTE Staff Inposts by Finacial Year and Employer*			
Financial Year	Council WTE	NHS WTE	Combined HSCP WTE
2014	3889.00	4030.00	7919.00
2015	3343.81	3929.00	7272.81
2016	3215.78	3884.96	7100.75
*Corrected to Exclude NHS Hosted Services			

4.1.2 Note that the NHS WTE in Figure 4.1 have been corrected to exclude staff who have moved into other NHSGGC divisions since 2014 i.e. Forensic and Learning Disability Services and Specialist Children's Services.

4.1.3 Also the Council Staffing inpost has been affected by the transfer of circa 500 wte staff into a centralised Business Support Function on 1st April 2014 which shows as a reduction in the HSCP workforce however these staff were transferred rather than left Council employment.

4.1.4 As at 30th September 2016 Glasgow City HSCP employed approximately 7800 headcount staff inputting circa 7050 wtes into the workforce.

Figure 4.2

Glasgow City HSCP
Staff in Post as at September 2016
Heaqdcount vs WTE
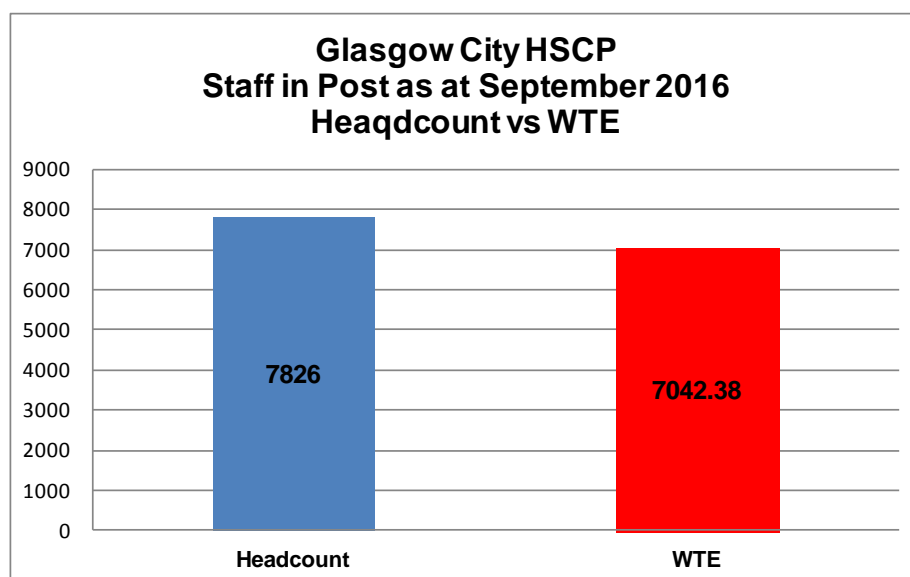
4.1.5 The HSCP workforce is employed by two separate employing authorities, NHS Greater Glasgow and Clyde and Glasgow City Council. As shown in figure 4.3 the NHS is slightly larger employer by headcount and wte although some of the NHS workforce is "hosted" by the HSCP and delivers services across a wider geographic area than just Glasgow City.

Figure 4.3

Glasgow City HSCP
Staff in Post as at Septemeber 2016
(Headcount vs. WTE by Employing Authority)
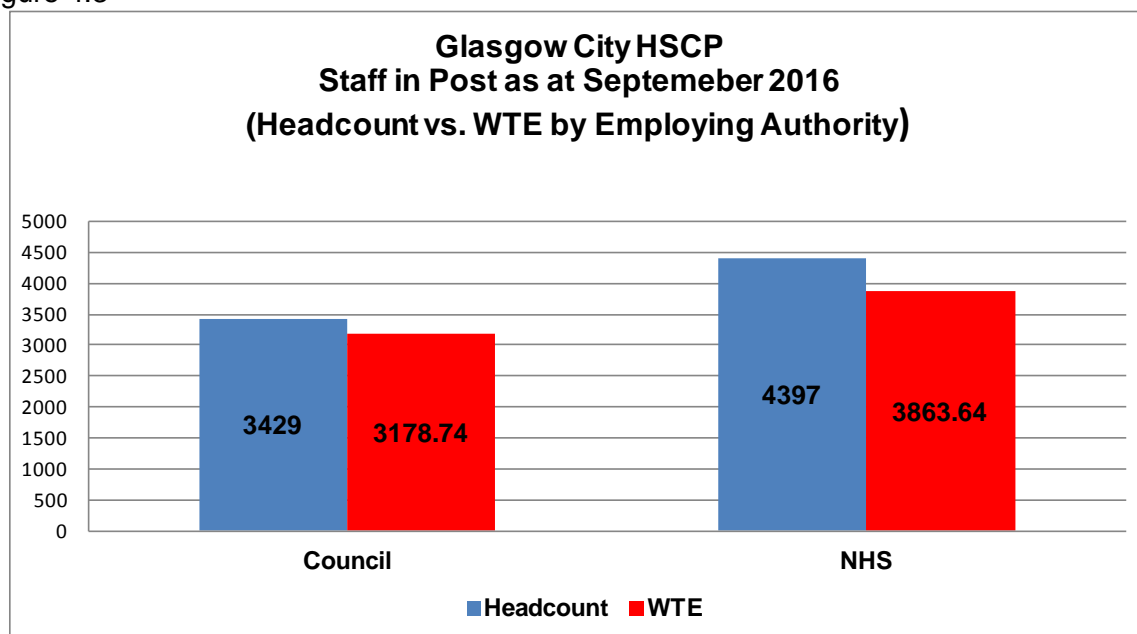
4.1.6 Figure 4.4 shows the workforce by employing authority as a percentage of the total wte inpost figure.

Figure 4.4

Glasgow City HSCP
Staff by Employing Authority
(as a % of total WTE)
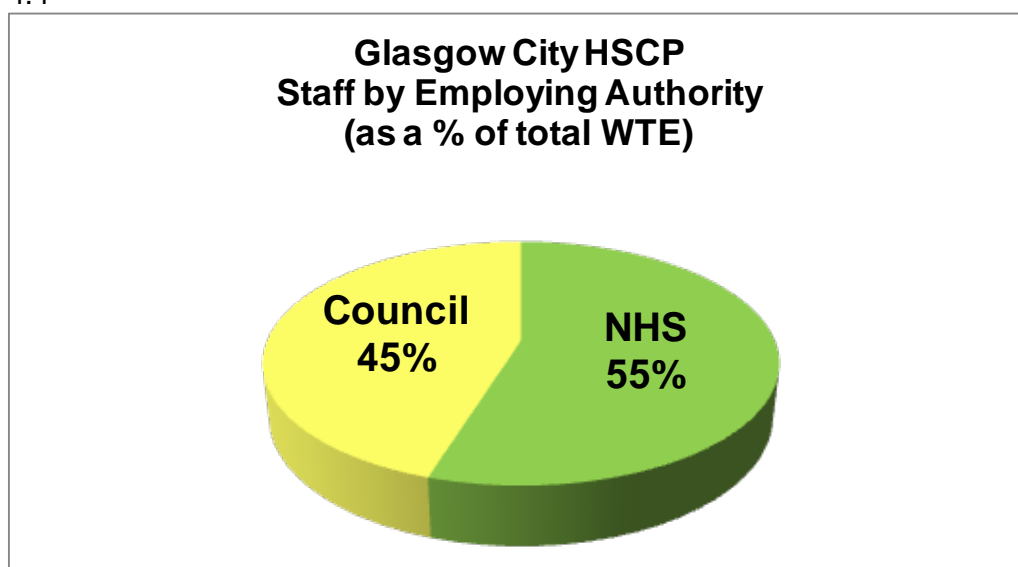
4.2 By Service Area/Leadership Group

4.2.1 Figure 4.5 shows the HSCP workforce broken down into the three core leadership groupings as well as a central business support category.

Figure 4.5

Glasgow City HSCP		
Staff in Post as at September 2016		
Headcont and WTE by Core Leadership Group		
Core Leadership Group	Headcount	WTE
Adult Services	3753	3449.18
Children & Families Services	1587	1442.31
Older Peoples Services	1935	1670.49
Business Support	551	480.40
Grand Total	7826	7042.38

4.2.2 Figure 4.6 shows the whole time equivalent workforce in core leadership groupings split by Council and NHS employing authorities.

Figure 4.6

Glasgow City HSCP			
Staff in Post as at September 2016			
WTE by Employer and Core Leadership Group			
Core Leadership Group	Council	NHS	Grand Total
Adult Services	823.74	2625.45	3449.18
Children & Families Services	1077.10	365.21	1442.31
Older Peoples Services	998.44	672.06	1670.49
Business Support	279.47	200.93	480.40
Grand Total	3178.74	3863.64	7042.38

4.3 Leavers Trends

4.3.1 Figure 4.7 shows the total WTE leavers recorded by each of the HSCP employing authorities across the 2013/14 to 2015/16 time frame.

4.3.2 The leavers figures for Council employed staff requires further explanation in that they have been affected by two "organisational change" exercises which have had an effect on the "natural" leavers patterns for the HSCP.

4.3.3 In financial year 2013/14 there was a redundancy exercise which resulted in approximately 50 wte staff exiting the organisation.

4.3.4   In financial year 2015/16 a similar number of staff transferred out of Glasgow City Council employment under Transfer of Undertaking (TUPE) regulations into other employment.

4.3.5   These two issues have had a disproportionate impact on what would be considered a usual annual leavers figure and, as such these staff have been removed to establish a more accurate leavers trend for workforce planning purposes.

Figure 4.7

Glasgow City HSCP			
WTE Staff Leavers by Financial Year and Employer*			
Financial Year Left	Council	NHS	Grand Total
2013/14	138.64	298.86	488.85
2014/15	149.41	330.10	479.85
2015/16	154.07	352.60	564.18
3 Year Average	147.38	327.19	510.96
*Corrected to Exclude NHS Hosted Services/Redundancy/TUPE			

4.3.6   Figures 4.8 and 4.9 shows the adjusted leavers figure which remove the staff who took voluntary redundancy in 2013/14 and the TUPE transfer staff in 2015/16.

Figure 4.8

Glasgow City HSCP			
Staff Leavers by Financial Year and Employer* as a % of average WTE inpost			
Financial Year Left	Council	NHS	Grand Total
2013/14	3.57%	7.42%	6.17%
2014/15	4.47%	8.40%	6.60%
2015/16	4.79%	9.08%	7.95%
3 Year Average	4.27%	8.30%	6.91%
*Corrected to Exclude NHS Hosted Services/Redundancy/TUPE			

4.3.7   Using the adjusted figures suggests a steadily increasing level of "natural" level turnover across both organisations over the previous three financial years.

Figure 4.9

Glasgow City HSCP
Adjusted WTE Leavers % 2013 to 2016

- Council
- NHS
- HSCP Average
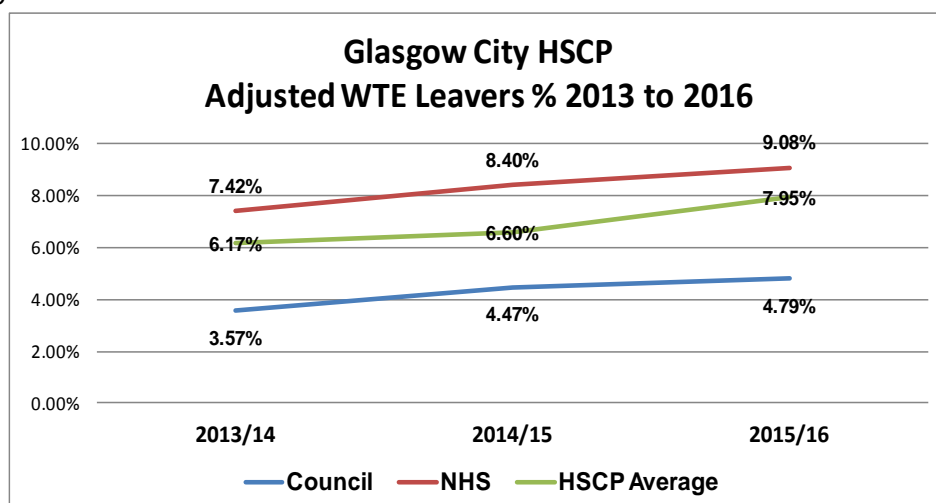
4.3.8 Once the figures have been adjusted for organisational change exercised the level of percentage turnover observed for the NHS is significantly higher than that for Council employed staff. In each of the three years NHS turnover is almost double that seen for Council staff.

4.4 Reason for Leaving

4.4.1 Further insight into patterns of turnover can be obtained from identifying the reasons provided by staff leaving the two employing organisations. This data is secured from Notification of Termination documentation completed by line managers at the time of departure. Note that in approximately 12% (NHS figure) of leavers the documentation is poorly completed and provides limited details on reasons for staff leaving.

4.4.2 For workforce planning analysis Glasgow City HSCP leavers have been broken down into three separate classifications for reason for leaving. These are:

Figure 4.10

Leavers Classification	Description
Retirals	• **Normal Age Retirals** (where staff have reached or exceeded the age retiral can take place under the employing bodies pension arrangements) • **Early Retirals** (where staff leave prior to the point retirals can take place under their existing pension arrangements with an actuarially reduced pension)
Natural Turnover	• **All resignations from current post** • **Dismissal** • **Unsatisfactory probation period** • **Death in Service** • **Ill Health** • **Unknown reason for leaving**
Organisational Change	• **Redundancies** • **Compromise Agreements** • **TUPE Transfers**

4.4.3 Figure 4.11 shows the three year retiral trends for both the HSCP employing authorities. The Council data shows that the number of retirals has doubled since 2013/14 and continued at that level in 2015/16. The figure for NHS retirals has remained between 3 and 3.5% in each of the years.

Figure 4.11
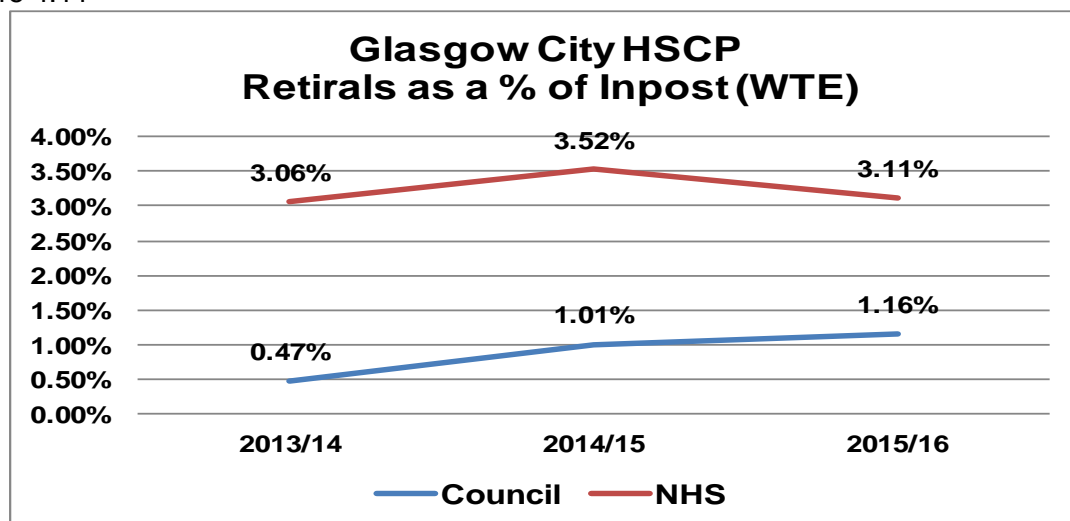
4.4.4 Figure 4.12 shows levels of natural turnover have shown a year on year increase over the past three financial years. Again the observed level for council employees (circa 3%) is lower than that for NHS employed staff which has risen from 4.36% to 5.97% over the time frame.

Figure 4.12
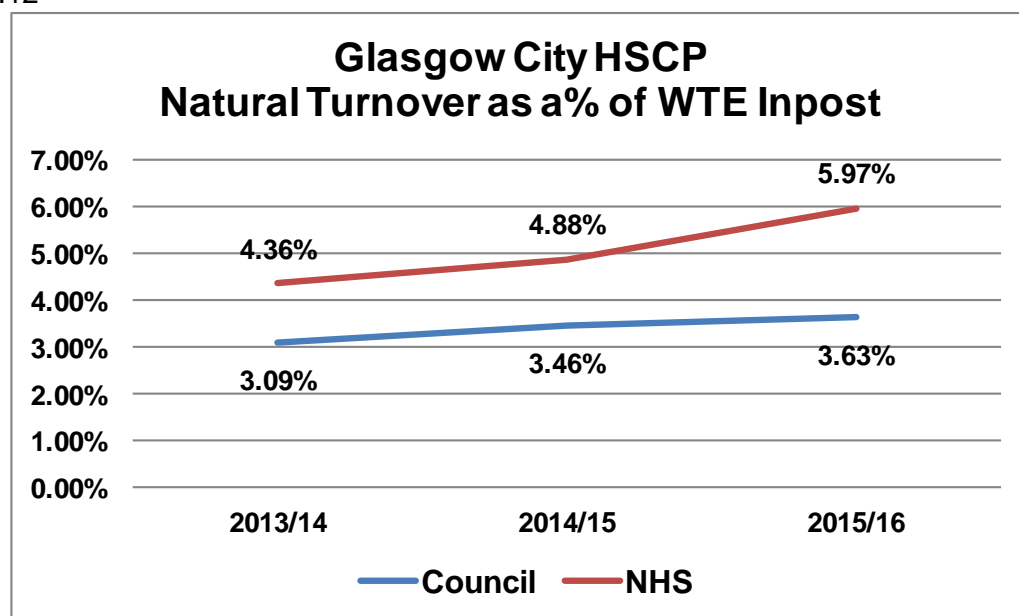
4.5 Risk of Retirals

4.5.1 The pattern of age retirals have been analysed to identify any factors which may provide additional details on the average ages where staff may choose to retire. The following factors were found to be indicative of retiral.

- Pay Band
- Job Role (Clinical vs. Non Clinical Staff)
- Pension Scheme Membership
- Enhanced Pension Status (NHS staff only)

4.5.2 Using the average age of retirals all HSCP staff have been classified into groups on the basis of the factors above and along with their current age this has been used to develop a risk of retiral for the HSCP using the following categories.

- **Red –** staff who's age, pay band and pension status indicate potential retiral by the end of the calendar year 2018
- **Amber –** anticipated retiral date during 2019 to 2022
- **Green –** anticipated retiral beyond 2022

4.5.3 Figure 4.13 shows a timeline of the estimated staff retiral years split by employing body. Note that small numbers of staff have chose to work beyond their estimated retiral year and, as such, show as years already reached.

Figure 4.13

Glasgow City HSCP
Projected Year of Retiral by Employing Body (Headcount)
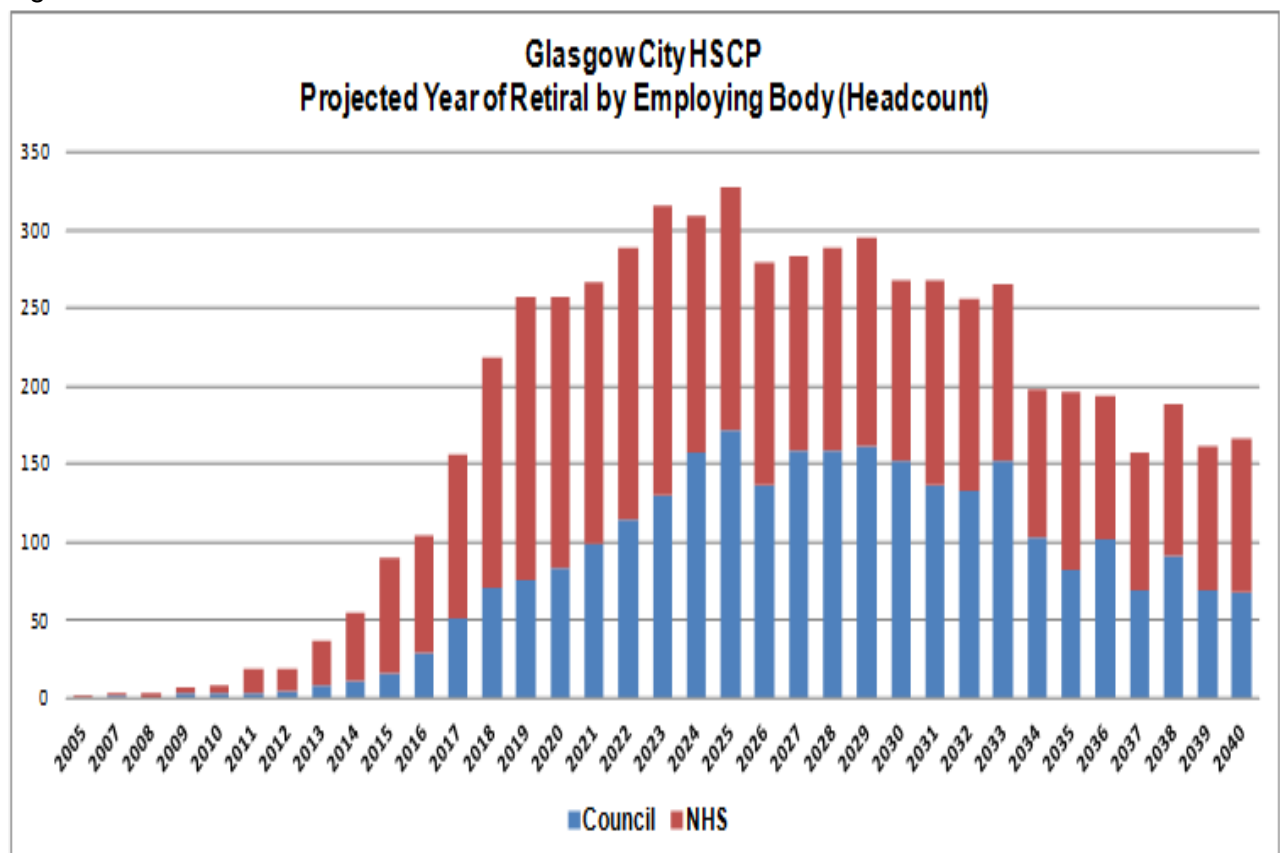
4.5.4 Figures 4.14 shows the proportion of the workforce falling into each category (as a percentage of the WTE inpost staffing levels)

Figure 4.14

Glasgow City HSCP
All Staff (WTE) Retiral Risk by Risk Category

9%   14%   77%

■ Amber   ■ Green   ■ Red
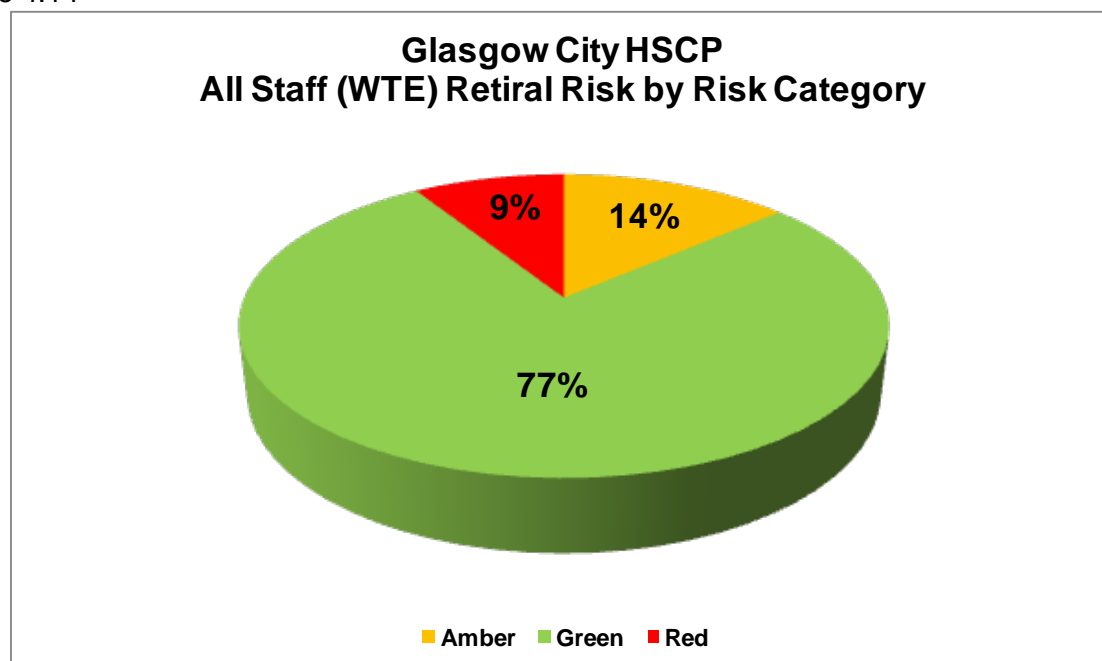
4.6 Estimated HSCP Turnover Levels

4.6.1 Using the WTE figure for the Red Retiral Risk category along with an assumed Natural Turnover rate of 3% for Council employees and 5.5% for NHS employees Figure 16 shows the potential leavers across the HSCP for the period 2016/17 to 2018/19.

Figure 4.15

Glasgow City HSCP				
Estimated WTE Staff Leavers by Category 2016-19				
Leavers Category	2016/17	2017/18	2018/19	Grand Total
Potential Retiral Pool (Red Risk)	163.00	207.99	267.25	638.24
Council Wastage (at 3.0%)	96.47	93.58	90.77	280.82
NHS Wastage (at 5.5%)	214.00	214.00	214.00	642.00
Total Estimated Leavers	473.47	515.57	572.02	1561.06

4.6.2 Note that for the purpose of this estimate that staff who have already reached their projected year of retiral (i.e. 2005 to 2015) have been evenly distributed across each of the next three financial years.

4.7 Equalities Profile

4.7.1 As noted previously in this document Glasgow City HSCP aim to remove discrimination in accessing all of our services; ensure that our services are provided in an equalities sensitive way; contribute to reducing the health gap generated by discrimination; and, work in partnership, to make Glasgow a fairer city.

4.7.2 Both the NHS Board and Council routinely publish Equalities progress reports which highlight the significant progress that is already being made.

4.7.3 For the purposes of this report this data has been amalgamated to present an overall picture of the diversity of the HSCP workforce.

4.7.4 Given that the data has been sourced from both organisations there have been some methodological issues experienced in relation to the presentation of the equalities data. Some of the diversity data definitions were not consistent between NHS and Council sources and as such have had to be amalgamated. While this is not ideal, it represents the current position in the newly integrated structure and equalities data is available for the HSCP.

4.8 Ethnicity

4.8.1 Staff in both employing organisations identified themselves a white with only a small percentage (circa 3% of NHS and Council staff) identifying themselves as Black or Minority Ethnic.

Figure 4.16

Glasgow City HSCP		
Staff Ethnicity as a % of Headcount Workforce by Employer		
Description	NHS	Council
Black or Minority Ethnic	**3.05%**	**3.44%**
White	**86.28%**	**79.25%**
Not Known	**10.67%**	**17.30%**

4.9 Religious Beliefs

4.9.1 The quality of data provided on religious beliefs is affected by the response rates with high levels of staff choosing not to disclose this information. At almost 85% the non disclosure figure for Council staff is more than double that of the NHS workforce.

Figure 4.17

Glasgow City HSCP		
Religious Beliefs as a % of Headcount Workforce by Employer		
Description	NHS	Council
Christian Based Religions	**38.51%**	**8.17%**
Other Religious Beliefs	**2.71%**	**0.82%**
No Religious Beliefs	**20.33%**	**6.20%**
Not Disclosed	**38.45%**	**84.80%**

4.10 Disability

4.10.1 The NHS workforce described a low level of staff with disabilities when compared to council figure (although both are below the estimated prevalence of disability within Scotland).

Figure 4.18

Glasgow City HSCP		
Disability Staff as a % of Headcount Workforce by Employer		
Description	NHS	Council
Staff who declared a Disability	0.60%	3.50%
Not Disabled/Chose not to answer	99.40%	96.40%
Grand Total	100.00%	100.00%

4.11 Sexual Orientation

4.11.1 Figure 4.19 shows a breakdown of the know data in relation disclosed sexual orientation.

Figure 4.19

Glasgow City HSCP		
Staff Sexual Orientation by Employer		
as a % of staff who disclosed data		
	NHS	Council
Lesbian/Gay	2.11%	4.33%
Hetrosexual	96.97%	95.29%
Bisexual	0.53%	0.38%
Other	0.40%	0.00%

5 Section Five

Action Plan

ACTION PLAN

OLDER PEOPLE'S SERVICES

Workforce Plan Reference	Description of Organisational Change Or Service Redesign	Workforce Implications	Measures of Success	Contribution to Outcomes	Leadership Group	Timescale
	Development of Older People's Neighbourhood Teams	Review of existing management structures in older people's services including the development of a flat management structure and the enhancement of frontline management posts. The establishment of integrated Service Manager posts that will manage all Health and Social Work community services for older people and people with a physical disability. The integration of the Rehab Service and the Social Work OT service.	Community-based multi-professional teams based around general practices that include generalists working alongside specialists Joint care planning and co-ordinated assessments of care needs Clinical records that are shared across the multi-professional team Streamlined	People are able to look after and improve their own health and wellbeing and live in good health for longer People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community Health and social care services are centred on helping to maintain or improve the quality of life of people who	Older People's Core Leadership Group	Dec 2017

Workforce Plan Reference	Description of Organisational Change Or Service Redesign	Workforce Implications	Measures of Success	Contribution to Outcomes	Leadership Group	Timescale
		The increased capacity of frontline management posts in District Nursing and Rehab and Support services. A detailed OD and training and development plan will be developed to ensure that staff taking on these new roles have the required skills; competency and knowledge to carry out the task. A detailed HR process and transitional management arrangements will be put in place.	access and response for service users/patients Earlier intervention and prevention approach.	use those services People using health and social care services are safe from harm		
	Development of the Home is Best Service	The development of a multi-disciplinary team to support acute admission avoidance and address delays in discharge from acute beds. An integrated Service Manager post will be developed to manage this service.	Avoid preventable admissions from front door where appropriate , 'whole system' approach -or patients/service users following assessment /screening	People are able to look after and improve their own health and wellbeing and live in good health for longer People, including those with disabilities or long term conditions, or who are frail, are able to live,	Older People's Core Leadership Group	Dec 2017

Workforce Plan Reference	Description of Organisational Change Or Service Redesign	Workforce Implications	Measures of Success	Contribution to Outcomes	Leadership Group	Timescale
		A multi-disciplinary team will be developed including Social Work; n Nursing and AHP staff. A service specification for the ream will be developed. A detailed OD and training and development plan will be developed to ensure that staff taking on these new roles have the required skills; competency and knowledge to carry out the task. A detailed HR process will be put in place for any new roles that are developed as part of this service redesign.	Plan discharge direct from admission involving patients and carers , develop a named person responsible for all aspects of the patients journey based on most relevant MDT professional Staff will work within a framework of integrated multi-disciplinary and multi- agency team working to manage all aspects of discharge.	as far as reasonably practicable, independently and at home or in a homely setting in their community Resources are used effectively and efficiently in the provision of health and social care services Health and Social Care services are centred on helping to maintain or improve the quality of life of people who use those services		
	Development of a Professional Nursing Governance and Support Structure	The separation of the general management function from the professional nursing	Accountable for both professional leadership and clinical	People who work in health and social care services feel engaged with the work they do	Older People's Core Leadership	Dec 2017

Workforce Plan Reference	Description of Organisational Change Or Service Redesign	Workforce Implications	Measures of Success	Contribution to Outcomes	Leadership Group	Timescale
		governance and support structure. The review and redesign of the adult community nurse management role. The review of the Senior Nurse role and the enhancement of the Nurse Team Lead role. The review of the Practice Development Nurse role. A professional nursing and support team will be developed which will include the Professional Nurse Advisor, Senior Nurse, Practice Development Nurses and the Vascular Nurse to deliver a professional nurse governance and support structure across the city. A detailed HR process will be put in place for any new roles that are	governance of nursing practice, professionally leading delivery, planning and development of, monitoring and review of clinical nursing practice. Provide professional leadership for nursing workforce in line with national policy including service modernisation, workforce planning, workload analysis, workforce development, recruitment and retention, performance issues, patient complaints and disciplinary matters.	and are supported to continuously improve the information, support, care and treatment they provide		

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Workforce Plan Reference	Description of Organisational Change Or Service Redesign	Workforce Implications	Measures of Success	Contribution to Outcomes	Leadership Group	Timescale
		developed as part of this service redesign.	Consistency of approach to professional issues and practice development			
	Development of Direct Access Hubs for older People's Services.	Development of a single point of access for older people and physical disability services. Review all access routes to older people's services including Single Point of Access for Nursing; OPMH services and Rehab services. Social Care Direct and Social Work duty services. Create a single point of access for all of these services in each locality and integrate staff into one multi-disciplinary team to deliver this service.	A single point of referral is established for all Health and Social Care community services for older people and people with a physical disability Service users and their carers get access to the right service at the right time.	Resources are used effectively and efficiently in the provision of Health and Social Care services People are able to look after and improve their own health and wellbeing and live in good health for longer Health and Social Care services are centred on helping to maintain or improve the quality of life of people who use those services	Older People Core Leadership	March 2018

Workforce Plan Reference	Description of Organisational Change Or Service Redesign	Workforce Implications	Measures of Success	Contribution to Outcomes	Leadership Group	Timescale
		Service Specification still to be developed but a comprehensive HR and OD programme will be developed for all staff involved.				
	Review of the external management arrangements for provided residential and day care services.	A review of the external management role and function will be established for provided residential and day care services. The current external management and support staff's role will be reviewed. A new service specification will be developed. A comprehensive OD and HR programme will be developed for staff affected by this review.	Robust support and quality assurance processes are in place for all provided residential and day care services.	Resources are used effectively and efficiently in the provision of Health and Social Care services People who work in Health and Social Care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide Health and Social Care services are centred on helping to maintain or improve the quality of life of people who use those services	Older People's Core Leadership	Dec 2017

ACTION PLAN

CHILDREN and FAMILIES SERVICES

Workforce Plan Reference	Description of Organisational Change Or Service Redesign	Workforce Implications	Measures of Success	Contribution to Outcomes	Leadership Group	Timescale
	Improve the care pathway	Staff fully involved in range of improvement projects, such as the Transformation Zone in the South and the Edge of Care programme Review of the working links between the localities and direct services	Reduction in the number of children moving into formal care More appropriate placements for young people Reduction in the use of high cost placements/ secure placements.	Resources are used more effectively	Children & Families Core leadership group	Dec 2017
	Monitor the impact of the review of management, staffing profile and skill mix to deliver on the Council's Transformation Programme	Ensure that employees are able to undertake their roles effectively and risks to children are minimised.	Structure and profile of our staff support the delivery of the strategic priorities	Resources are used more effectively	Children and families Core leadership group	On going

Workforce Plan Reference	Description of Organisational Change Or Service Redesign	Workforce Implications	Measures of Success	Contribution to Outcomes	Leadership Group	Timescale
			Contribution to Corporate Savings Achieve consistency in management to staff ratios			
	Development and implement the family support Strategy	Potential to reduce demand on workforce by preventing children needing more intensive services Involvement of workforce in developing the strategy	Improved support for families who need extra help Reduction in costs of care More flexible and robust approach to Family Support Increased sustainability, where appropriate, of family preservation and rehabilitation		Children & Families Core leadership group	Implement 2018/19
	Develop and modernise the continuing care arrangements	Role and function of staff may need to change to reflect changing profile and needs of young	Improve outcomes for young people (e.g. education,		Children & Families Core leadership group	By 2019/20

Workforce Plan Reference	Description of Organisational Change Or Service Redesign	Workforce Implications	Measures of Success	Contribution to Outcomes	Leadership Group	Timescale
		people	training, employment, housing) Enhance capacity in response to the increasing number of young people who may opt to stay in care longer.		Adult core leadership group	
	Continue to enhance kinship care services, including evaluation and possible roll out of Family Group Decision making and family finding services and utilising third sector to support long term and stable kinship placements	New roles being developed to undertake FGDM Potential reduction in workload for staff	Stability of placements Kinship care remains the primary consideration when children are no longer able to remain in the care of birth parents short term or long term.		Children & Families Core leadership group	By 2018/19
	Implement recruitment and training programme for health visiting	Substantial increase in workforce Reduction in caseload sizes	Increased capacity to focus on early intervention and prevention		Children & Families Core leadership group	Complete by 2019/20

Workforce Plan Reference	Description of Organisational Change Or Service Redesign	Workforce Implications	Measures of Success	Contribution to Outcomes	Leadership Group	Timescale
			More time spent with vulnerable families			
	Review of functions to take account of health visiting recruitment programme, including delivery of immunisation, parenting education, practice development nurse role and specialist health visiting posts	Depends on outcome of review but potential for service re-designs which may result in roles and functions of staff changing with possible re-deployment to alternative posts	Efficiency savings and improved productivity		Children & Families Core leadership group	From 2018/19
	Implement the Named Person Service Implement the new universal early years' child health pathway	Training and development requirements Changes in day to day work of staff	Enhanced focus on early intervention and prevention		Children & Families Core leadership group Children's Services Executive Group	Named person Services - Depends on legislation being in place (possibly during 2018/19) Child health pathway by 2019/20
	Complete the review of health and wellbeing for school age children and re-design of school nursing to realise the savings plan	Potential re-deployment for staff New roles and responsibilities to reflect revised functions of	Ensure a provision of health and wellbeing services for school age		Children & Families Core leadership group Child and	Review complete 2017/18 with implementation from 2018/19

Workforce Plan Reference	Description of Organisational Change Or Service Redesign	Workforce Implications	Measures of Success	Contribution to Outcomes	Leadership Group	Timescale
		school health and wellbeing services	children which takes into account both the local context the national agenda		Maternal Health Strategy Group (NHSGG&C)	
	Consider the future roll out of Family Nurse Partnership in Glasgow City as part of the wider discussions on the family support strategy.	This will depend on future funding for FNP	Promotion of early intervention and prevention Improved used of resources		Children & Families Core leadership group	2018/19
	Continue to monitor the impact on children and our staff of implementing the "critical activity" for social work staff and ensure, where possible, that risks are minimised.	Roles and functions of staff focused primarily on a core set of activities which limits the wider support that they can provide for children and families.	Risks to children are minimised		Children & Families Core leadership group	Ongoing
	Review and re-design of commissioned services	Workforce involved in review and re-design process Should support staff in providing more effective services for children and families	Greater focus on early intervention and prevention Improved use of resources		Children & Families Core leadership group	By 2019/20
	Review and transform residential care • Continue the building modernisation programme	Investment in training and development of workforce	Creating flexibility and space within residential care in response to the		Children & Families Core leadership group	By 2019/20

Workforce Plan Reference	Description of Organisational Change Or Service Redesign	Workforce Implications	Measures of Success	Contribution to Outcomes	Leadership Group	Timescale
	through investment in new build residential units. • Re-design of services to reflect changing profile of looked after children, such as the increasing number of younger children (under 12) and older young people who are staying in care longer but are not ready to move on to supported accommodation • Creating capacity and re-designing services to enable young people who are in high cost placements to reside in our own provided units. • Residential Unit Managers will chair the reviews of care plans for looked after children reviews • Responding to the Scottish Government's requirement all residential workers to have Level 9, degree level qualification	Involvement of workforce in re-design programme Potential for roles and functions of staff to change to reflect changes in service specification	increase in demand as a result of the expansion in continuing care Improving outcomes for young people			

ACTION PLAN

ADULT SERVICES

Workforce Plan Reference	Description of Organisational Change Or Service Redesign	Workforce Implications	Measures of Success	Contribution to Outcomes	Leadership Group	Timescale
	Learning Disability • Develop a 5 year plan to ensure that services are delivered within projected financial parameters • Manage associated workforce consequences of the implementation of a NHSGGC-wide resource allocation model (RAM).	Develop a workforce plan to support planned change	Continued delivery of LD care with minimum service impact	People using health and social care services are free from harm. Resources are used efficiently and effectively	Adult Core Leadership Group	2017/18
	Alcohol & Drugs Day Service • Develop a 5 year plan to ensure that services are delivered within projected financial parameters • Implementation of day service review - Move day services to a single model in April 2017 and consolidation onto a single site from October 2017	Develop a workforce plan to support planned change This will include a reduction in workforce which is being managed within the wider Alcohol & Drugs Service.		People using health and social care services are free from harm. Resources are used efficiently and effectively	Adult Core Leadership Group	October 2017

Workforce Plan Reference	Description of Organisational Change Or Service Redesign	Workforce Implications	Measures of Success	Contribution to Outcomes	Leadership Group	Timescale
	• Review of Prevention & Education contracts	Existing contracts are due to be terminated in June 2017 New contract sum will be less than the current value.				June 2017
	Sexual Health Services • Clinical resource and change programme	Review of management and team structures, localities and workforce skill mix.	Make more efficient use of resources through the development of self-management options	Resources are used efficiently and effectively		Update the IJB by September 2017. Recommendations to be fully implemented by 2018/9
	Mental Health • Develop a 5 year plan to ensure that services are delivered within projected financial parameters • Unscheduled Care Review - Review of NHS Mental Health out of hours CPN, all MH Liaison and Crisis services to ensure we have a co-ordinated 24/7 MH response to unscheduled care for Primary Care services and Acute Hospitals.	Develop a workforce plan to support planned change	Streamlined Service arrangements will deliver a more cost-efficient service whilst continuing to deliver current performance necessary to support a reducing inpatient model.	People using health and social care services are free from harm. Resources are used efficiently and effectively	Adult Core Leadership Group	October 2017

Workforce Plan Reference	Description of Organisational Change Or Service Redesign	Workforce Implications	Measures of Success	Contribution to Outcomes	Leadership Group	Timescale
	• Primary Care Mental Health Team review	Review existing functions including commissioned options and increased use of e-Health solutions.				
	• Review of Psychotherapy Services	The redesign will address current resources shortfall in North West Glasgow and also address savings requirements.	Deliver the requirement that more patients will access the service and at the same time continue to delivery 18-week target.			
	• Review of Adult Inpatient Bed Capacity	Capital investment, delivering improved estate on Stobhill site. Investment will release fixed costs and overheads currently consumed at Parkhead.				
	Mental Health Services – Reviews of Specialist Services • Early Intervention for Psychosis Service - (Esteem) • DART service review - liaison	Workforce areas for consideration include business processes, skill mix, and other support costs.	Redesigns will seek to identify areas for improved efficiency with minimal impact			

Workforce Plan Reference	Description of Organisational Change Or Service Redesign	Workforce Implications	Measures of Success	Contribution to Outcomes	Leadership Group	Timescale
	function in conjunction with the local community mental health resource centres to return people to home.		on front line services including performance and quality.			
	• PSYCIS Review - clinical and demographic information on people who are in contact with Adult Mental Health Service's in Glasgow & Clyde with a diagnosis of psychosis					
	• TRAUMA Review - includes newly configured NHS GGC wide service, delivering responses for people who have mental health difficulties following traumatic events.					
	• GIPSI/SPRINT Review- supervision and skills based training to staff in psychosocial interventions for those with mental disorders and research in psychosocial therapies					
	• RESTART review - vocational training, workshops and meaningful to those with severe and enduring mental health conditions					

Workforce Plan Reference	Description of Organisational Change Or Service Redesign	Workforce Implications	Measures of Success	Contribution to Outcomes	Leadership Group	Timescale
	Occupational Therapy Review • Review role of Occupational Therapists in traditional Health and Social Work roles and to consider how these currently distinct services can become more connected. • Review the OT support staff role and consider where they are best placed within the care pathway • Develop a performance management system for OT	Workforce Skill Mix implications arising from review of roles	Occupational Therapy resource in the community to facilitate early discharge and provide re-ablement and rehabilitation		OT Professional Lead	March 2018
	Homelessness Services Review • Establish project team to develop a project plan and to formalise recommendations for more effective cross care service delivery		Transformational change and financial efficiencies arising from a more rational redeployment of directly provided purchased resources and a more defined role for the voluntary sector.			

ACTION PLAN

CORPORATE SERVICES

Workforce Plan Reference	Description of Organisational Change Or Service Redesign	Workforce Implications	Measures of Success	Contribution to Outcomes	Leadership Group	
	The development of integrated and multi-disciplinary team working arrangements - including purpose, roles , responsibilities and objectives	Review of existing structures. Establishment of integrated management posts and teams Development of integrated roles and objectives Ensure good understanding of all organisational requirements for both NHS and GCC staff	Seamless co-ordination of HSCP priorities in terms of service planning and delivery. Clarity of objectives and expected outcomes for all service areas Single HSCP culture and structures across the organisation	Effective and responsive organisational arrangements ensuring delivery of effective care in all services	SMT	2017-19
	Review and implement streamlined and improved professional leadership and advisory arrangements – links to decision	Review of existing structures to reflect on new integrated working	Recognised, joint professional leadership	Health and social care services are focussed on maintaining or	SMT	

Workforce Plan Reference	Description of Organisational Change Or Service Redesign	Workforce Implications	Measures of Success	Contribution to Outcomes	Leadership Group	
	making and communication structures	arrangements and ensure that these reflect new ways of working Reflect on any opportunities for integrated professional leadership	structures in place across services	improving the quality of care and life of service users		
	Support the development of strong teams including agreed and resourced team leader spans of control and skill mix.- manage risk, support innovation , develop new ways of working	As service redesigns move forward ensure agreed team management models are developed and implemented consistently within each service area, reflecting local requirements. Ensure relevant and effective learning plans are in place for all service areas. Ensure ongoing	Confirmed staffing models reflecting care group service delivery and consistent management arrangements. Staff are clear on responsibilities and actively engaged in service	Resources are used effectively and efficiently in the provision of health and social care services	SMT	

Workforce Plan Reference	Description of Organisational Change Or Service Redesign	Workforce Implications	Measures of Success	Contribution to Outcomes	Leadership Group	
		engagement with staff to encourage comment and feedback on opportunities to continue to improve service delivery.	improvement across the HSCP.			
	Further development of organisational supports to maximise front line staff efficiency and effectiveness including improvement in IT arrangements to support agile/flexible working, accommodation solutions to support co-location, business support including administration systems One HSCP induction and on-going development arrangements	Focus on sharing and improving a joined up I T infrastructure for all staff as far as possible. Development of a common approach to accommodation arrangements and flexible or agile staffing detail as accommodation arrangements evolve across the HSCP Develop a single induction programme for new staff and managers of integrated teams to ensure clear understanding of organisational	Less duplication of work, more streamlined I T processes in place freeing up more time for service delivery. Staff and managers feel informed and able to access any required organisational information	Resources are used effectively and efficiently in the provision of Health and Social Care services	SMT	2017-19

Workforce Plan Reference	Description of Organisational Change Or Service Redesign	Workforce Implications	Measures of Success	Contribution to Outcomes	Leadership Group	
		arrangements and consistency of approach to policy interpretation and application.				
	Structures and resourced PDP arrangements, iMatters, team development and organisational culture etc. – opportunities for succession planning	All staff must have a completed PDP in place, reviewed annually in line with organisation and professional requirements.

Additional resource has temporarily been identified for iMatter implementation. Further discussion required re mainstreaming of processes moving forward

OD and learning and education plans to be in place across all service areas | Measurable improvement in eKSF and PDP compliance levels for all staff across the HSCP demonstrating active engagement with staff about their learning and development requirements.

Following completion of iMatter survey processes, action plans in place reflecting local priorities highlighted by the engagement | Staff are appropriately trained and engaged within their teams and service areas. | SMT | |

Workforce Plan Reference	Description of Organisational Change Or Service Redesign	Workforce Implications	Measures of Success	Contribution to Outcomes	Leadership Group	
			process and preparation underway for further surveys.			
	The development of a change agent team, mentoring and coaching opportunities as part of our improvement programme	Enhance current OD team with improvement specialists and use improvement skills within HSCP appropriately to support change	Clear and consistent support to large scale pieces of change Measurable improvements ROI conducted	Resources are used effectively and efficiently in the provision of Health and Social Care services Staff are appropriately trained and engaged within their teams and service areas.	Integration Transition Board	Sept 2017
	Invest in systems and capacity to develop improved and real time workforce planning information	Proposals to develop an integrated HR function are to be scoped. Within this there is a need to focus on workforce planning resource for the HSCP to reflect both health and social care information needs. This will include a review of current staffing arrangements within the	Local workforce planning capacity is responsive to any information requirements and working closely and participating in service redesign discussions.	Resources are used effectively and efficiently in the provision of Health and Social Care services	SMT	2017/18

Workforce Plan Reference	Description of Organisational Change Or Service Redesign	Workforce Implications	Measures of Success	Contribution to Outcomes	Leadership Group	
		teams. Current information systems within Social care are responsive to real time requirements. Health will implement eESS in due course, but this is a number of years ahead. In the interim further work regarding use of SSTS should continue	HR process become increasingly streamlined and, where possible single processes have been implemented to simplify approaches to HR work, e.g. recruitment and advertising process, knowledge and implementation of policy, etc			
	Implement a management and leadership review that results in efficient and effective arrangements and protects front line capacity. – define relevant competencies and ways to measure them	Review and streamlining of senior management and leadership arrangements within the HSCP, ultimately reducing the numbers of senior management posts within the HSCP.	Clear governance and decision making arrangements are established and understood. More cost efficient	Resources are used effectively and efficiently in the provision of Health and Social Care services		

Workforce Plan Reference	Description of Organisational Change Or Service Redesign	Workforce Implications	Measures of Success	Contribution to Outcomes	Leadership Group	
			management and leadership arrangements are established Enhanced and productive partnership arrangements are developed and resourced.			

6 Section Six

Implementation, Monitoring & Review

6.1 Workforce Plan Governance & Monitoring

6.1.1   Monitoring of progress with the actions and intentions set out in the 2017/20 Workforce Plan will be carried out within the governance framework described in this document.

6.1.2   The Workforce Plan will be published on the HSCP webpage after it has been approved by the Integration Joint Board (IJB).

6.1.3   The initiation and implementation of service plans and redesigns and the consequent workforce implications are also closely monitored and progress will be reported to local management and partnership groups as appropriate.

6.1.4   It should be recognised by all stakeholders that the redesign and service change plans set out in this Workforce Plan are at varying stages of development and implementation. In addition a number of the projects are still the subject of continuing discussion with Staff Side and therefore outcomes may change as consultations are completed. This flexibility is reflected in the narrative of the plan. Some of these plans will change in response to external influences and events and this may affect projected workforce change.

6.1.5   The achievement and implementation of specific actions within the 2017/20 Workforce Plan will be reviewed by the Senior Management Team (SMT), Staff Partnership Forum (SPF), Trade Union liaison arrangements and, ultimately, the Glasgow City HSCP Workforce Board.

7 Appendices

7.1 The 6 Steps Methodology

The 6 Steps Methodology sets out a consistent, practical framework that outlines the elements that should be contained in workforce plans whether they are at departmental, service or Board level.

The format of the guidance reflects the 6 Step Methodology to Integrated Workforce Planning and contains workforce planning checklists at each step of the process and sign-posts to other data and information sources that will be of particular help in ensuring that workforce plans are evidence based.
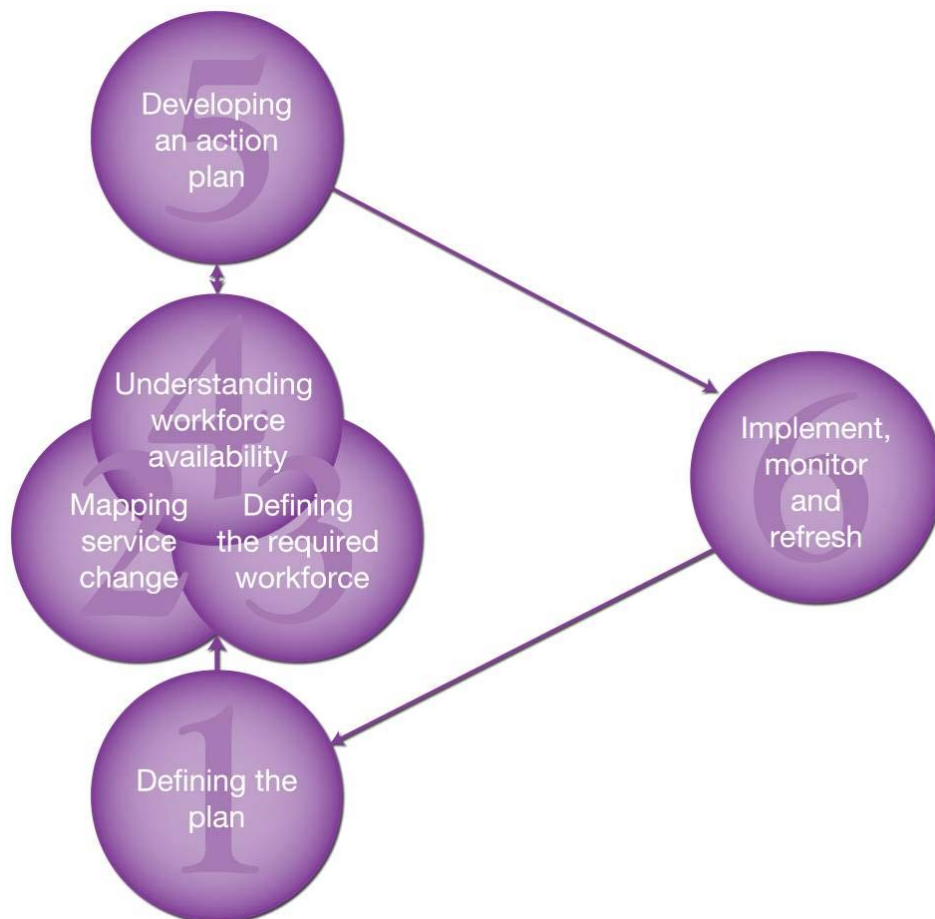
Step 1 - Defining the Plan

Is the first step in any planning process and outlines why a workforce plan is necessary and how it will support the achievement of wider corporate goals and objectives. The purpose, scope and ownership of the workforce plan are made explicitly clear within this section.

Step 2 - Service Change

The second step of the plan indicates the goals and benefits of change, the future context for how services will be delivered. At this point it important to identify the options for future service delivery, the drivers for and/or constraints against future changes and what any preferred option(s) might look like.

This step is an excellent way of ensuring appropriate engagement with a range of stakeholders in the planning process.

From here is it possible to determine the specific benefits, goals and objectives of any future service delivery. It is also possible to begin to create a range of service scenarios for the future and how this may specifically impact on the workforce.

Care must be taken not to unduly replicate information that is available in other plans such as the Local Delivery Plan (LDP), finance plan, service plans etc. The intention is not to duplicate information but to ensure that underpinning information and context is taken into consideration.

Step 3 – Defining the Required Workforce

This step should outline the workforce required to meet the predicted service needs and requires all of the key issues local and national which will impact on workforce design and deployment to be taken into account.

Step 4 – Workforce Capability

Describes the characteristics of the current workforce (i.e. baseline data), how any supply data can inform workforce forecasting and identify what options can be implemented in managing future supply.

Step 5 – Action Plan

Developing an action plan is a high priority in the process because it identifies the actions and sets out how these will be progressed and managed.

Step 6 – Implementation and Monitoring.

Step 6 is the monitoring process for plans, it also allows for reflection on actions and taking account of any new drivers and any unintended consequences of developments.

7.2 Appendix 2 - Glasgow City HSCP Workforce Plan Board Membership

Suzanne Miller, Chief Officer, Strategy and Planning

Alex MacKenzie, Chief Officer, Operations

Sharon Wearing, Chief Officer, Finance and Resources

Christina Heuston, Head of Corporate Services

Sybil Canavan, Head of People and Change

Chris Carron, Workforce Planning Lead, NHSGGC

David Walker, Head of Operations, South

Jackie Kerr, Head of Operations, North West

Anne-Marie Rafferty, Head of Operations, North East

Sheena Morrison, Head of Public Protection & Quality Assurance

Colin Christie, Head of SWS Finance

Johnny Bryden, Head of Finance - NHS