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**Item No: 10**

**Meeting Date: Wednesday 24<sup>th</sup> June 2026**

## **Glasgow City Integration Joint Board**

**Report By: Pat Togher, Chief Officer**

**Contact: Duncan Goldie, Performance Planning Manager**

**Phone: 07917 040856**

### **Annual Performance Report 2025-26**

**Purpose of Report:**

To present and seek approval of the Full (Appendix 1) and Summary (Appendix 2) Annual Performance Reports for the Health and Social Care Partnership for the year 2025-26.

**Background/Engagement:**

The Public Bodies (Joint Working) (Scotland) Act 2014 requires Integration Joint Boards to publish an Annual Performance Report (APR) by the 31 July each year, setting out an assessment of their performance in planning and carrying out those functions for which they are responsible over the last financial year.

Guidance upon these APRs has been published by the Scottish Government, which indicates that they are primarily for consideration by the Partnerships themselves, who have responsibility to act upon the information and recommendations within them. It also states that they should be made accessible to local communities and the wider public, using diverse forms of publication such as easy read versions or shorter summaries.

To date, there have been nine [Annual Performance Reports](#) produced for Glasgow HSCP, covering the financial years 2016-17 to 2024-25. along with accompanying summary documents,

**Governance Route:**

The matters contained within this paper have been previously considered by the following group(s) as part of its development.

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|  |   |
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|  | HSCP Senior Management Team <input checked="" type="checkbox"/><br>Council Corporate Management Team <input type="checkbox"/><br>Health Board Corporate Management Team <input type="checkbox"/><br>Council Committee <input type="checkbox"/><br>Update requested by IJB <input type="checkbox"/><br>Other <input type="checkbox"/><br>Not Applicable <input type="checkbox"/> |
|--|---|

|                         |  |
|-------------------------|--|
| <b>Recommendations:</b> | The Integration Joint Board is asked to:<br><br>a) Approve the Full (Appendix 1) and the Summary (Appendix 2) Annual Performance Reports for 2025-26;<br>b) Note that some final year-end figures will be included within these reports once available; and<br>c) Approve that responsibility for any final amendments to the reports to incorporate these year-end figures, will be delegated to the Chief Officer. |
|-------------------------|--|

### Relevance to Integration Joint Board Strategic Plan:

|  |
|--|
| The report contributes to the ongoing requirement for the Integration Joint Board to provide scrutiny over HSCP operational performance, as outlined within the Strategic Plan, and review performance against agreed local and national performance indicators. |
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### Implications for Health and Social Care Partnership:

|   |   |
|---|---|
| <b>Reference to National Health &amp; Wellbeing Outcome(s):</b> | HSCP activity and performance within the report is mapped against the Partnership's strategic priorities and the 9 National Health and Wellbeing Outcomes ensuring that performance management activity within the Partnership is outcomes focused. |
|---|---|

|                   |  |
|-------------------|--|
| <b>Personnel:</b> | Activity and Performance in relation to Human Resources is included in the report. |
|-------------------|--|

|                |   |
|----------------|---|
| <b>Carers:</b> | Activity and Performance in relation to Carers is included in the report. |
|----------------|---|

|                                |      |
|--------------------------------|------|
| <b>Provider Organisations:</b> | None |
|--------------------------------|------|

|                    |  |
|--------------------|--|
| <b>Equalities:</b> | An Equalities section is included in the report. |
|--------------------|--|

|                                    |                |
|------------------------------------|----------------|
| <b>Fairer Scotland Compliance:</b> | Not applicable |
|------------------------------------|----------------|

|                   |      |
|-------------------|------|
| <b>Financial:</b> | None |
|-------------------|------|

|               |   |
|---------------|---|
| <b>Legal:</b> | This Annual Performance Report (APR) is required to be published within 4 months of the end of each reporting |
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|  | year (by 31 July) in line with the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014. |
| <b>Economic Impact:</b>                                    | None  |
| <b>Sustainability:</b>                                     | None  |
| <b>Sustainable Procurement and Article 19:</b>             | None  |
| <b>Risk Implications:</b>                                  | None  |
| <b>Implications for Glasgow City Council:</b>              | The Integration Joint Board's performance framework includes social work performance indicators.          |
| <b>Implications for NHS Greater Glasgow &amp; Clyde:</b>   | The Integration Joint Board's performance framework includes health performance indicators.               |
| <b>Direction Required to Council, Health Board or Both</b> |   |
| <b>Direction to:</b>                                       |   |
| 1. No Direction Required                                   | <input checked="" type="checkbox"/>   |
| 2. Glasgow City Council                                    | <input type="checkbox"/>  |
| 3. NHS Greater Glasgow & Clyde                             | <input type="checkbox"/>  |
| 4. Glasgow City Council and NHS Greater Glasgow & Clyde    | <input type="checkbox"/>  |

### 1. Purpose

- 1.1 The purpose of this report is to present and seek approval of the Full (Appendix 1) and Summary (Appendix 2) Annual Performance Reports (APR) for Glasgow Health and Social Care Partnership for 2025-26.

### 2. Background

#### *Scottish Government Performance Guidance*

- 2.1 The Public Bodies (Joint Working) (Scotland) Act 2014 requires the Integration Joint Board to publish an Annual Performance Report, setting out an assessment of performance in planning and carrying out those functions for which they are responsible. This Annual Performance Report is required to be published within 4 months of the end of each reporting year (by 31 July).
- 2.2 Guidance on these Annual Performance reports was produced by the Scottish Government in March 2016 and reviewed in 2024. This indicates that APRs are for HSCPs to provide an assessment of performance in planning and carrying out the integrated functions for which they are responsible. It states that they are to be produced for the consideration of the Partnerships themselves, and it is primarily their responsibility to act upon the information and recommendations within them. It also indicates that the reports should be made available online with consideration

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given to making them accessible to their local communities and the wider public, using diverse forms of publication such as easy read versions or shorter summaries.

### *Developing the HSCP Performance Culture*

- 2.3 Performance management is at the heart of the work of the HSCP with a comprehensive Performance Framework and a range of mechanisms in place to scrutinise performance. In addition to the attached Annual Performance Report (APR), these include the production of a Quarterly Performance Report (QPR) which is shared with and scrutinised by individual services, the HSCP Senior Management Team and the IJB Finance, Audit and Scrutiny Committee (FASC). FASC also receives updates on the delivery of the wider Strategic Plan; and reviews and responds to Inspection Reports produced by local audit teams or by national agencies such as Healthcare Improvement Scotland and the Care Inspectorate. Robust professional and clinical governance structures are also in place, overseen by an Integrated Clinical and Professional Governance Group.
- 2.4 Work has been undertaken over the last 18 months to review and refresh the performance management culture within the HSCP, with the aim of ensuring officers retain a focus on improving performance as a core and routine part of their role. The results of this review were reported to FASC in [December 2025](#), with a number of actions identified to further develop and embed a performance culture within the HSCP. These include the establishment of a monthly Performance and Finance Reporting meeting, along with new Performance Oversight Boards for each Assistant Chief Officer's area of responsibility. These are promoting accountability for financial and service performance and improvement and are being chaired by the HSCP Chief Officer.
- 2.5 A key part of the work to develop and embed a performance culture is the alignment of the performance management framework with the revised risk policy and strategy. A key proposal being considered for the revised risk policy is alignment with the "three lines of defence" model, which clarifies responsibilities for **managing** risk, **overseeing** risk and providing independent **assurance**. The intention is to provide evidence risks are being effectively controlled by linking them to relevant Key Performance Indicators, internal audit and inspection findings etc.

## **3. Recommendations**

- 3.1 The Integration Joint Board is asked to:
- a) Approve the Full (Appendix 1) and the Summary (Appendix 2) Annual Performance Reports for 2025-26;
  - b) Note that some final year-end figures will be included once available; and
  - c) Approve that responsibility for any final amendments to the report to incorporate these year-end figures will be delegated to the Chief Officer.

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# GLASGOW CITY HSCP ANNUAL PERFORMANCE REPORT 2025/26



| <b>SECTION</b>  | <b>PAGE NUMBER</b> |
|---|--------------------|
| <b>1. INTRODUCTION</b>  | <b>4</b>           |
| <b>2. DELIVERING OUR KEY PRIORITIES</b>                             | <b>15</b>          |
| <b>3. PREVENTION, EARLY INTERVENTION AND WELLBEING</b>              | <b>17</b>          |
| <b>4. SUPPORTING GREATER SELF-DETERMINATION AND INFORMED CHOICE</b> | <b>34</b>          |
| <b>5. SUPPORTING PEOPLE IN THEIR COMMUNITIES</b>                    | <b>48</b>          |
| <b>6. STRENGTHENING COMMUNITIES TO REDUCE HARM</b>                  | <b>76</b>          |
| <b>7. A HEALTHY, VALUED AND SUPPORTED WORKFORCE</b>                 | <b>85</b>          |
| <b>8. BUILDING A SUSTAINABLE FUTURE</b>                             | <b>93</b>          |
| <b>9. EQUALTIES</b>   | <b>98</b>          |
| <b>10. INSPECTION AND PRACTICE AUDIT</b>                            | <b>101</b>         |
| <b>11. FINANCIAL PERFORMANCE</b>                                    | <b>107</b>         |
| <b>Appendix A – City Profile – Additional Information</b>           | <b>114</b>         |
| <b>Appendix B – National Health &amp; Wellbeing Outcomes</b>        | <b>117</b>         |
| <b>Appendix C – National Integration Indicators</b>                 | <b>118</b>         |



# 1. INTRODUCTION



## 1. INTRODUCTION

### 1.1 PURPOSE OF REPORT

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

This is the tenth Annual Performance Report for the Glasgow City Integration Joint Board (IJB). Within it, we review our performance and demonstrate how we have taking forward our Strategic Priorities, as set out in our [Strategic Plan](#), by:

- Providing examples of key service developments and achievements which we have progressed over the last 12 months in relation to each Strategic Priority;
- Reviewing performance against our local Key Performance Indicators; and the [National Integration Indicators \(Appendix C\)](#) published by the Scottish Government to measure progress against the [National Health and Wellbeing Outcomes \(Appendix B\)](#).
- Demonstrating the impact of our service interventions at an individual level, by drawing upon examples of case studies, surveys and other user/carer/staff feedback mechanisms.

### 1.2 PARTNERSHIP OVERVIEW

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

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

- School nursing and health visiting services
- Social care services for adults and older people
- Carers support services
- Social care services provided to children and families
- Homelessness services
- Justice social work services
- Police custody and prison healthcare services
- Palliative care services
- District nursing services
- Services provided by allied health professionals
- Dental services
- Primary care medical services (including out of hours)
- Ophthalmic services
- Pharmaceutical services
- Sexual health services
- Mental health services
- Alcohol and drug services

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- Services to promote public health and improvement
- Strategic planning for hospital accident and emergency services
- Strategic planning for inpatient hospital services relating to general medicine; geriatric medicine; rehabilitation medicine; and respiratory medicine

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

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

Across all services, as of March 2026, the Health and Social Care Partnership has a workforce of 10,975 Whole Time Equivalent (WTE) staff, made up of 6,238 WTE employed by Glasgow City Council and 4,737 by NHS Greater Glasgow and Clyde.

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

Within the Partnership's area, there are 138 GP practices providing general medical services to their practice populations. There are also 157 community pharmacies, 115 optometry practices and 157 dental practices which includes 7 orthodontic practices.

### 1.3 AREA PROFILE

Key demographic characteristics of the city are summarised below. A more comprehensive [Demographics and Needs Profile](#) is available, which includes data on population, health, lifestyles, poverty and deprivation. The profile also covers other topics including social care, social health/capital, education, learning, employment and crime. Other information sources where further information can be found are listed in Appendix A.

#### Population

Glasgow has a population of 650,300. It is densely populated with 3,724 people per km<sup>2</sup>, with 31.4% of residents living in houses and 68.6% living in flats. This is very different from the Scottish average of 71 people per km<sup>2</sup>, where more than two thirds live in houses (67.3%) (Sources: NRS Small Area Population Estimates (SAPE) Mid-2024; Scottish Household Survey (2024)).

Glasgow is a diverse city. Of those who disclosed their country of origin, 80.9% were born in the UK and 19.1% outside the UK. This percentage from outwith the UK is almost double that of Scotland as a whole (where 10.2% are from outside the UK (Sources: NRS Small Area Population Estimates (SAPE) Mid-2024; Scotland's Census (2022)).

80.7% of Glasgow's total population has a White ethnic background, with 19.3% from a Black or Minority Ethnic (BME) background, compared to 92.9% (White) and 7.1%

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(BME) for Scotland as a whole. The proportion of Glasgow local authority school pupils with a non-white ethnic background is 31.4% compared to 13.3% across Scotland. (Sources: NRS Small Area Population Estimates (SAPE) Mid-2024; Scotland's Census (2022); Scottish Government Pupil Census - Supplementary Statistics (2025)).

### Projected Population

In 2024, the National Records of Scotland (NRS) produced estimated 2022-based population projections. These indicate that:

- The overall population of Glasgow is expected to grow by 2.7% in the five-year period between 2026 and 2031; 4.7% in the ten-year period between 2026 and 2036; and 7.3% in the 21-year period between 2026 and 2047
- Scotland's population is also expected to grow overall, by 1.3% between 2026 and 2031; by 2.2% between 2026 and 2036; and by 3.2% between 2026 and 2047
- Within the overall increase in Glasgow between 2026 and 2036, the child population (0-17 years) is forecast to decrease by 1.3%; the adult (18-64 years) population is expected to increase by 3.5%; and the older people (65+) population is expected to increase by 18.1%
- This compares to expected decreases in both the child and adult populations (7.6% and 0.9% respectively) and an increase of 19.2% in the older people population across Scotland as a whole (Source: NRS Population Projections 2022)

### Life Expectancy

The Life Expectancy (LE) and Healthy Life Expectancy (HLE) indicators shown below illustrate that on average, Glasgow residents live fewer years in good health and die younger than Scotland's population. The figures for males for both measures are lower than those for females.

- A Glasgow male baby aged under one year is expected to live to 55.7 years of age in good health (HLE), with a Scottish male expected to live a further 3.4 years in good health (to 59.1 years)
- A Glasgow female baby aged under one year is expected to live to 56.1 years of age in good health (HLE), with a Scottish female expected to live a further 3.3 years in good health (to 59.4 years)
- A Glasgow male baby aged under one year is expected to live to 74.3 years of age (LE), compared to 77.2 years for a Scottish male (2.9 years less)
- A Glasgow female baby aged under one year is expected to live to 78.7 years of age (LE), compared to 81.1 years for a Scottish female (2.4 years less)

Glasgow has higher than average death rates attributable to a range of causes. The death rate from all causes for people under 75 in Glasgow, is 584 per 100,000 population, more than 1.3 times the Scottish average rate (434.8 per 100,000 population) (Sources: Public Health Scotland (2022-2024)).

### Key Health and Wellbeing Indicators

The following indicators illustrate some key features of the health of Glasgow's population, as well as factors that may impact upon their health. More detailed

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information on these and other related indicators can be found in our [Demographics and Needs Profile](#):

- 72.7% of people in Glasgow rated their health as good/very good compared to 72.3% for Scotland (Source: Scottish Surveys Core Questions (2024))
- 73.7% of Glasgow P5-S6 school pupils rated their health positively, similar to Scotland as a whole (73.9%) (Source: Scottish Government Schools Health and Wellbeing Census (2021/22))
- 10.8% of people in Glasgow rated their health as bad/very bad, compared to 8.7% in Scotland (Source: Scottish Surveys Core Questions (2024)).
- 29.0% of Glasgow adults have a limiting condition or illness (Source: NHSGGC Adult Health and Wellbeing Survey – Glasgow City (2022/23))
- 16.0% of Glasgow P5-S6 school pupils have a long term physical or mental health condition or illness, compared to 14.2% of Scottish pupils (Source: Scottish Government Schools Health and Wellbeing Census (2021/22))
- 27.0% of Glasgow adults have common mental health problems, scoring 4+ on GHQ12a, compared to 23.0% of Scottish adults (Source: Scottish Health Survey (She's) (2021 to 2024))
- 30.0% of Glasgow S2-S6 school pupils have a WEMWBS wellbeing score indicating probable depression (Source: Scottish Government (Schools) Health and Wellbeing Census 2021/22 - Glasgow City Council Education Services Infographics)
- 5,959 people living in Glasgow are estimated to have dementia; the percentage population ranges from 0.82% in Glasgow North constituency to 1.11% in Glasgow South constituency (Source: Alzheimer's Research UK Dementia Prevalence by UK Constituency 2024)
- 61.0% of Glasgow adults are overweight (BMI of 25 or higher) whilst 29.0% are obese (BMI of 30 or higher) compared to 66.0% overweight and 31.0% obese across Scotland (Source: Scottish Health Survey (2021 to 2024))
- 25.0% of Glasgow adult males and 18.0% of Glasgow adult females are current smokers (Source: NHSGGC Adult Health and Wellbeing Survey – Glasgow City 2022/23))

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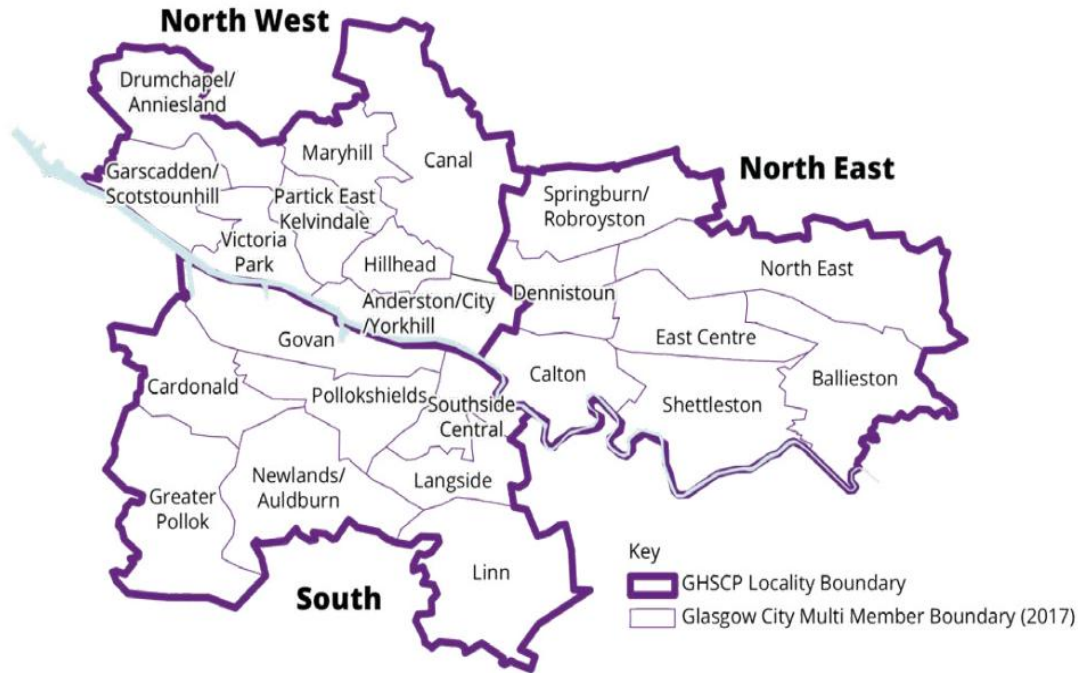


- 2.1% of Glasgow S2 and S4 school pupils are current smokers and 5.4% are current vapers, lower than the comparative rates for Scotland of 2.7% (smoking) and 6.7% (vaping). (Source: Scottish Government Schools Health and Wellbeing Census (2021/22))
- 29.0% of adult males and 15.0% of adult females in Glasgow have hazardous /harmful levels of alcohol consumption, compared to 30.0% (males) and 14.0% (females) across Scotland (Source: Scottish Health Survey (2021 to 2024))
- There are an estimated 11,869 to 18,060 problem drug users in Glasgow (Source: Public Health Scotland (PHS) – Prevalence of Problem Drug Use in Scotland (2015/16))
- 12.9% of Glasgow adults provide unpaid care to others compared to 13.5% of Scottish adults (Source: Scotland's Census (2022))
- 92.0% of Glasgow households have home internet access – a little higher than the national average of 91.0% (Source: Scottish Household Survey (SHS) (2023))
- 97.9% of Glasgow P5-S6 school pupils have home internet access compared to 98.3% of Scottish pupils (Source: Scottish Government Schools Health and Wellbeing Census (2021/22))
- 19.3% of all Glasgow people are classed as income deprived compared to 12.1% of all Scots (Source: Scottish Index of Multiple Deprivation (SIMD) (2020))
- 19.8% of Glasgow children aged 0-15 are living in relative low income families (before housing costs) compared to 12.3% of Scotland's children (Source: UK Gov Official Statistics: Children in Low Income Families Statistics (2024/25))

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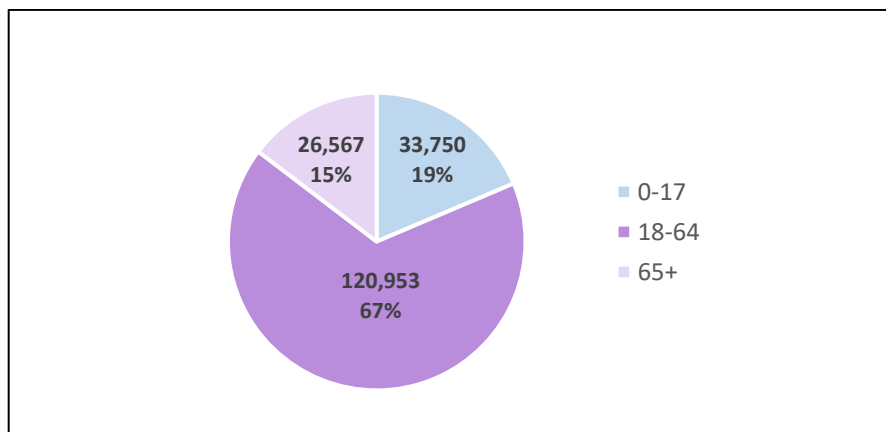
### 1.4 LOCALITIES

Glasgow is divided into three areas, known as localities, to support HSCP operational service delivery and respond to local needs. These mirror the strategic areas adopted by the Glasgow Community Planning Partnership. These localities – North West, North East and South – are shown on the city map and described in more detail below.



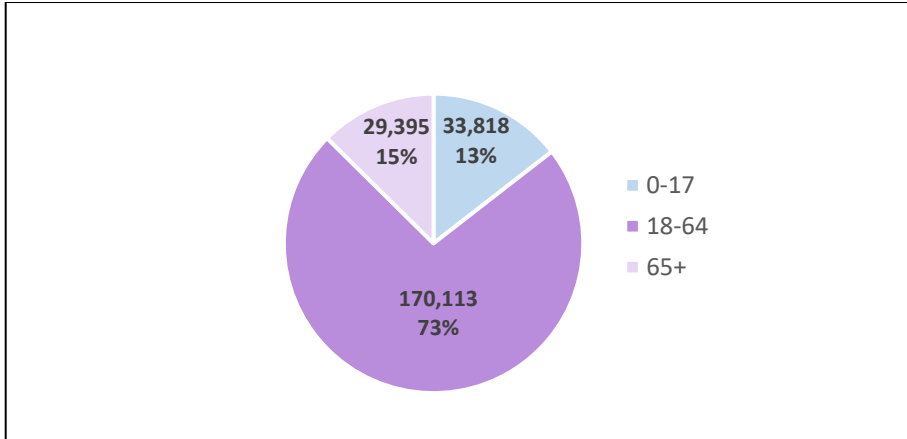
#### North East Locality

North East Locality covers the wards of Calton, Dennistoun, Springburn/Robroyston, East Centre, North East, Shettleston and Baillieston. The total population of North East Glasgow is 181,270 people and a breakdown by age is shown on the chart below.



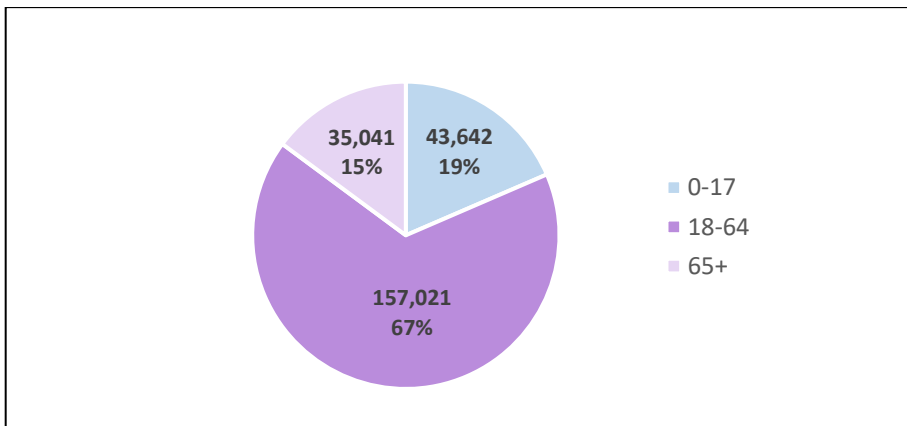
**North West Locality**

North West Locality covers the wards of Anderston/City/Yorkhill, Hillhead, Canal, Maryhill, Partick East/Kelvindale, Victoria Park, Garscadden/Scotstounhill and Drumchapel/Anniesland. The total population of North West Glasgow is 233,326 people and a breakdown by age is shown on the chart below.



**South Locality**

The South Locality covers the wards of Greater Pollok, Cardonald, Govan, Pollokshields, Newlands/Auldburn, Southside Central, Langside and Linn. The total population of South Glasgow is 235,704 people and a breakdown by age is shown on chart below.



**Locality Management Arrangements and Plans**

Each of the 3 localities takes a lead role for co-ordinating care group activities across the City, as follows:

- North East Locality: Children and Family Services
- North West Locality: Adult Services
- South Locality: Older People's Services

Each of the Assistant Chief Officers who have City-wide operational responsibilities for the above Care Groups also provide a leadership role for their corresponding locality.

## Locality Engagement Forums

The HSCP places a strong emphasis on stakeholder engagement, adhering closely to the [Participation and Engagement Strategy](#) and the Scottish Government's [Planning with People](#) guidance. Applying this approach is central to decision-making, ensuring that any modifications to services are informed by the views and needs of local populations, while also considering the unique characteristics of their communities.

Glasgow City HSCP [Locality Engagement Forums](#) (LEFs) play a crucial engagement role, acting as a vital connection between local communities and the governance and planning structures of the HSCP. The LEFs are essential in raising awareness of both the Integration Joint Board and the Public Engagement Committee, facilitating consultation on [Locality Plans](#), and encouraging active participation from service users and organisations. Through meaningful engagement, these forums help to ensure that health and social care services remain responsive to the distinct requirements of each community. Meeting papers from the LEFs held over the past year can be accessed [on the HSCP website](#), providing transparency and supporting ongoing engagement with local communities.

## Primary Care Partnerships

Glasgow City HSCP engages with primary care contractors (general practice, dental, community pharmacy and optometry) through locality primary care groups and a city-wide strategy group. The 138 General Practices have been grouped into 21 'clusters' to take forward the Quality agenda in primary care, with Quality leads in place at practice and cluster levels. The clusters provide an opportunity for GPs and primary care services to share good practice, identify quality improvement priorities and look at how they can facilitate more integrated working with community services. To support improvement activity locally, the HSCP developed a Quality Improvement Plan in collaboration with NHSGG&C's Primary Care Support and Clinical Governance teams. The HSCP also run a flourishing education, training and awareness programme that brings together a wide range of practitioners across primary care, community health and social care. There is also ongoing work at a national level to understand how the cluster approach in primary care can be further improved. This will be issued in 2026 as part of the new deal for general practice which focuses on workforce, data and the development of a quality framework for general practice.



## 1.5 STRATEGIC VISION AND PRIORITIES

As indicated above, in accordance with the Public Bodies (Joint Working) (Scotland) Act 2014, we have prepared a Strategic Plan for the delivery of those functions which have been delegated to the Integration Joint Board by Glasgow City Council and NHS Greater Glasgow and Clyde (NHSGGC). The latest [Strategic Plan](#) was approved by the IJB in June 2023 and sets out the following Strategic Priorities for health and social care services in Glasgow. Within this Annual Performance Report, we capture some of our key achievements in relation to delivering these, as well as the nine National Health and Wellbeing outcomes (See **Appendix B**).

### Our Priorities

- Prevention, early intervention, and wellbeing
- Supporting greater self-determination and informed choice
- Supporting people in their communities
- Strengthening communities to reduce harm
- A healthy, valued and supported workforce
- Building a sustainable future

## 1.6 PERFORMANCE MANAGEMENT ARRANGEMENTS

A comprehensive Performance Framework and a range of mechanisms are in place within the Partnership to monitor delivery of our Strategic Plan, and to consider the impact of HSCP and partner activity, on individual, service and wider health and wellbeing outcomes.

A [Quarterly Performance Report](#) is produced which provides information on how services are responding to areas of under-performance. All KPIs within it have been aligned to the HSCP's Strategic Priorities and to the Scottish Government's [National Health and Wellbeing Outcomes](#). This report is shared with and scrutinised by individual services, the HSCP Senior Management Team and the Integration Joint Board's [Finance, Audit and Scrutiny Committee \(FASC\)](#). The FASC focus upon specific service areas at each of their meetings, where the relevant strategic leads are invited to discuss their performance and demonstrate how they are taking forward the HSCP's Strategic Priorities. The FASC also reviews and responds to any Inspection Reports produced by local audit teams or by national agencies such as Audit Scotland, Healthcare Improvement Scotland, or the Care Inspectorate.

In addition to the above, Health Improvement staff in partnership with the wider public health intelligence community in NHS Greater Glasgow and Clyde, also undertake a range of activities to identify and assess population health and wellbeing trends, using a variety of national and local resources including the [Schools and Adults Health and Wellbeing Surveys](#). A range of such information is captured within the HSCP's [Demographics and Needs Profile](#) which is updated annually.

## 1.7 STRUCTURE OF THE REPORT

Chapters 2 to 9 of this report are structured around the HSCP's strategic priorities, including equalities. Within them, we highlight some of the key service developments over the last 12 months, then consider our performance in relation to Key Performance Indicators associated with each priority. Drawing on this information, key achievements in relation to our performance are highlighted and areas for improvement identified. Consideration is also given to the HSCP's performance in relation to the [Core Suite of National Integration Indicators](#) (**Appendix C**) as well as other national and local information sources and surveys.

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

In Chapter 11, we provide a summary of our financial performance for 2025/26. We also describe some of the key transformation programmes and resultant savings that have been achieved as a consequence. Key capital investments are also summarised and the financial outlook for 2026/27 considered.



## 2. DELIVERING OUR KEY PRIORITIES



## 2. DELIVERING OUR KEY PRIORITIES

Chapters 3 to 8 are structured around the HSCP’s Strategic Priorities:

- Prevention, early intervention, and wellbeing
- Supporting greater self-determination and informed choice
- Supporting people in their communities
- Strengthening communities to reduce harm
- A healthy, valued and supported workforce
- Building a sustainable future








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

Indicators where performance has shown the greatest improvement over the last 12 months are highlighted. Areas where we would like to see improvements over the next year are then identified, with key actions planned to achieve this summarised.

Under each priority, where relevant, we also include other information such as local surveys and case studies, as well as our performance in relation to the [National Integration Indicators](#) (**Appendix C**).

### Key

Within Chapters 3 to 8, **Performance Status** has been classified as Red, Amber or Green (RAG), as explained below. The **Status** is provided for the end of 2025/26 and the previous 5 years where possible. The **Direction of Travel** details whether the current figure (2025/26) is better or worse in comparison with i) the previous year (2024/25) and ii) 5 years ago (2020/21).

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



# 3. PREVENTION, EARLY INTERVENTION AND WELLBEING



### 3 PREVENTION, EARLY INTERVENTION AND WELLBEING

Within this section, we profile some of the key developments progressed in relation to our strategic priority of Prevention, Early Intervention and Wellbeing and consider performance in relation to KPIs associated with this theme. Activities undertaken have contributed to a range of the national Health and Wellbeing Outcomes, most notably the following:

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|--|
| <b>Outcome 1</b>   |
| People are able to look after and improve their own health and wellbeing and live in good health for longer                        |
| <b>Outcome 4</b>   |
| Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services |
| <b>Outcome 5</b>   |
| Health and social care services contribute to reducing health inequalities   |

#### 3.1 KEY DEVELOPMENTS/ACHIEVEMENTS

##### 3.1.1 Health Improvement Annual Report

The latest [Health Improvement Annual Report \(2024-25\)](#) highlights the wide range of activities the HSCP's Health Improvement Team are continuing to support. These include mental health, poverty and inequality, which remain key causes of ill health within the city. It also reflects the Team's refreshed strategic direction and their partnerships with other organisations to reduce health inequalities within our communities. Some of the areas in this report are discussed in the sections below.

##### 3.1.2 Mental Health

###### *Promoting Mental Health Awareness*

The HSCP is committed to promoting mental wellbeing among staff, service users, and the wider community. Activities undertaken during the last year included:

- Organising a range of events and sessions to raise awareness of [Mental Health Awareness Week 2025](#) which focused on 'The Power and Importance of Community', celebrating the vital role that positive community connections play in reducing isolation, building resilience, and improving wellbeing
- Launching of a new 'Helping Hands' resource, which can be used by groups and organisations to initiate conversations about ways to improve mental health and wellbeing, and about local networks and supports people can be signposted to.
- Supporting NHS Greater Glasgow and Clyde (NHSGGC) wide efforts to promote the use of [My App: My Mental Health](#) which offers easy access to advice, information and tools to help manage common mental health concerns
- Supporting the production of a new [guide](#) for children and young people on accessing mental health supports and services, including online services such as [Togetherall](#) and [Kooth](#), whose contracts were extended by Glasgow in 25/26
- Health Improvement delivered training to build partner capacity in responding to mental health and distress (including Healthy Minds and Mental Health First Aid) and continued to lead the Flourish Glasgow Partnership, bringing partners together to promote mental wellbeing

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- Produced a six-part [podcast](#) with East End Community Radio, which featured over 30 local people and sought to promote open conversations about mental health and to tackle the stigma commonly associated with it

### *Managing Stress*

Health Improvement commission and manage the Adult Stress Service, delivered by Lifelink, who provide one-to-one counselling and a range of wellbeing sessions and workshops. Over the last year, their annual target has been exceeded with 4680 clients referred and 252 wellbeing workshops delivered. Counselling has been delivered primarily face to face (60%), as well as by video (5%) and telephone (35%). Outcomes have been measured for individual clients and results show consistent improvement using the CORE mental health index.

### *Suicide Prevention*

[Glasgow City Suicide Prevention Partnership](#) brings the HSCP and partners together to plan and deliver suicide prevention activities, including training, communication and awareness raising in support of the [National Suicide Prevention Action Plan](#). Over the last year, activities undertaken included:

- Launching of a citywide campaign during [Suicide Prevention Week](#) aimed at raising awareness and encouraging open conversations around suicide prevention. Events included a commemorative event for people affected by suicide and an online session showcasing suicide prevention resources
- Continued to provide frontline HSCP and partner staff with suicide intervention skills through a range of suicide prevention training. This included Suicide Contagion training aimed at supporting partners to take a proactive role in reducing suicide risk. This was delivered to Police Scotland and the University of Strathclyde, enabling them to roll this out within their respective organisations
- The University of Strathclyde were also supported with their [Suicide Prevention Strategy](#), which aims to embed suicide prevention into everyday life, challenge stigma and ensure timely support is readily available for those in distress
- As part of a wider health and wellbeing programme for justice services clients, suicide prevention training was delivered to 46 Justice Services and Unpaid Work staff. This aimed to enable them to recognise signs of suicidal thoughts and equip them with the skills to respond confidently when working with people serving Community Payback Orders (CPOs), given evidence that people in the justice system face much higher suicide risks than the general population
- During the construction of the new Parkhead Hub, Health Improvement partnered with BAM Construction to deliver [Mental Health sessions](#) for construction workers, again in response to evidence of significantly higher suicide rates amongst male workers within this sector
- Launched a comprehensive list of [Suicide Prevention Resources and Supports](#), providing staff with access to online learning, helplines, and materials to enhance suicide prevention knowledge

**Case Study**

*Client A attended their unpaid work placement and signed in as normal but then asked to speak to their supervisor, advising them that they were intent on taking their own life. The supervisor took A into a separate room, thanked them for telling him how he was feeling and allowed him to open up and speak about his feelings. With A's permission, the supervisor made a call to emergency services and an ambulance arrived along with a member of the Community Mental Health Team around 2 ½ hours from Client A first disclosing his suicidal thoughts. Reflecting on the incident, both staff members commented on how valuable the suicide prevention training had been in giving them confidence and skills to remain calm and support Client A at this time. The following week, the client passed on a message to them via their Criminal Justice Social Worker, saying 'thank you both for your support, compassion and communication. I felt better within myself having spoken to you and honestly don't know if I would be here if it wasn't for you.'*

*Children and Young People's Mental Health Framework*

During the last year, the HSCP has completed a full [review of the Children's and Young People Mental Health \(CYPMH\) Framework](#) with key partners. This sought to identify what changes are needed to improve mental health support for children and young people from 2026 onwards, when the budget made available nationally will be mainstreamed. Following on from this review, funding of £1.843m per year is being invested, enabling fixed-term posts to become permanent and ensuring greater stability in services that children and young people rely on. A key aim has been to improve care pathways and strengthen early intervention and prevention services, ensuring children and young people can access support quickly and at the right level, without unnecessary escalation to specialist services such as CAMHS.



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### *Social Media and Mental Health*

During the last year, a youth engagement project examining the impact of social media on the mental health of children and young people was delivered in partnership with Barnardo's Scotland. This involved focus groups and an online survey, with over 300 young people sharing their experiences of the online world and its impact on their mental health and wellbeing. This project has provided insights on digital wellbeing at a time of significant national debate around children's use of social media and the findings will directly inform future local activities, workforce development, as well as influencing national policy discussions. Work was also undertaken to create the [Digital Wellbeing Conversation Starters Toolkit](#) which supports practitioners to have open, meaningful and supportive conversations with children and young people about their online lives. Following a pilot, participants reported that the toolkit had made them much more confident in starting a conversation, that they had a much greater understanding of how the online environment affects young people's mental health, and of where young people could be signposted for support.



### *Perinatal and Infant Mental Health Network*

The Perinatal and Infant Mental Health Network brings together partner organisations who support new and expectant parents across NHS Greater Glasgow and Clyde, with membership increasing to 117 last year. During the last twelve months, the network's activities included the organisation of 'service spotlights' where organisations promote their activities and available supports; the delivery of a new *Healthy Minds Infant Mental Health* session; the development of a new resource for practitioners working with neurodiverse new and expectant parents; and the delivery of a range of information sessions and training. Feedback from partners has highlighted the value of the network as a platform for sharing knowledge, improving understanding and accessing high-quality resources.

### 3.1.3 Supporting Children and Families

#### *Breastfeeding*

HSCP Health Improvement staff have continued to encourage local businesses to sign up to the [Breastfeeding Friendly Scotland Scheme \(BFS\)](#). Staff have also continued to roll out the Breastfeeding Friendly Early Learning Scheme, which is targeted at early learning or childcare facilities, with 77 establishments signed up and 40 being fully accredited. Both schemes are intended to create supportive environments where breastfeeding is normalised, as well as contributing to long-term cultural change that promotes and supports breastfeeding in the wider community.

#### *Youth Health Service*

The Youth Health Service (YHS) continues to deliver holistic early-intervention support for young people aged 12–19. Over the past year, activities have included:

- The development of a Communications Strategy (2025–27) with a strong focus on targeting under-represented groups and improving information for parents and carers, with a Digital Communications Officer recruited to support these efforts
- Strengthening of mental health provision, with additional evening sessions at Maryhill and Gorbals introduced
- A multi-agency Test of Change with other HSCP services and partners. This involves reviewing referrals and waiting lists at weekly meetings and directing children and young people to the most appropriate support as early as possible, making better use of citywide resources and reducing CAMHS waiting times

#### **Case Study**

*P (aged 14) was supported during a period of his life which was marked by bullying, bereavement and significant changes at home and school, as well as past trauma. As an autistic young person, P often felt misunderstood and struggled to make sense of overwhelming emotion, initially presenting with low confidence, high anxiety, and considerable distress. After an initial period of clinical assessment and support by the Youth Health Service, P moved onto the Multiple Risk (MR) programme which enabled them to explore their grief, their neurodivergence, and to express themselves creatively while building their confidence and resilience. P became safer, more self-aware, and better able to communicate their needs. As a result, their relationships improved as did their ability to respond to and navigate challenges.*

#### *Family Wellbeing Hub*

The [Family Wellbeing Hub](#) works closely with the Youth Health Service and in the last year, supported 109 parents and carers through a combination of resources including a parent carer peer support group (PCPSG). This group informed the development of a national [Enabling Conversations Toolkit](#) by Suicide Prevention Scotland and is working with Education Services to support the development of a toolkit for local schools, as well as a range of resources to enable schools to take a whole family approach to pupils' support needs. In the last year, Health Improvement Senior Ayisha Azam was

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also awarded the [Jane Davies Award \(2025\)](#) by Health Improvement Scotland, for her person-centred practice work with the Family Wellbeing Hub.

### *Whole Family Support Programme*

Building upon the success of the Community Link Worker initiative described in 3.1.6 below, the Scottish Government Whole Family Wellbeing Fund (WFWF) has supported the Whole Family Support in General Practice (WFSGP) programme. The overall WFWF focuses on the wider family, with key aims to improve family well-being and reduce the numbers of children living away from home. The Glasgow WFSGP programme works with 12 GP practices in the most deprived parts of the city with Family Wellbeing Workers (FWW) based within these practices. The FWWs support families with issues influencing their health and wellbeing, linking them to local services and organisations as required. The programme also comprises a range of 'wrap around' support to help families with issues including financial inclusion, trauma, food & physical activity and community activities. 391 families were referred to the service during 2025/26 with the most common reasons for referral including parenting issues, anxiety and stress, neurodiversity, housing and relationship issues. The programme is currently being evaluated by the University of Glasgow who have published an [interim evaluation](#) which once completed, will inform future service delivery decisions.

There are also local WFWF-funded programmes, for example, within Parkhead Hub, where third sector funding via Glasgow East Arts Company (GEAC) led to the establishment of a programme of creative early years play, with local artists delivering focused and varied activities for children and their parents and carers. With coordination support from the HSCP, GEAC is continuing to lead the programme, which is attended by around 50 participants each week, with over 2,000 families participating, speaking a range of languages and making new connections.

The HSCP is also collaborating with the Council and other partners to provide holistic support to families across three Demonstrations of Change projects in Carlton, Govan and Southside Central, with work ongoing in Drumchapel to establish proactive support pathways for families impacted by poverty. This programme is supporting families to maximise their income and to access childcare, transport and language courses in order to engage with employability opportunities.

### **3.1.4 Sexual Health**

During the last year, the Sexual Health Improvement Team provided a range of capacity building support to increase confidence, knowledge and practice around sexual health and Blood Borne Viruses across key frontline services. These included staff supporting children and young people, asylum seekers, vulnerable adults, as well as people experiencing homelessness. Good Practice Guidance for staff supporting adults living with a learning disability was also developed, along with materials for discussing relationships and sexual health. Work also continued on the development of a Right Decisions online toolkit, focused on sexual health, wellbeing and relationships, which will be launched in 2026/27.

Prison Healthcare services and Public Health colleagues also worked jointly with the Hep C Trust to deliver a 'High Intensity Test and Treat (HITT)' initiative to all prisoners living in Barlinnie and Low Moss. This programme ran over several days in each prison and involved screening the whole population for hepatitis C and other blood borne

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viruses. Over 90% of all people detained in both prisons were tested, with those testing positive offered immediate treatment.



### 3.1.5 Alcohol, Drugs & Smoking

#### *Quit Your Way Smoking Cessation Service*

During 2025-26, the Quit Your Way (QYW) smoking cessation service continued to provide a variety of support options to suit client needs/preferences, including telephone, face to face (1:1s and group) and digital support via the 'Smoke Free App'. This year the service have also been working to implement recommendations from a recent city wide service review, which included making processes more consistent, developing a new tiered service approach and implementing new telephone and appointment systems. New face to face services in health centres and pharmacies have also continued to be developed. Clients in touch with QYW also receive support from advisers for wider health and wellbeing issues and are signposted to local services for a range of issues including mental health, isolation, addictions, and financial advice.

#### *Supporting Justice Clients with Alcohol Issues*

In addition to suicide prevention activities discussed above, another key development within the health and wellbeing programme for justice clients has been the expansion of Alcohol Brief Interventions (ABIs) delivery for people serving Community Payback Orders (CPOs). Unpaid Work staff are now delivering ABIs routinely as part of their day-to-day engagement. An ABI is a short, evidence-based, structured conversation about drinking that aims to motivate individuals to reflect on and potentially change their alcohol use, in a non-confrontational way. Since July 2025, Unpaid Work staff have carried out 420 screenings, with 35% leading to the delivery of an ABI. Of those, 59% of service users requested further information or signposting.

### Unpaid Work Staff Feedback

*'I'm certainly no expert but being on the ABI training has given me confidence and enabling tools to have conversations with clients about alcohol and pass on further information when needed. It has helped me break down the supervisor/client barrier and promote the fact we are here to help people – not just to tell them what to do.'*

*'Along with mental health, alcohol is one of the key factors we see each day that continue to impact on people's health and wellbeing, as well as their offending behaviours. This training has been pivotal in taking unpaid work delivery to where we need it to be – a model that allows people to 'payback' to their communities, but at the same time creates opportunities for meaningful interventions and support for clients experiencing issues with alcohol.'*

### *Youth Drug Trend Monitoring Pilot*

In 2025/26, new online youth drug trend monitoring arrangements have been piloted for practitioners working with under-18s, to improve recording and to capture emerging youth drug trends more consistently and timeously. These were co-designed with youth partnerships and agreed with the NHSGGC Drug Trend Monitoring Group (DTMG). Early feedback indicates increased practitioner confidence and engagement, generating higher-quality intelligence to inform better service planning and rapid responses.

### 3.1.6 Tackling Inequalities

#### *Placed Based Approaches*

Tackling health inequalities and improving health in Glasgow's most vulnerable communities remains a core priority of the Glasgow City Health Improvement Strategy. In support of these aims, HSCP staff have worked with Community Planning partners to take forward the ['Place Based'](#) approach, building upon the learning from the previous Community Planning Thriving Places programmes. This seeks to ensure that communities are involved in planning and delivering activities that improve outcomes in neighbourhoods disadvantaged by inequalities. Work undertaken in the last year across localities include the following:

- Organisation of two 'Hubcap' network events in the North East that brought together over 100 professionals from more than 50 organisations supporting young people experiencing the greatest inequalities. These events strengthened partnerships, enabled joint activity and generated local intelligence on priorities including multiple risk behaviours, mental health challenges, digital harms, and the impact of poverty and cost-of-living pressures
- Supporting the Possilpark/Ruchill and the Milton Connecting Communities Networks. These provide forums for organisations and community groups to share information, build relationships and work collaboratively on agreed local priorities. Output included the re-establishment of a shared community noticeboard in Possilpark; the publication of 'A Celebration of Milton Report' highlighting the network's achievements; and various community events showcasing local opportunities and support.

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- Establishment of the Sustain Govanhill & East Pollokshields group involving local elected members, community members, and voluntary and statutory organisations. This is focusing on local food priorities with an action plan focused on the thematic areas of Greenspace, Growing and Biodiversity; Emergency Food Provision; and Training

### *Community Link Workers*

Community Link Workers (CLWs) are embedded in 80 GP practice teams in areas of highest deprivation and help patients to identify and address social or economic issues that may be affecting their health and wellbeing. Some have also become involved in supporting the development of services that address identified gaps in support such as bereavement and walking groups. There have been approximately 13,000 referrals received over the course of the last year, with over 20,415 reasons for referral. CLWs have made over 22,000 onward referrals to local organisations and services. CLWs have also made use of a 'Patient Fund' which has enabled them to provide assistance for those experiencing financial difficulty, with over 2400 small items being provided including heated blankets, air fryers, and supermarket or community pantry vouchers.

### *Supporting Asylum Seekers and Refugees*

HSCP staff have worked in partnership with health and third sector organisations over the last year to enhance access to health services and improve the range of support available for asylum seekers and refugees. Several events have been held, bringing together participants from over 60 organisations across Glasgow and beyond, with the aims of increasing awareness of available supports, strengthening collaboration and improving service responses in support of asylum seekers and refugees. In addition to these events, a number of other activities were supported within localities, including trauma informed training for 23 ESOL (English for Speakers of Other Languages) teachers to improve language support for refugee and asylum seeking learners; and local support for key national campaigns including Black History Month, Wear it Red Day and the Scottish Refugee Festival.

### *Supporting People with Disabilities*

Following a successful pilot initiated by HSCP Local Area Coordinators, along with partners such as Key Housing, a new programme of weekly [Disability Sport Days](#) are now running across Glasgow. They run from 10am to 2.30pm and include a mix of sports as well as circuits and gym sessions. These sessions are designed to help adults with disabilities stay active, build confidence, socialise and feel part of their community. Feedback from participants and staff has been very positive with families reporting how they have increased participants confidence and independence.



*Women's Health Network*

Glasgow Women's Health Network (GWHN) marked its seventh anniversary in the last year and continued to expand its membership with 168 individuals now involved from a range of statutory and voluntary sector organisations and community groups. This network continues to raise awareness of women's health needs and seek improvements in service design and support in order to address these needs and remove barriers to health equity. Activities have included training and capacity-building opportunities for partner staff including primary care teams on a range of topics such as endometriosis and menstrual health; as well as organising events around key campaigns such as International Women's Day and 16 Days of Activism against gender based violence.

3.2 PERFORMANCE

3.2.1 Local KPIs

| INDICATOR<br>(Health & Wellbeing Outcome)   | 2020/21<br>YEAR<br>END | 2021/22<br>YEAR<br>END | 2022/23<br>YEAR<br>END | 2023/24<br>YEAR<br>END | 2024/25<br>YEAR<br>END | 2025/26<br>TARGET | 2025/26<br>ACTUAL<br>(Year End<br>unless<br>stated) | Direction<br>of Travel<br>since<br>2020/21 | Direction<br>of Travel<br>since<br>2024/25 |
|---|------------------------|------------------------|------------------------|------------------------|------------------------|-------------------|---|--|--|
| % of HPIs (Health Plan Indicators) allocated by Health Visitors by 24 weeks. (Outcome 4)            | NE<br>96%<br>          | NE<br>97%<br>          | NE<br>94%<br>          | NE<br>95%<br>          | NE<br>96%<br>          | 95%               | NE<br>99%<br>                                       | NE<br>▲                                    | NE<br>▲                                    |
|   | NW<br>96%<br>          | NW<br>97%<br>          | NW<br>93%<br>          | NW<br>98%<br>          | NW<br>94%<br>          |                   | NW<br>96%<br>                                       | NW<br>▶                                    | NW<br>▲                                    |
|   | South<br>99%<br>       | South<br>97%<br>       | South<br>95%<br>       | South<br>97%<br>       | South<br>96%<br>       |                   | South<br>95%<br>                                    | S<br>▼                                     | S<br>▼                                     |
|   |                        |                        |                        |                        |                        |                   | (Dec 25)  |  |  |
| Mumps, Measles & Rubella (MMR) Vaccinations: (% uptake at 24 months) (Outcome 1)                    | 94.2%<br>              | 93%<br>                | 92.3%<br>              | 90.2%<br>              | 90.7%<br>              | 95%               | 89.6%<br><br>(Q3)                                   | ▼  | ▼  |
| Mumps, Measles & Rubella (MMR) Vaccinations: (% Uptake at 5 years) (Outcome 1)                      | 96.3%<br>              | 94.8%<br>              | 94.9%<br>              | 95%<br>                | 94.5%<br>              | 95%               | 94.3%<br><br>(Q3)                                   | ▼  | ▼  |
| Psychological Therapies: % of people who started treatment within 18 weeks of referral. (Outcome 9) | NE<br>56.6%<br>        | NE<br>46.3%<br>        | NE<br>58%<br>          | NE<br>78.7%<br>        | NE<br>85.7%<br>        | 90%               | NE<br>75.9%<br>                                     | NE<br>▲                                    | NE<br>▼                                    |
|   | NW<br>93.6%<br>        | NW<br>92.4%<br>        | NW<br>91.7%<br>        | NW<br>93.7%<br>        | NW<br>91.4%<br>        |                   | NW<br>74.6%<br>                                     | NW<br>▼                                    | NW<br>▼                                    |
|   | S<br>91.4%<br>         | S<br>81.2%<br>         | S<br>82.9%<br>         | S<br>81.6%<br>         | S<br>80.9%<br>         |                   | S<br>81.9%<br>                                      | S<br>▼                                     | S<br>▲                                     |
| % service users commencing alcohol or drug treatment within 3 weeks of referral (Outcome 7)         | 99%<br>                | 95%<br>                | 96%<br>                | 93%<br>                | 88%<br>                | 90%               | 92%<br><br>(Q3)                                     | ▼  | ▲  |

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| INDICATOR<br>(Health & Wellbeing<br>Outcome)  | 2020/21<br>YEAR<br>END | 2021/22<br>YEAR<br>END | 2022/23<br>YEAR<br>END | 2023/24<br>YEAR<br>END | 2024/25<br>YEAR<br>END      | 2025/26<br>TARGET                | 2025/26<br>ACTUAL<br>(Year End<br>unless<br>stated) | Direction<br>of Travel<br>since<br>2020/21 | Direction<br>of Travel<br>since<br>2024/25 |
|---|------------------------|------------------------|------------------------|------------------------|-----------------------------|----------------------------------|---|--|--|
| Alcohol Brief<br>Intervention<br>Delivery<br>(Outcome 4)                                      | 4,269<br>              | 7,749<br>              | 8,966<br>              | 10,479<br>             | 10,376<br>                  | 5,066 per<br>annum               | 10,929<br>  | ▲  | ▲  |
| Smoking Quit<br>Rates at 3 months<br>from 40% most<br>deprived areas.<br>(Outcome 5)          | 1,280<br>              | 1,260<br>              | 1,050<br>              | 1,097<br>              | 1,105<br><br>(792<br>at Q3) | 1,190 per<br>annum/<br>845 to Q3 | 710<br><br>(Total<br>Q1-3)                          | ▼  | ▼  |
| Women smoking<br>in pregnancy<br>(general<br>population)<br>(Outcome 1)                       | 8.2%<br>               | 9.5%<br>               | 8.4%<br>               | 7.3%<br>               | 5.5%<br>                    | <10%                             | 5.3%<br>  | ▲  | ▲  |
| Women smoking<br>in pregnancy<br>(20% most<br>deprived data<br>zones) (Outcome<br>5)          | 12.4%<br>              | 16.7%<br>              | 13.9%<br>              | 10.8<br>               | 8.1%<br>                    | <14%                             | 8.0%<br>  | ▲  | ▲  |
| Exclusive<br>Breastfeeding at<br>6-8 wks (general<br>population)<br>(Outcome 1)               | 29.6%<br>              | 28%<br>                | 31.1%<br>              | 30.7%<br>              | 36.0%<br>                   | 33%                              | 35.3%<br><br>(Q3)                                   | ▲  | ▼  |
| Exclusive<br>Breastfeeding at<br>6-8 wks (15%<br>most deprived<br>data zones).<br>(Outcome 5) | 21.9%<br>              | 20.6%<br>              | 25.0%<br>              | 24.2%<br>              | 30.1%<br>                   | 24.4%                            | 29%<br><br>(Q3)                                     | ▲  | ▼  |

Note: i) targets may have been adjusted over the period shown, so RAG ratings for previous years may be against historical targets

### 3.3 KEY ACHIEVEMENTS

Local KPI Indicators where performance has shown the greatest improvement over the last 12 months:

| INDICATOR  |                              | YEAR END 2024/25 | YEAR END 2025/26    |
|--|------------------------------|------------------|---------------------|
| % of HPIs (Health Plan Indicators) allocated by Health Visitors by 24 weeks            | North East                   | 96%<br>          | 99%<br><br>(Dec 25) |
|  | North West                   | 94%<br>          | 96%<br><br>(Dec 25) |
| Psychological Therapies: % of people who started treatment within 18 weeks of referral | South                        | 80.9%<br>        | 81.9%<br>           |
| % service users commencing alcohol or drug treatment within 3 weeks of referral        |                              | 88%<br>          | 92%<br><br>(Q3)     |
| Alcohol Brief Intervention Delivery  |                              | 10,376<br>       | 10,929<br>          |
| Women smoking in pregnancy   | General population           | 5.5%<br>         | 5.3%<br>            |
|  | 20% most deprived data zones | 8.1%<br>         | 8.0%<br>            |

### 3.4 AREAS FOR IMPROVEMENT

Ongoing improvement is sought across all services. KPIs relating to this Strategic Priority which we would specifically like to improve within the next 12 months are:

| INDICATOR  | Performance Issues and Actions to Improve Performance  |
|--|--|
| <p>Mumps, Measles &amp; Rubella (MMR) Vaccinations: (% uptake at 24 months)</p> <p><b>Target:</b> 95%</p> <p><b>Actual:</b> 89.6% (Q3)</p> | <p><b>Performance Issues:</b></p> <ul style="list-style-type: none"> <li>Vaccine uptake has declined internationally, reflecting reduced confidence following the Covid-19 pandemic</li> <li>MMR hesitancy, influenced by misinformation on social media, continues to affect uptake among younger children</li> <li>Reported data includes all children registered with a GP, including those not available for vaccination, which can lower recorded uptake rates</li> <li>Within this context, performance in Glasgow City remains comparatively strong when set against national trends</li> </ul> <p><b>Actions to Improve Performance Include:</b></p> <ul style="list-style-type: none"> <li>Targeted work is focused on areas and population groups with lower uptake, with bespoke approaches developed in partnership with public health colleagues</li> </ul> |

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|  | <ul style="list-style-type: none"> <li>• National awareness campaigns in response to measles outbreaks are strengthening messages on vaccine safety and importance, supporting increased awareness among parents and carers</li> <li>• Vaccine-specific booster clinics have been established in low-uptake communities, using culturally sensitive approaches to improve access and build trust</li> <li>• Ongoing engagement with migrant families is being strengthened through joint working between Immunisation Teams and Health Visiting services</li> <li>• Health Visitors continue to promote vaccination from an early stage, supported by HSCP and public health partners to ensure consistent, inclusive messaging</li> </ul>   |
| <p>Smoking Quit Rates at 3 months from 40% most deprived areas.</p> <p><b>Target:</b> 1,190 per annum/ 845 to Q3</p> <p><b>Actual:</b> 710 (Total to Q3)</p>                               | <p><b>Performance Issues:</b></p> <ul style="list-style-type: none"> <li>• Service delivery has been significantly impacted by staff absences and vacancies across the city, affecting overall capacity</li> <li>• The community Quit Your Way (QYW) Service is implementing recommendations from a service review, with ongoing changes as processes are standardised</li> <li>• Clients are presenting with increasingly complex needs, including poor mental health, isolation, substance use and financial pressures. The intensity of support required for these clients, including holistic intervention and signposting, is placing additional demand on service capacity</li> </ul> <p><b>Actions to Improve Performance include:</b></p> <ul style="list-style-type: none"> <li>• Face-to-face community clinics are operating across all three localities, providing accessible, in-person support in a range of community settings</li> <li>• A range of alternative support options is also available, including telephone and digital support via the Smoke Free App</li> <li>• Performance continues to be monitored through the NHS Greater Glasgow and Clyde Tobacco Planning and Implementation Group and the City Tobacco Group to inform ongoing improvement</li> </ul> |
| <p>Psychological Therapies: % of people who started treatment within 18 weeks of referral.</p> <p><b>Target:</b> 90%</p> <p><b>Actual:</b></p> <p><b>North East Locality</b><br/>75.9%</p> | <p><b>Performance Issues:</b></p> <ul style="list-style-type: none"> <li>• Workforce vacancies, particularly in senior psychology roles, continue to reduce service capacity and increase waiting times</li> <li>• Variation across teams in referral criteria, appointment management, and approaches to improving attendance, are contributing to differing performance outcomes</li> <li>• Inconsistent data quality and delays in correcting errors are impacting the accuracy of reported waiting times and overall performance</li> </ul>  |

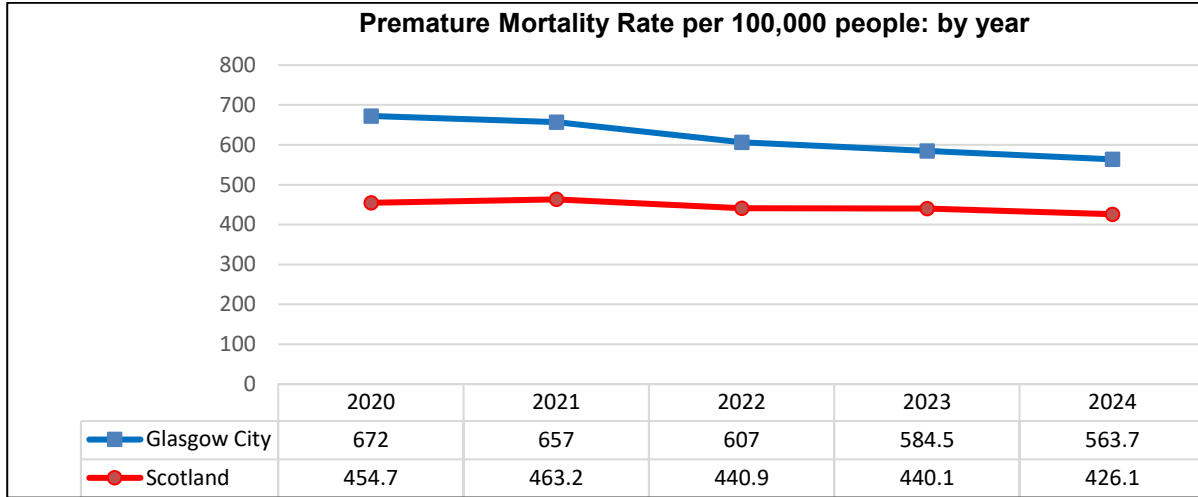
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|   |  |
|---|--|
| <p><b>North West Locality</b><br/>74.6%</p> <p><b>South Locality</b><br/>81.9%</p> <p>(N.B. This indicator is reported at locality level, not city-wide.)</p> | <p><b>Actions to Improve Performance include:</b></p> <ul style="list-style-type: none"><li>• An independent panel has been established to review all waits over 52 weeks, identifying systemic issues and informing strategic improvements</li><li>• Clinical leads are taking forward recommendations on therapy input and frequency to optimise treatment delivery and throughput, with progress being monitored through the Performance and Quality Improvement Subgroup (PQIS)</li><li>• Analysis of variation in referral management and appointment practices is underway to identify and promote the most effective approaches across teams</li><li>• Increased focus is being placed on maximising digital therapy options, including expanding use of computerised CBT to improve access and performance</li><li>• Recruitment challenges are being actively managed, with recognition of the need to streamline approval processes to reduce delays in filling vacancies, particularly at senior levels</li><li>• Actions are being implemented to improve data quality, including development of staff guidance, video-based training and FAQs to reduce recording errors.</li></ul> |
|---|--|

### 3.5 NATIONAL INTEGRATION INDICATORS

#### National Integration Indicator 11



- Decrease in Glasgow over the period shown.
- Glasgow consistently higher than Scottish average but gap has been narrowing
- No data currently available beyond 2024



## 4. SUPPORTING GREATER SELF-DETERMINATION AND INFORMED CHOICE

## 4. SUPPORTING GREATER SELF-DETERMINATION AND INFORMED CHOICE

Within this section, we profile some of the key developments progressed in relation to our strategic priority of Providing Greater Self-Determination and Informed Choice and consider performance in relation to KPIs associated with this theme. Activities undertaken have contributed to a range of the national Health and Wellbeing Outcomes, most notably the following:

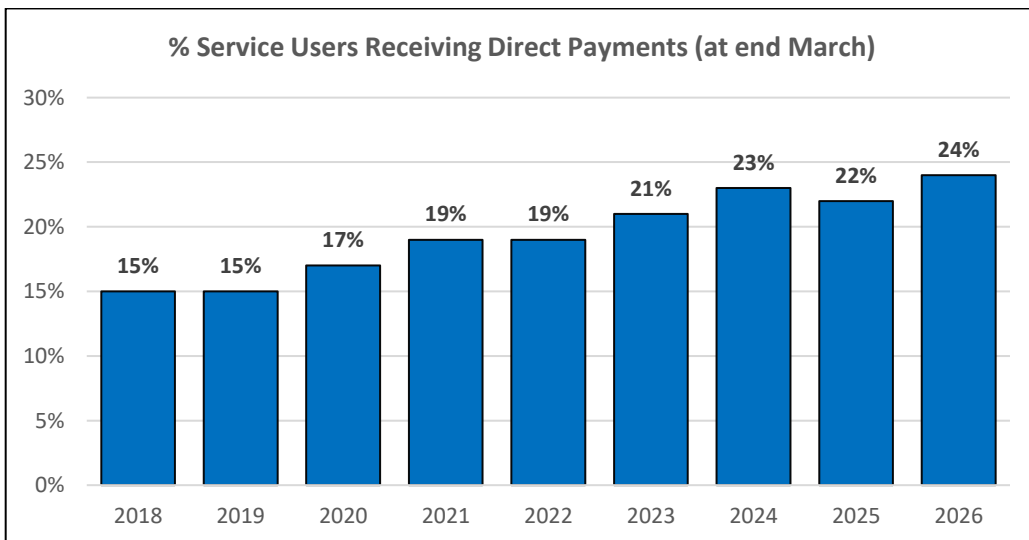
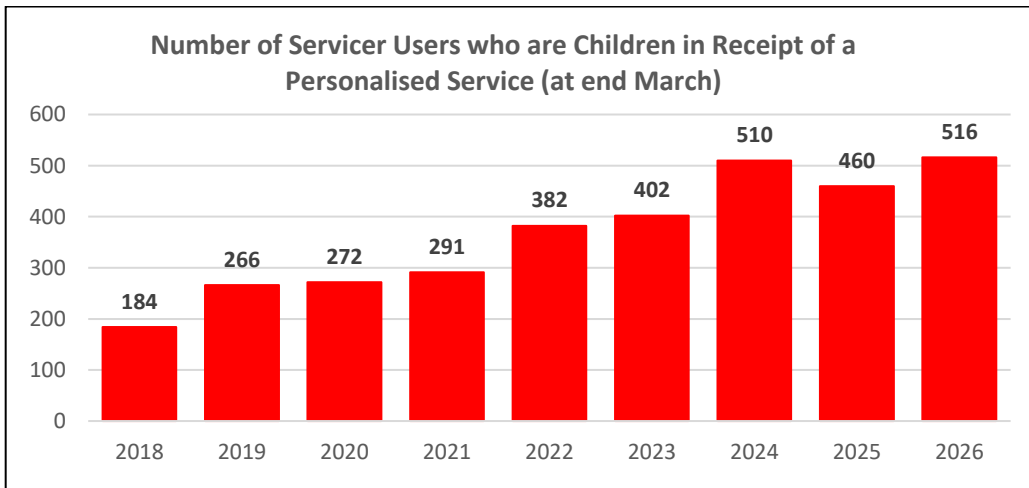
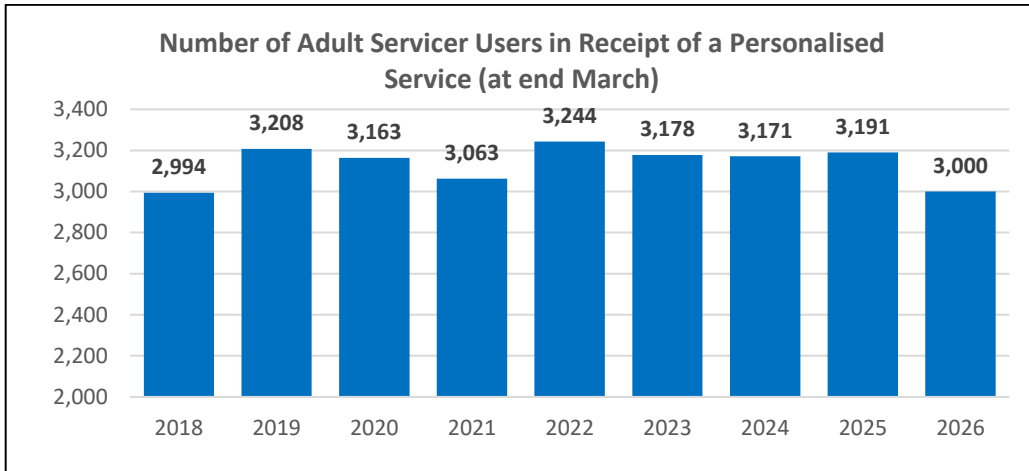
|  |
|--|
| <b>Outcome 1</b>   |
| People are able to look after and improve their own health and wellbeing and live in good health for longer                        |
| <b>Outcome 3</b>   |
| People who use health and social care services have positive experiences of those services, and have their dignity respected       |
| <b>Outcome 4</b>   |
| Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services |
| <b>Outcome 5</b>   |
| Health and social care services contribute to reducing health inequalities   |
| <b>Outcome 9</b>   |
| Resources are used effectively and efficiently in the provision of health and social care services.                                |

### 4.1 KEY DEVELOPMENTS/ACHIEVEMENTS

#### 4.1.1 Self Directed Support (SDS)

Personalisation, as outlined in the Social Care (Self-directed Support, SDS) (Scotland) Act 2013, aims to provide service users with greater choice and control over the support they receive. At the end of March 2026, a total of 3,000 adults were in receipt of a personalised social care service, a decrease since March 2025 (3,191). The number of children with disabilities with SDS rose over this period (from 460 to 516).

The overall proportion of service users who chose the [Direct Payment](#) option to receive their personalised budget increased from 22% to 24% over this period, as shown below. There is considerable variation between age groups in the proportion of service users who opt to have a Direct Payment, with 73% of children with disabilities receiving a direct payment compared to 16% of adults.



#### 4.1.2 Listening To Our Service Users

As explained in Chapter 1, we seek the views of people who access our health and care services through the [Locality Engagement Forums](#) (LEFs). They provide a mechanism for listening to and involving patients, service users and carers to ensure that our services reflect the priorities of local communities. In addition to the LEFs, services have also engaged with a range of service users and community members in various ways in the last year. Examples from across care groups include the following:

##### **Children**

###### *The Promise*

The [Promise](#) is a national commitment to care experienced children and young people, that they will 'grow up loved, safe and respected'. [Glasgow's Promise Plan](#) set out how this will be achieved locally and delivery progress has been reviewed in the last year. Significant progress has been made, with nearly half of the 100 Calls to Action completed and the remainder being actively implemented. Key achievements include strengthening participation of care-experienced children and young people and the introduction of child-centred planning and review approaches. Practice in children's houses has also been strengthened through the Nurture Framework, contributing to improved Care Inspectorate outcomes, with the inspections highlighting nurturing practice and improved participation. While progress has been substantial, the review also identified key areas for continued focus which will shape the development of the Promise Plan 2026–2030 and its associated performance framework.

###### *Children's Rights Service*

The [United Nations Convention on the Rights of the Child \(UNCRC\)](#) sets out the rights of children under 18, with the [UNCRC \(Incorporation\) \(Scotland\) Act 2024](#) placing a duty on councils to uphold these, strengthening protection, accountability and the meaningful participation of children and young people. Within Glasgow HSCP, the Children's Rights Service (CRS) provides rights information, advice and advocacy, to children and young people in foster and residential care, as well as those in continuing care and aftercare. It also supports staff across the HSCP to understand and apply children's rights in their day to day practice. Through these efforts, the CRS seeks to embed a rights-based approach and organisational culture and strengthen meaningful participation. The aim is to ensure that the voices of care experienced children and young people influence decision making and the development of policy, practice and procedures across the HSCP. During 2025 activities of the service included the following:

- Delivered 54 training sessions for staff
- Attended over 190 service meetings involving a range of HSCP teams, to ensure children's views are represented and to support rights-based decision making
- Provided direct advocacy for young people at over 200 individual meetings
- Provided advocacy for 212 young people, who have been supported for over 970 different reasons, with young people returning repeatedly to access support. This reflects the complexity of the issues raised and the strength of the relationships and trust between young people and their CRS workers

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- All Children's Rights Officers achieved an SCQF Level 7 qualification in Advocacy, reinforcing our commitment to delivering a consistent, high-quality, rights based service, underpinned by professional standards

Participation also remains a core focus of the CRS and a wide range of opportunities were created for young people to be involved, share their experiences and shape the work of the service. This included co-designing and delivering 11 CRS staff briefing sessions, with staff feedback from these highlighting the value of hearing directly from young people themselves. Young people also contributed to the [Stronger Together Report](#), sharing their experiences and writing about issues including autism diagnosis, mental health and moving into independent living. In addition, some participated in planning and contributing to the annual Care Leavers Event run by Arts in the City, with the CRS supporting them to ensure they could engage confidently and safely.

### Young People's Feedback

- *'It was really good having someone to speak up for me when I did not want to do that.'*
- *'I always get to know when my meeting is as my Children's Rights Officer lets me know and they help me plan for what I want to say before my meeting.'*
- *'I feel better when I have my Children's Rights Officer supporting me and I like when they check in on me.'*



### Children's Services Planning

The [Glasgow City Integrated Children and Young People's Services Plan \(2023-26\)](#) outlines the key priorities for children's services. During the last year, the Children's Services Plan Steering Group has undertaken a programme of engagement with young people, which will inform the development of a refreshed set of priorities for our next Plan (2026 to 2029). A range of engagement methods are being used, including creative approaches, with the aims of encouraging as many children and young people as possible to participate and ensuring partner agencies involved in supporting

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children and young people can influence the priorities. Efforts are also being made to improve the evidence base underpinning the Plan to track and improve outcomes for children and young people across Glasgow.

### *Glasgow Child Interview Team*

The Glasgow Child Interview Team is made up of specially trained social workers and police officers, who work together to interview children and young people who have been victims of or have witnessed abuse or crime. The team uses a trauma-informed approach called the Scottish Child Interview Model (SCIM), which helps make the experience less stressful for children, reduces their risk of further trauma and improves the quality of information gathered during interviews. The team received funding from the Scottish Government's 'Bairns' Hoose' fund to create animations designed to help children, young people, and their carers understand the processes involved and make the process less intimidating. These are available on the HSCP's YouTube channel and include one for [younger](#) children and another aimed at [older](#) children.

### **Carers**

Glasgow City HSCP, the University of Strathclyde, and Lanarkshire Carers have been working together on a new [Future Hospitals Initiative](#). This project, which has been funded by the Wellcome Trust, seeks to improve understanding of the needs, insights, and experiences of carers. The aim is to inform the design of innovative solutions for carers and the people they care for in relation to issues such as quality of life, skills training, and financial support.

The HSCP has also been taking [a number of steps](#) to increase young carers engagement locally. Funded carer organisations in the city provide young carers with one-to-one and group support sessions and are required to evidence engagement with at least 150 young carers per year, demonstrating how their voices have been heard. Work is also underway to facilitate young carer involvement in HSCP Locality Engagement Forums, to enable them to influence local decision-making.

### **People Affected by Homelessness**

In August 2025, the HSCP launched the [WAYfinder](#) homelessness outreach initiative. This was co-designed with individuals who have lived experience of homelessness and developed in collaboration with the Glasgow Homelessness Involvement and Feedback Team (GHIFT). WAYfinder represents a significant shift in how services are commissioned, emphasising the importance of understanding each person's unique journey and of designing services with those people who will be supported by them. A [video](#) narrated by GHIFT members, replaced the traditional service specification document and allowed potential service providers to hear about what matters most to the service users who will experience these services.

### **Older People in Residential Care**

Staff from all five Glasgow City HSCP care homes have taken part in the 'Effective Leadership for Dementia Care Services programme', delivered by the University of Stirling's Dementia Services Development Centre (DSDC). Around 80% of our care home residents are living with dementia and the programme seeks to ensure local leadership and care approaches are aligned with best practice in dementia care. A key aim of the programme was to embed a fully person-led approach to dementia care,

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ensuring people living with dementia have a genuine voice and can direct and shape the support they receive.

### **Participant Feedback**

*'It was a great session with valuable conversations and key takeaways for leadership in dementia, particularly around developing and delivering person-led care to support people living with dementia'.*

*'We explored how language matters. By using inclusive, respectful language it reinforces the message that everyone living with a dementia has a voice, choice and control.'*

### **Deaf Community**

British Sign Language (BSL) is the preferred language of most deaf people in the UK, for whom English may be a second or even third language. During the last year, a group of staff successfully achieved a BSL Signature Level 1 qualification, with others completing a six-week taster course. By learning BSL and improving their understanding of deaf culture, staff are helping to break down barriers, improve communication with deaf service users, and make the HSCP's services more responsive to the needs of the deaf community. Glasgow's [BSL Action Plan](#) also continues to be implemented which seeks to ensure that our services are accessible and inclusive for everyone in the deaf community.



### **Local Communities**

#### *Parkhead Hub*

A [Community Network Approach](#) has been central to taking forward the planning and implementation of the new Parkhead Hub facility and activities operating from it. Since opening, community groups have been able to book the Hub's five community rooms, with over 40 groups now delivering activities that reflect what people in the area have said they want, ranging from counselling and wellbeing sessions, men's health MOTs,

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parent and child play groups, to employability support and advice sessions. Residents have also influenced the themes and focus of larger community networking events, with successful sessions held on mental health and wellbeing for children and families; and poverty and inclusion. These events combine information stalls with activities such as dance, fitness, or crafts and play, showcasing the range of support available locally.

#### *The Thistle Centre*

The HSCP continues to actively [listen and respond](#) to the views of local residents, service users and partners in relation to the activities of the Thistle Centre, which provides a supervised, hygienic space for people to inject drugs obtained elsewhere (see Chapter 6 for more detail). A service user forum has been established, helping to shape service improvements and overcome barriers to use. A Community Engagement Forum also meets regularly and in addition to keeping the community informed, has led to practical actions to address concerns raised, including deep cleans of known injecting areas, more frequent litter pick-ups and new drug-related litter bins. To support transparency and build public confidence, staff also offer regular tours, organise 'myth-busting' communications to address misinformation and publish monthly service data.

### **4.1.3 Employability**

#### *No One Left Behind – Supporting Young People into Employment*

The HSCP continues to provide a young person's employability service with an employability coach embedded within a number of HSCP services. These coaches work intensively with young people over a 12 month period, providing a highly personalised programme of learning and activity to secure and sustain a 'positive destination', such as starting higher education or training, gaining work experience or obtaining employment. The coaches also support young people in a range of other ways including helping them to obtain funding, open a bank account or access local services such as gyms.

#### **Case Study**

*A and her siblings stayed with their gran in a kinship placement. Gran had concerns for her future given her poor school attendance and lack of interest in employment or further education. Before becoming involved with employability services, she stayed in her room, had no structure in her life and often felt depressed. With their support, she started a college placement and obtained a bursary, which helped her to start driving lessons she thought she would never be able to afford. Gran has seen a big difference in her and has indicated she takes much more care of her appearance and is now out of the house regularly. She feels that's A's confidence and self-esteem have improved considerably and that she has become much more mature. A herself has reported that working with the employability service has helped to change her life.*

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### *Wellbeing and Employability Programme*

During the last year, a group of care-experienced young people completed a four-week [Wellbeing and Employability](#) programme delivered jointly by the HSCP's Continuing Care and Aftercare Employment Services (CCAES) and ng homes. Alongside a range of physical activity opportunities, employability workshops focused on helping participants identify their strengths and interests and consider future career options. The group also completed a course covering personal money management, budgeting, debt advice and preparation for independent living.



### *Restart*

Restart is an NHS recovery service and works with people who have experienced severe or enduring mental health problems, working with them to set and achieve their personal goals and plan for the next step in their recovery journey. A variety of support is offered including one-to-one and group based mental health sessions, along with opportunities to take part in a range of activities, including volunteering, education and training. Vocational guidance counsellors support 'trainees' along the way and facilitate access to 'move on' opportunities, with individuals making the ultimate decisions upon the next steps in their recovery journey. During the last year, the service completed a comprehensive review of its in-house employability services, as well as of its referral pathways and interface with other commissioned services. This recommended the delivery of a single integrated in-house Recovery Service under a unified governance and management structure, with standardised referral, triage, assessment and review processes and strengthened outcomes measurements.

### **Case Study**

*A 35-year-old woman with Bipolar Affective Disorder, who was subject to a Community Treatment Order, experienced a manic relapse requiring hospital admission. On discharge, she was referred to Restart where she engaged with a range of supports, including Social Science courses and a Peer 2 Peer training course. As a result, she showed significant improvements in self-esteem, greater independence and an increased sense of purpose and self-belief. This enabled her, as part of the next stage of her recovery, to successfully apply for a volunteer advisor role at the Citizens Advice Bureau (CAB), where she completed training and began volunteering two days per week. Access to meaningful activity, skills development, and progression opportunities through Restart have played a key role in promoting her stability and recovery. As a result, she is now much more focused on the future and is considering employment opportunities.*

#### **4.1.4 Financial Inclusion**

##### *Social Work Welfare Rights Service*

Social Work operate a welfare rights service for service users and during 2025/26, they represented 248 clients at social security appeals. They also generated a total of £4.79m (£2.6m in ongoing benefits and £2.19m in backdated benefits) in successful claims for service users who receive a chargeable non-residential care service.

##### *Welfare Advice and Health Partnerships (WAHP)*













Recognising the strong link between financial security and health, the Scottish Government supported Welfare Advice and Health Partnerships (WAHP) programme, has enabled welfare rights services to be embedded in GP practices within deprived communities. WAHP supports early conversations about money concerns and is intended to reach the people most affected by poverty and poor health who may not otherwise engage with advice services, while supporting more efficient use of GP time. Despite reduced national funding, Glasgow has continued to sustain the model, with the service offering weekly/fortnightly advice sessions in 53 GP practices. Demand has been consistently high, reflecting the financial strain faced by many households in the city and the need for financial support and advice. In Q1-Q3 2025/26, 3164 referrals and over 12,000 cases were supported, resulting in £7.3million in financial gains and £1.27 million in total debt reconciliation. This included £412,000 in housing related debt and £858,000 in non-housing debt.

##### *Family Finance Advisors*

With the support of the Scottish Government's Whole Family Wellbeing Fund, Glasgow was awarded monies to appoint Family Finance Advisors (FFA) who support families to access financial wellbeing support and to develop their financial awareness, knowledge and skills. These advisors also work within GP practice teams, linking closely with the above WAHP advisers and with the Community Link and Family Wellbeing Workers discussed in Chapter 3.

## 4.2 PERFORMANCE

### 4.2.1 Local KPIs

| INDICATOR<br>(Health & Wellbeing Outcome)  | 2020/21<br>YEAR<br>END   | 2021/22<br>YEAR<br>END   | 2022/23<br>YEAR<br>END   | 2023/24<br>YEAR<br>END   | 2024/25<br>YEAR<br>END   | 2025/26<br>TARGET | 2025/26<br>ACTUAL<br>(Year End<br>unless<br>stated)  | Direction<br>of Travel<br>since<br>2020/21 | Direction<br>of Travel<br>since<br>2024/25 |
|--|--|--|--|--|--|-------------------|--|--|--|
| No. Future Care Plan summaries completed and shared with the patient's GP (Outcome 2)                              | 69<br>  | 50<br>  | 276<br> | 399<br> | 605<br> | 360               | 903<br> | ▲<br>(since 2020/21)                       | ▲  |
| % young people currently receiving aftercare service known to be in employment, education or training. (Outcome 4) | 80%<br> | 80%<br> | 80%<br> | 77%<br> | 72%<br> | 75%               | 73%<br> | ▼  | ▲  |

Note: targets may have been adjusted over the period shown, so RAG ratings for previous years may be against historical targets.

### 4.2.2 Local Surveys

#### *Home Care and Reablement*

Home Care and Reablement Services continue to support individuals to live as independently as possible within their own homes, promoting dignity, choice, and control. Structured engagement with service users is central to service improvement, with a regular Service User Questionnaire survey providing a key mechanism for gathering feedback and shaping future delivery. The survey is aligned with the Health and Social Care Standards: *My Support, My Life*, ensuring that services continue to uphold principles of dignity, respect, compassion, and human rights. It forms part of ongoing quality assurance activity, with findings directly informing service improvements through the 'We Asked, You Said, We Did' approach. The most recent questionnaire was issued in August 2024, with response rates of approximately 19%. Some of the key findings from this survey in relation to our Strategic Priority of Supporting Greater Self-Determination and Informed Choice, are presented below:

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| <b>Statement</b>   | <b>% of respondents who “strongly agreed” or “agreed” with statement*</b> | <b>National Health &amp; Wellbeing Outcome</b> |
|--|---|--|
| I am treated with dignity and respect  | 91% – 97%   | Outcome 3                                      |
| My regular carers know me well and they know what is important to me.  | 85% – 91%   | Outcome 3                                      |
| My home carers have enough time during their visit to support and care for me and to speak to me.  | 65% – 68%   | Outcome 3                                      |
| I am fully involved in developing and reviewing my PSP (Personal Support Plan) and, if I consent, my family and friends can be included. | 70% – 73%   | Outcome 3                                      |
| Home carers recognise when I may need additional support or medical assistance and seek out appropriate support.                         | 79% – 86%   | Outcome 8                                      |
| My home care service empowers and enables me to be as independent and as in control of my life as I want to be.                          | 85% – 86%   | Outcome 2                                      |
| If my care needs change, I know I can request that my care plan be re-assessed.  | 77% – 80%   | Outcome 4                                      |

\*Figures reflect variation across locality areas (North East, North West and South).

The findings demonstrate consistently positive experiences across key areas, particularly in relation to dignity, respect, staff skills, and support for independence. Continuity of care and strong relationships with regular carers were also highlighted as important contributors to positive outcomes. Areas for improvement identified through the feedback included ensuring greater continuity of carers, where possible; improving communication around changes to visit times or staffing; addressing concerns regarding time available during visits; and strengthening involvement in care planning and communication updates. These themes have informed a range of service improvement actions, including enhancements to scheduling systems, workforce recruitment and retention initiatives, improved communication approaches, and the development of clearer information for service users regarding care delivery and review processes.

As part of ongoing improvement activity, Home Care and Reablement Services have also initiated a review of its broader stakeholder engagement approaches, with a Stakeholder Engagement Form issued to service users to better understand how they wish to be involved in shaping service design and improvement. This will inform the development of a refreshed Engagement Plan, supporting more meaningful, flexible, accessible, inclusive and person-centred approaches to service user and stakeholder engagement and communication. Early findings suggest that while there is a need for a mix of involvement methods, there is a preference for simple, low-effort engagement, with most respondents favouring telephone or paper surveys once or twice a year. It has also found that many respondents require support to take part, with common needs including large print and easy read formats, with some requiring translation or family members or carers to engage.

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### Carers Centres

The commissioned Carers services provide an Evaluation form to Carers in recent contact with the service which asks several questions, one of which relates to the Strategic Priority of Supporting Greater Self-Determination and Informed Choice. Feedback from the latest survey covering 2025/26 is included below:

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

### 4.3 KEY ACHIEVEMENTS

Local KPI Indicators where performance has shown the greatest improvement over the past 12 months:




| INDICATOR  | YEAR END<br>24/25   | YEAR END<br>25/26   |
|--|---|---|
| No. Future Care Plan summaries completed and shared with the patient's GP                              | 605<br>  | 903<br>  |
| % young people currently receiving aftercare service known to be in employment, education or training. | 72%<br> | 73%<br> |

### 4.4 AREAS FOR IMPROVEMENT

Ongoing improvement is sought across all services. KPIs relating to this Strategic Priority which we would specifically like to improve within the next 12 months are:

| INDICATOR   | Performance Issues and Actions to Improve Performance   |
|---|---|
| <p>% young people currently receiving aftercare service known to be in employment, education or training.</p> <p><b>Target:</b> 75%</p> <p><b>Actual:</b> 73%</p> | <p><b>Performance Issues:</b></p> <ul style="list-style-type: none"> <li>• Initial analysis is underway to assess the impact of the current financial context on wider youth unemployment trends</li> <li>• Performance is believed to have been affected by the transfer of young people with leave to remain from the Youth Advice Service (YAS) to the Continuing Care Team; as well as the erroneous inclusion of young people with significant barriers to employment who should not be counted e.g. due to complex support needs, pregnancy, or on remand</li> </ul> <p><b>Actions to Improve Performance include:</b></p> <ul style="list-style-type: none"> <li>• Efforts to improve performance are ongoing. Heads of Service are also working with locality teams to reinforce the importance of accurate and consistent recording of employability outcomes and of those with a barrier to employment</li> </ul> |

**4.5 NATIONAL INTEGRATION INDICATORS (see Appendix C)**

| National Integration Indicator  | 2023/24 Survey Results |         |          |  |
|---|------------------------|---------|----------|--|
|   | Outcome                | Glasgow | Scotland | Compared to Scottish average   |
|   |                        |         |          | Above <br>Below  |
| 3. % adults supported at home who agree that they had a say in how their help, care or support was provided | 3                      | 61.5%   | 59.6%    |   |

**Note**

This indicator is derived from the national [Health and Care Experience Survey \(HACE\)](#). Due to changes in the survey wording, no comparisons can be made with the last report in 2021/22.



# 5. SUPPORTING PEOPLE IN THEIR COMMUNITIES



## 5. SUPPORTING PEOPLE IN THEIR COMMUNITIES

Within this chapter, we profile some of the key developments progressed in relation to our strategic priority of Supporting People In Their Communities and consider performance in relation to KPIs associated with this theme. Some of these developments apply across all services while others are service specific and both are considered in turn below. These activities have contributed to a range of the national Health and Wellbeing Outcomes, most notably the following:

|   |
|---|
| <b>Outcome 1</b>  |
| People are able to look after and improve their own health and wellbeing and live in good health for longer.  |
| <b>Outcome 2</b>  |
| 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. |
| <b>Outcome 4</b>  |
| Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.   |
| <b>Outcome 6</b>  |
| People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.                    |
| <b>Outcome 7</b>  |
| People using health and social care services are safe from harm.  |
| <b>Outcome 9</b>  |
| Resources are used effectively and efficiently in the provision of health and social care services.   |

### 5.1 KEY DEVELOPMENTS/ACHIEVEMENTS

#### 5.1.1 HSCP Wide Developments

HSCP wide developments relating to the Strategic Priority of Supporting People at home that have had an impact across services have included the following:

##### *Health and Social Care Connect*

Health and Social Care Connect (HSCC) serves as the single point of access for referrals to the HSCP, providing a multi-disciplinary response which adopts a strength-based assessment model promoting user independence. It seeks to reduce the need for longer-term social work involvement, with the aim of maintaining onward referrals to localities at 30% or below. Demand continues to rise, with an average of 5,400 referrals received each month. Over the last year, efforts have continued to streamline processes and minimise duplication and have included the following:

- A service review which has led to changes to staffing and service scope, with the aim of ensuring the 'right people come into the service at the right time'

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- Strengthened relationships with the third-sector, introducing a 'Support Enquiry Form' alongside the online referral form, to provide information on third-sector services where statutory involvement may not be required
- Improved the processes undertaken when tenants are threatened with eviction with the aim of preventing evictions taking place
- Successfully implemented No Recourse to Public Funds (NRPF) cases within the HSCC, with cases unresolved within 6-8 weeks transferred to the localities.

### Case Study

*T had become housebound within his upper-floor tenement flat where he had lived for over 60 years and had to move after the building was deemed structurally unsafe. To avoid homelessness, he moved into his retired son's one-bedroom flat, where his son and daughter-in-law gave up their bed to accommodate him. Following an HSCC assessment, he was allocated a Clustered Supported Living flat with a small package of care. Since the move, he has reflected upon how it has provided him with new opportunities and helped him regain his independence, without the need for ongoing statutory involvement.*

### *Make it Local Communities*

Working with community organisations, Glasgow City HSCP has been taking forward the *Make it Local Communities* project, which seeks to support the development and expansion of community-based activities across Glasgow. Formerly known as Community Hubs, the project was renamed 'Make it Local Communities', to reflect its focus on building a network of local organisations rather than physical venues. Small amounts of funding are available through the programme, which seeks to facilitate learning and the sharing of best practice with other community-based organisations across the city. Five key themes are being focused upon within the project: *community resources information; home technology support; food and nutrition; living with long-term conditions; and improving strength and balance*

### *Volunteering*

Volunteers play a key role in supporting a range of HSCP services including residential care, alcohol and drugs services, and mental health services. To mark National Volunteers Week, some of the HSCP volunteers took part in a [civic reception](#) hosted by the Deputy Lord Provost of Glasgow. These included eight senior school pupils, who took part in the Youth Health Service (YHS) Volunteer Pilot, which involved them volunteering to support city-wide evening YHS sessions.

## 5.1.2 Older People's and Care Services

In line with this Strategic Priority, Older People's services are continuing to work with partners to shift the balance of care away from institutional care towards supporting people safely in the community; prevent unnecessary hospital admissions; and facilitate timely discharges from acute care. Some of the key developments progressed in the last 12 months are described below, firstly in relation to the use of technology and then more generally across a range of other community based services.

### ***Supporting People with Technology***

#### *Digital Switchover*

The Community Alarms and Telecare Service supports approximately 8,654 active service users all year round. It plays a key role in care planning by reassuring users and families, helping people stay at home and delaying long-term care admissions. Over the past year, the service successfully transitioned from analogue to a cloud-based digital platform, completing the switch by March 2026, making Glasgow one of the first areas to meet the 2027 national deadline. This achievement earned a [Gold Level 2 Award](#) by the Digital Office for Scottish Local Government.

The new digital system delivers faster response times and greater reliability, with user feedback highlighting clearer sound, improved performance, and increased peace of mind. It also enables future enhancements as technology evolves. including integration with advanced devices such as GPS trackers, and other smart home technologies, offering the potential to support more preventative care and reduce the need for hospital or care home admissions. As digital technology continues to develop, the service is also exploring a 'family first' approach, which would enable alerts to be directed initially to a nominated contact, such as a family member or caregiver, before being escalated to the Alarm Receiving Centre (ARC) if required. Although this is at an early stage, it demonstrates how digital innovation can be used to support a person-centred approach to care, with technology enhancing and not replacing the human aspects of support and connection.

#### *Helpful Hints for Home Technology*

Glasgow City HSCP has also continued to expand its Helpful Hints with Home Technology initiative to raise awareness of simple, effective technologies, that can help people stay safe, connected and independent in their own homes. This has involved the delivery of [Information Sessions](#) in a range of local community venues, with devices showcased including smart plugs, sensors, video doorbells and voice-activated assistants. To improve accessibility, the team has also developed short '[How To?](#)' videos that address common questions people have about using these devices, with dedicated sessions for carers planned that will also offer guidance on financial help for purchasing them. Early feedback has been very positive, with participants reporting increased confidence and families noting the greater peace of mind the use of these devices bring.

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### *Connected Care and Wellbeing*

In Phase 1 (Apr 2024–Apr 2025), Glasgow’s Connected Care and Wellbeing initiative piloted voice-activated devices (Amazon Alexa) with 75 older people, many with memory, mobility, or chronic health conditions. Aimed at reducing digital exclusion and loneliness, the devices supported tasks such as accessing care information, medication and appointment reminders, controlling home devices and providing entertainment. The trial exceeded expectations with 89% finding the devices easy to use; 64% reporting improved quality of life; 59% feeling more informed; 52% feeling in more control of daily routines; and 34% feeling less isolated. These results have secured additional funding for a [Phase 2](#), which will expand the trial, enhance functionality of the devices, address user feedback on content, use the devices for accessing other health and care services, and explore how they could integrate and connect to other technologies and systems.

### *Red Cross Support at Home*

During the last year, work has also been undertaken by the Home Technology Team in partnership with the British Red Cross to deliver the *Support at Home* pilot which aims to support timely hospital discharge following a hospital stay including Adults with Incapacity (AWI). This pilot has focused on reducing barriers faced at discharge by providing hands-on advice and practical assistance with digital devices such as smartphones and tablets, assistive technologies supporting home safety, and with accessing online resources and services. Beyond the immediate goal of supporting safe discharge, this personalised support has equipped people leaving hospital with the practical knowledge, tools, and confidence to use technology that supports their longer term wellbeing independence and social connection.

#### **Case Study**

*N has been diagnosed with Lewy Body Dementia, which affects memory and can make managing daily routines more challenging. He lives independently and receives limited informal support from friends and his sister. To support him, an Amazon Echo Show was provided which was set up with reminders to help him manage his medication routine more safely and consistently. He also uses the device to play music and stay in touch with friends and family. He has also been supported to use a smartphone and associated apps which help him in his daily living. His example highlights how combining accessible home technology with personalised digital support can help individuals living with dementia maintain independence, manage daily routines more safely, and stay socially connected within their own home.*

### **Community Based Support**

There have also been several other developments across a range of community based services which have been intended to enable people to live safely in the community, reducing the need for unnecessary hospital admissions and supporting timely hospital discharge. These include the following:

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### *Enhanced Residential Care Pathway Pilot*

Glasgow City HSCP is taking part in a [Scottish Government Pilot](#) to reduce the number of people with more complex needs who are waiting to move from hospital wards to more appropriate settings. To support timely discharge, 30 beds for short term advanced care have been identified within units in HSCP care homes. The emphasis is upon recovery, rehabilitation and independence, with services working together with patients and their families to find the best place for their long-term care, which could include nursing care, residential care or back in the community with appropriate support. The pilot is going well with [positive feedback](#) received from patients and staff.



### *Hospital at Home*

An updated [Hospital at Home](#) Service re-commenced in 2025, with capacity increasing from 10 to 15 beds in July. This service has moved from the previous frailty-based approach, towards supporting people with respiratory conditions at home. New referral pathways have been introduced and a wider range of clinical interventions delivered, enabling people to be treated at home and avoiding potentially lengthy hospital stays. The service works closely with the Scottish Ambulance Service staff who are providing assessments where appropriate. There have been over 270 accepted referrals since opening, with the average referrals rising to 1.3 per day in recent months, and an estimated 2375 hospital bed days have saved to date. This initiative is supporting the wider work being taken forward across NHS Greater Glasgow & Clyde to expand the number of 'virtual beds' and reduce pressure on acute hospitals.

### *Dementia Post Diagnostic Support*

Around 1,000 referrals for Dementia Post Diagnostic Support (PDS) are received annually, with Alzheimer's Scotland delivering the service on behalf of the HSCP. In 2025, alongside one-to-one support, group-based PDS sessions were introduced for people with newly diagnosed dementia, aligning with the national dementia strategy aims of offering more flexible, person-centred options. Delivered in care homes across the city, the sessions promote peer support, reduce isolation and stigma, and encourage wider community participation. Run over five-week programmes, they achieved strong uptake, with over 320 attendees in the first six months. Sessions are delivered in partnership with HSCP staff and third sector organisations, with referrals

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made via community mental health teams at diagnosis. Future plans for development of these sessions include the introduction of digital and online options.

### Service User Feedback

*'I feel more confident about discussing diagnosis now and telling others whereas before I was embarrassed'.*

*'The group was a safe space to talk openly about my feelings about dementia.'*

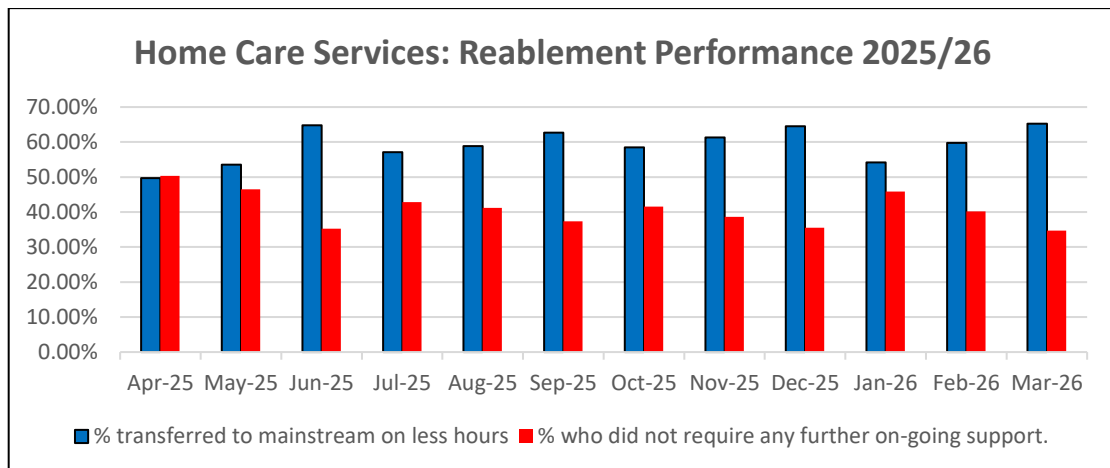
*'I have been emotional and felt alone in my caring role, but I was reassured by the group and by what I found out about the services there to provide support.'*

### Falls Prevention

Falls are a leading cause of hospital admissions for over-75s in Glasgow (around 4,000 annually). During Falls Awareness week in September 2025, Older People's Services led a [Falls Awareness and Prevention Campaign](#). This campaign achieved 22,056 contacts with staff and the public. It included Level 1 Falls training attended by over 100 staff; and community events where staff met members of the public and disseminated falls prevention advice and information. As part of this campaign, a [video](#) was also produced to help get key messages across to target groups.

### Care at Home and Reablement

Glasgow's Home Care Service supports over 4,600 people, delivering around 81,000 visits each week. In 2025/26, it received over 8,625 hospital discharge referrals, 40% of which were new with 97.4% being referred to a 7-day service. The service has maintained no delays in accessing Care at Home following hospital discharge over the past five years. Reablement remains central, helping people regain confidence and skills after illness or crisis. In 2025, over 3,532 service users completed reablement, with more than 40% requiring no ongoing support - as indicated in the chart below - avoiding an estimated £8.5m in annual care costs. The service was visited by [Tom Arthur, MSP, Minister for Social Care, Mental Wellbeing and Sport](#) in December 2025 who recognised the vital role of the service in enabling people to live independently with dignity and choice



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### *Community Rehabilitation Service*

During the last year, Glasgow City HSCP progressed a Community Rehabilitation Service refresh in response to rising complexity and system pressures. Led by frontline staff and team leaders, improvements included updated service descriptors, new referral criteria and guidance, and clearer referral pathways to enable more equitable access. Recording was also enhanced to better evidence impact upon avoiding admissions and supporting discharge, with new outcome measures and routine patient and carer feedback introduced. The service also strengthened the role of Frailty Practitioners, supporting a more coordinated, multidisciplinary approach across hospital and community settings. Through structured assessment, teams are identifying frailty earlier and helping to prevent or delay deterioration.

### *Community Respiratory Service*

The multidisciplinary Community Respiratory Team (CRT) support people with severe COPD to manage exacerbations at home, avoiding unnecessary admissions, as well as enabling early supported discharge after an A&E visit or hospital stay. A short [video](#) produced this year highlights the value of this support, particularly for older people with limited support networks or who have difficulty accessing hospital care. In response to rising demand, the service also reviewed and redesigned its delivery model, prioritising patients with the highest clinical need with the urgent exacerbation pathway strengthened through rapid telephone triage, home visits and structured follow-up. Recovery and self-management support have also improved through enhanced input from occupational therapy, pharmacy and support workers, alongside new web-based resources, with a patient-facing website nearing publication. The service has also piloted Attend Anywhere, a secure platform enabling remote patient consultations.

### *District Nursing*

The District Nursing service provides skilled nursing care to people at home and in care settings who are housebound, have complex needs, or require ongoing clinical support to prevent hospital admission. As demand and the complexity of patients grows, and the aspiration to support discharge and prevent hospital admissions increases, the service has continued to adapt and evolve. A geographical hub model has replaced GP-aligned caseloads, balancing staff workloads, reducing staff travel time, and better aligning resources to patient need. These changes have enabled core hours to be extended from 08:30–16:30 to 08:30–20:00, improving staff availability. Quality assurance has also been strengthened through embedding of the Combined Care Assurance Audit Tool (CCAAT), with consistently high ratings reflecting strong clinical performance and a high standard of care.



### *Occupational Therapy*

Occupational Therapy services in Glasgow operate across localities and within Health and Social Care Connect. A shared Professional Lead and city wide networks are in place across all of these areas to improve consistency and coordinate service development and improvement. Developments in the last year have focused on seeking to reduce inappropriate referrals, increasing access to minor adaptations without the need for OT intervention, improving specialist equipment recycling rates and strengthening partnerships with housing providers. Work has also been undertaken to enhance practice education and expand HSCP wide falls prevention training.

### *Care Home Teams*

Over the past year, Glasgow City HSCP's five directly provided care homes maintained high occupancy, reaching 97% in Q4 2025/26, supported by improved referral coordination and oversight. Areas of progress in the last year with respect to supporting care homes and their residents have included:

- A strategic review of Older People's Residential Services was completed, with recommendations and funding for 2026/27 approved. Work is now underway to implement enhanced dementia and complex care pathways and further strengthen service sustainability and resident outcomes
- Around 3,000 residents have been supported by the Care Home Quality Assurance Team (CHQAT), which has reduced overdue statutory reviews despite staffing pressures and increased Adult Support and Protection activity. In 2025, 121 care assurance visits were completed, with follow-up action plans and support developed

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- The Call Before You Convey (CBYC) falls prevention service was expanded, increasing care home coverage and reducing unnecessary hospital attendances, with further rollout planned
- Enhanced pressure ulcer prevention training was delivered, resulting in no reported care-acquired pressure ulcers in January 2026 which avoided the need for any associated hospital attendance and treatment
- The Care Home Advanced Nurse Practitioner (ANP) team, which was established to improve [urgent care in residential care homes](#), has introduced immediate antibiotic treatment at the point of assessment, avoiding delays which can lead to a decline in health and subsequent hospital admissions. Between June 2025 and January 2026, 232 first doses were given and 79 hospital admissions avoided



### 5.1.3 Children's Services

#### *Glasgow's Family Support Strategy 2024–2030*

Glasgow's updated [Family Support Strategy \(2024-2030\)](#) was developed with partners in the Children's Services Planning Partnership and approved in May 2025. It sets out a long-term plan to strengthen support for children, young people and families, building upon previous progress. Its focus is on early intervention, strengths-based approaches and partnership with the third sector, to provide accessible support that reduce the need for statutory intervention and help families stay together safely within their own communities. Family Support leads are working with Locality Planning Groups to progress delivery of the strategy, with activities including delivering engagement sessions, developing a Family Support Insight Brief, and planning implementation of the strategy across in-house and commissioned services.



#### *Family Support Services*

The HSCP is investing over £50m in family support services over the period 2024-30. Delivery is structured across three pathways: the Locality Family Support Service and the Health Visiting and Family Nurse Partnership pathways (supporting pre-birth children to young people aged 12); and the Glasgow Intensive Family Support Service (supporting young people aged 12–18). A review of the first year found strong demand and sustained engagement across all pathways, particularly among families in deprived areas with more complex needs. Common issues for families included mental health challenges, isolation, housing difficulties and financial hardship, particularly impacting single parents. Across all pathways, families typically receive 6–7 months of tailored, needs led support, with low re-referral rates to date indicating a positive longer-term impact.

**Case Study**

*'Aberlour have been helping our family for a year or so now. My son's seven and with my own health problems making things harder, had been struggling at school. Aberlour come and take him out for the day and do things with him. He looks forward to it and he's a lot more settled now. They are such good people, easy to talk to, helpful, practical, and, when it came to the crunch, were right there beside us. I just mentioned the washing machine was broken. I wasn't expecting them to help but couldn't have been more wrong. They were terrific, explaining there were emergency grants and helping us to apply. We had the money within days and a new machine the day after. A broken washing machine might not sound like the end of the world but it can feel like it. When money is tight and there are so many things to worry about, it can take just one small thing to bring everything down on top of you. The stress just starts building and building. You can feel it. The money from Aberlour was a lifesaver'.*

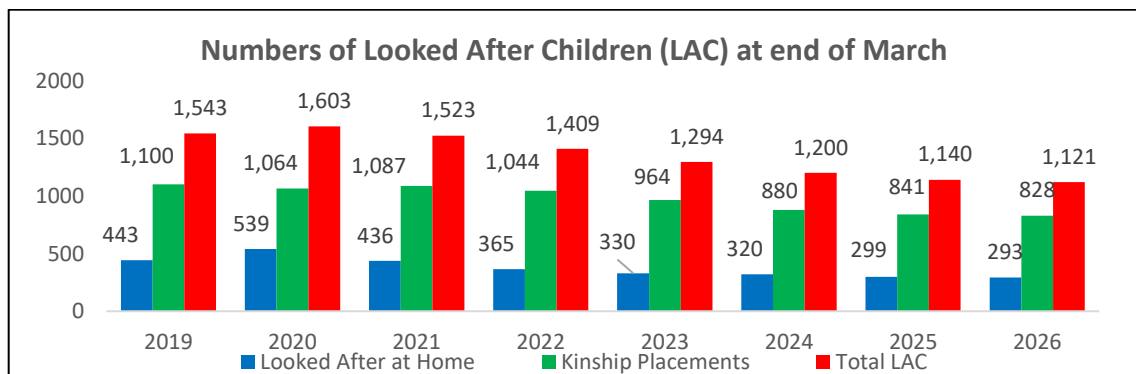
*(Parent in family being supported by Aberlour)*

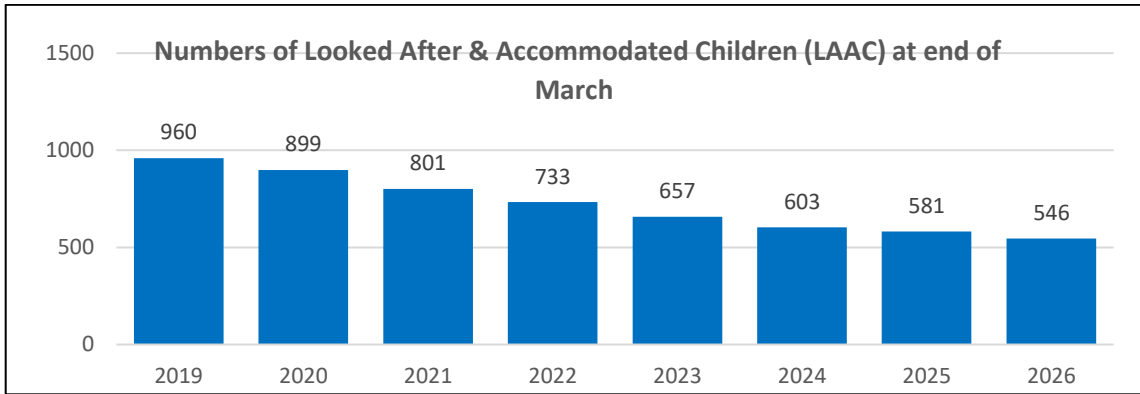
**Family Support Dashboard**

A dashboard launched in May 2025 provides real-time data, refreshed weekly, on referrals to commissioned Family Support Services across health, locality and intensive support pathways. It allows reports to be filtered by service, locality and council ward and has been used to support children's services inspections and inform decision-making across children's services.

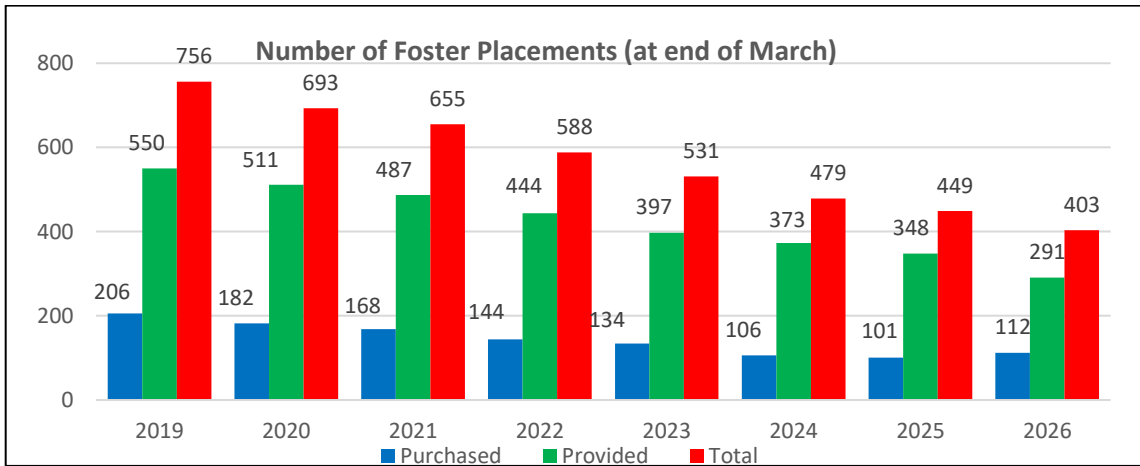
**Children's Balance of Care Indicators**

The success of the Family Support approach can be seen in the children's balance of care, which demonstrate a consistent reduction in the number of i) Looked After Children (at home or in kinship care) and ii) Looked After and Accommodated Children (includes residential placements and foster care), as shown in the two charts below:





Collectively, across both of the above categories, the numbers of children in care, either at home or away from home, fell from 1721 in March 2025 to 1,667 in March 2026. The total numbers of Foster Placements, a subset of the LAAC (Looked After and Accommodated Children) has also continued to reduce, as shown below.



## 5.1.4 Homelessness and Asylum

### *Homelessness Prevention*

In 2025/26, Homelessness Services continued to prioritise prevention, contributing to a 5% reduction in homelessness applications, with only around half of households seeking advice progressing to an application. Support with money, debt and housing options helped many remain in their homes or secure alternatives, reducing demand for temporary accommodation. Alongside prevention work, strong partnerships with housing associations enabled over 3,600 settled lets, matching the previous year's record. In addition, working with colleagues in Neighbourhoods, Regeneration and Sustainability (NRS), 157 large family homes were acquired through the open market to support long-term homeless households. The Housing Options Explorer was also launched, providing accessible online advice on a range of housing options and issues, with further development underway to offer more personalised guidance.

### *Temporary Accommodation*

Despite a reduction in homelessness applications in 2025/26, use of temporary accommodation increased by 18%, with a 47% rise in B&B and hotel use. In response, the HSCP has prioritised safeguarding visits to support residents' wellbeing. It is also progressing plans to introduce environmental sensors in temporary furnished flats to identify quality issues and to detect where a tenancy has been left empty without any tenant notification. This will speed up the process of identifying property voids to allow these to be reallocated and reduce reliance on unsuitable bed and breakfast and hotel placements. Work has also progressed on a [10 Year Temporary Accommodation Strategy \(TAS\)](#), building upon the existing [Rapid Rehousing Transition Plan](#). This will set out plans to reduce the use of unsuitable accommodation and transform temporary housing provision over the longer term. A public consultation, co-designed with people with lived experience, launched in March 2026 and will inform the final strategy.

### *Asylum and Refugee Team*

Demand for homelessness support from refugee households remains high, rising from 2,750 applications in 2024/25 to around 3,500 in 2025/26. Around 900 of these households moved to Glasgow after being granted leave to remain elsewhere, reflecting the city's ongoing role as an asylum dispersal area. In response, the Asylum and Refugee Support Team has expanded to meet demand. Working with health services, the team has also embedded a safeguarding approach to ensure the health and social care needs of refugee households in temporary accommodation are regularly assessed and addressed.

### WAYfinder

As introduced in chapter 4, WAYfinder is a redesigned homelessness outreach and support service which aims to help people experiencing or at risk of homelessness to access settled housing. The model is designed to provide joined-up support across the homelessness journey - from prevention and crisis response through to resettlement and tenancy sustainment. It provides a single, integrated model, bringing multiple outreach functions together and avoiding the need for people to engage with several separate services. It is being delivered by four third-sector providers - Simon Community Scotland, Wheatley Care, Turning Point Scotland and The Salvation Army - operating as one integrated WAYfinder service.

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### *Ask and Act: Preventing Youth Homelessness*

In 2025/26, a multi-agency consortium led by Glasgow City HSCP secured Ask and Act funding to deliver a one-year test-and-learn pilot focused on preventing youth homelessness at key transition points. The pilot aims to improve early identification of housing risk and enable timely preventative intervention before homelessness occurs. It includes embedding early 'Ask' housing risk questions into routine contact across social work, health, education, justice and third sector settings; strengthening service responses and pathways; and testing flexible, cash-first approaches that provide targeted financial support for pressures that may lead to tenancy breakdown such as rent or utility bill arrears. The learning from the pilot will inform future rollout of Ask and Act duties as well as longer-term system changes across Glasgow.



### 5.1.5 Mental Health

#### *Making it Happen*

The [Making It Happen](#) project supports people with severe and enduring mental health issues, who have spent many years in hospital, to successfully transition into community living. Delivered in partnership with Lanam Health Care, the project focused on person-centred care, with multidisciplinary teams developing tailored Discharge Support Plans and providing three months of outreach support following discharge.

All twelve individuals involved in the project successfully moved into the community, achieving greater independence, improved mental health and wellbeing and increased participation in a range of meaningful activities. The project also reduced reliance on long-term hospital beds, crisis interventions and out-of-area placements. It has demonstrated that with the right support, people with complex needs can thrive in their communities. Feedback from families, carers and staff has also been very positive.

#### **Staff Feedback**

*'The 'Making it Happen' project demonstrates how to achieve a reduction in the need for long term mental health hospital beds and increase the availability of community based complex needs care models. We are proud of what has been achieved and are committed to using the lessons from 'Making It Happen' to shape future services. The project has proven that change is possible, and that with the right approach, we can help people live well, with dignity, in the heart of their communities' (Head of Adult Services, North East).*

### 5.1.6 Primary Care

#### *Primary Care Action Plan*

Glasgow's [Primary Care Action Plan \(PCAP\) \(2023-26\)](#) sets out the HSCP's responsibilities for primary care, including managing the prescribing budget and progress is reported regularly to the IJB and in [Regular Bulletins](#). In 2025/26, the HSCP received £23.8m from the Scottish Government's Primary Care Improvement Fund, including £1.2m for the Community Link Worker Programme discussed in chapter 3. This funding has supported continued investment across a range of existing [PCAP workstreams](#) including vaccination, community treatment and care, and pharmacotherapy services, responsibility for which has been transferred from GPs to the HSCP. It has also enabled further development of urgent care and expansion of multidisciplinary teams, including physiotherapy and mental health services.

#### *Parkhead Hub*

Parkhead Hub services commenced on a phased basis over the past year and was officially opened in [December 2025](#) by First Minister John Swinney. As Scotland's largest health and care facility, it brings together health and social care services with a public library, community spaces, and the 'Social Blend' café, which provides training and employment for young people with additional needs. As discussed in chapter 4, it hosts regular events and engagement sessions, and is widely used by the community sector delivering activities supporting wellbeing, reducing isolation, and building social connections.

#### *Whole Family Support Project*

Work has continued on taking forward the [Whole Family Support Programme](#) within 12 GP practices in deprived areas across Glasgow. This has been supported by Scottish Government funding and has included the establishment of the Family Wellbeing Workers (FWWs) and Family Finance Advisors (FFAs) discussed in chapters 3 and 4. These aim to improve family wellbeing, by enabling access a range of support services to help families in poverty, who are at risk of poor health outcomes. The project also supports outreach work with families who might benefit from further engagement with primary care services to address complex health needs. As described in chapter 3, this work is being complemented by Demonstrations of Change projects in three areas of the city, which are seeking to deliver seamless, holistic support to families impacted by poverty.

### 5.1.7 Supporting Carers

The Carers (Scotland) Act 2016 gave all carers the right to an adult carer support plan or young carer statement. During 25/26 2,561 adults and young carers requested or accepted the offer of a Carers Support Plan or Young Carer Statement, compared to 2,748 in 2024/25, and 3,229 in 2023/24, as shown in the KPI section at the end of this chapter.

#### *Carers Strategy*

To mark Carers Week (10-16 June 2025), the HSCP launched our new [Carer Strategy \(2025 to 2028\)](#). This strategy sets out our vision for Glasgow as a carer aware, carer friendly city where carers are recognised, listened to and supported to live well, while continuing in their caring roles. A wide range of other activities were also undertaken during Carers Week to raise awareness of caring, highlight the challenges carers face and recognise their contributions. These included the launch of a [new video](#) which highlights the voices of local carers and the work being done across services and communities to build a more inclusive, supportive environment for carers. Further events were held on 20 November to mark [Carers Rights Day](#), which focused this year on making carers aware of their rights and what they are entitled to, either in the workplace or in education, or in respect to accessing health or social care services.

## 5.2 PERFORMANCE

### 5.2.1 Local KPIs

| INDICATOR<br>(Health & Wellbeing Outcome)   | 2020/21<br>YEAR<br>END | 2021/22<br>YEAR<br>END | 2022/23<br>YEAR<br>END | 2023/24<br>YEAR<br>END | 2024/25<br>YEAR<br>END | 2025/26<br>TARGET | 2025/26<br>ACTUAL<br>(Year End<br>unless<br>stated) | Direction<br>of Travel<br>since<br>2020/21 | Direction<br>of Travel<br>since<br>2024/25 |
|---|------------------------|------------------------|------------------------|------------------------|------------------------|-------------------|---|--|--|
| <b>Children</b>   |                        |                        |                        |                        |                        |                   |   |  |  |
| Number of out of authority placements (Outcome 4)   | N/A                    | N/A                    | 30<br>                 | 26<br>                 | 24<br>                 | 25 or fewer       | 21<br>  | ▲<br>(since 22/23)                         | ▲  |
| <b>Older People</b>   |                        |                        |                        |                        |                        |                   |   |  |  |
| No. Clustered Supported Living tenancies offered to Older People (Outcome 2)  | N/A                    | 84<br>                 | 83<br>                 | 88<br>                 | 85<br>                 | 75 per annum      | 84<br>  | ▶<br>(since 21/22)                         | ▼  |
| % service users who receive a reablement service following referral for home care:<br><b>i) from hospital</b><br>(Outcome 2)  | 70.9%<br>              | 71.7%<br>              | 70.1%<br>              | 73.9%<br>              | 84.0%<br>              | 75%               | 84.2%<br>   | ▲  | ▲  |
| <b>ii) from the community</b><br>(Outcome 2)  | 81.5%<br>              | 72.5%<br>              | 79.6%<br>              | 88.4%<br>              | 90.7%<br>              | 75%               | 89.1%<br>   | ▲  | ▼  |
| No. carers identified that have requested or accepted the offer of a Carers Support Plan or Young Carer Statement (Outcome 6) | 1,928<br>              | 2,391<br>              | 2533<br>               | 3,229<br>              | 2,748<br>              | 1,900 per annum   | 2,561<br>   | ▲  | ▼  |

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| INDICATOR<br>(Health & Wellbeing Outcome)                                | 2020/21<br>YEAR<br>END          | 2021/22<br>YEAR<br>END          | 2022/23<br>YEAR<br>END          | 2023/24<br>YEAR<br>END          | 2024/25<br>YEAR<br>END          | 2025/26<br>TARGET                 | 2025/26<br>ACTUAL<br>(Year End<br>unless<br>stated) | Direction<br>of Travel<br>since<br>2020/21 | Direction<br>of Travel<br>since<br>2024/25 |
|--|---------------------------------|---------------------------------|---------------------------------|---------------------------------|---------------------------------|-----------------------------------|---|--|--|
| Telecare referrals   | n/a                             | n/a                             | n/a                             | 3,475<br>                       | 3,313<br>                       | 1,310                             | 3,441<br>   | ▼<br>Since<br>23/24                        | ▲  |
| <b>A&amp;E Attendances</b>   |                                 |                                 |                                 |                                 |                                 |                                   |   |  |  |
| New Accident & Emergency attendances (18+). MSG 3 (Outcome 9)            | 113,633<br><br>9,469/<br>month  | 139,967<br><br>11,664/<br>month | 141,753<br><br>11,813/<br>month | 147,080<br><br>12,257<br>month  | 146,996<br><br>12,250/<br>month | 161,155<br><br>(13,430/<br>month) | 112,659<br><br>12,518/<br>month<br>(To Q3)          | ▼  | ▼  |
| <b>Emergency Admissions and Bed Days</b>                                 |                                 |                                 |                                 |                                 |                                 |                                   |   |  |  |
| Emergency Admissions (18+) MSG 1 (Outcome 9)                             | 54,947<br><br>4,579/<br>month   | 59,197<br><br>4,933/<br>month   | 56,574<br><br>4,715/<br>month   | 58,878<br><br>4,907/<br>month   | 57,732<br><br>4,811/<br>month   | 63,855<br><br>5,321/<br>month     | 28,860*<br><br>4,810/<br>month<br>(To Q2)           | ▲  | ▼  |
| Unscheduled Hospital Bed Days - Acute (18+) MSG 2 (Outcome 9)            | 450,954<br><br>37,580/<br>month | 522,500<br><br>43,542/<br>month | 548,108<br><br>45,676/<br>month | 553,550<br><br>46,129/<br>month | 547,042<br><br>45,587/<br>month | 507,633<br><br>42,303/<br>month   | 255,396<br><br>42,566/<br>month<br>(To Q2)          | ▼  | ▲  |
| <b>Delayed Discharges</b>  |                                 |                                 |                                 |                                 |                                 |                                   |   |  |  |
| Total Acute Delays (Outcome 9)   | 103<br>                         | 136<br>                         | 142<br>                         | 140<br>                         | 172<br>                         | 160                               | 139<br>   | ▼  | ▲  |
| Bed Days Lost to Delays (All delays, all reasons 18+). MSG 4 (Outcome 9) | 49,902<br><br>4159/<br>month    | 64,853<br><br>5404/<br>month    | 74,875<br><br>6,240/<br>month   | 76,777<br><br>6,398/<br>month   | 83,528<br><br>6,961/<br>month   | 45,318<br><br>3,776/<br>month     | 66,357<br><br>7,373/<br>month<br>(To Q3)            | ▼  | ▼  |
| Total number of Mental Health delays (Adult & Older People) (Outcome 9)  | N/A                             | 47<br>                          | 42<br>                          | 45<br>                          | 39<br>                          | 20                                | 68<br>  | ▼<br>(2021/<br>22)                         | ▼  |

\*Provisional figures

Note: targets may have been adjusted over the period shown, so RAG ratings for previous years may be against historical targets

## 5.2.2 Local Surveys

### *Home Care and Reablement*

As described in Chapter 4, Home Care and Reablement Services undertake a regular Service User Questionnaire survey. The most recent questionnaire was carried out in 2024 and some of the key findings from this survey in relation to our Strategic Priority of Supporting People at Home are presented below.

| Statement  | % of respondents who “strongly agreed” or “agreed” with statement | National Health & Wellbeing Outcome |
|--|---|-------------------------------------|
| My carers are professional and supportive.                                       | 94%   | Outcome 8                           |
| I tend to be supported by a regular group of home carers.                        | 73%   | Outcome 3                           |
| My home carers support me to feel safe and live in my own home.                  | 90%   | Outcome 7                           |
| My home carers recognise the importance of good hygiene for both me and my home. | 87%   | Outcome 4                           |
| I am confident that my home carers have the right skills to support me.          | 88%   | Outcome 8                           |
| I am informed of any changes to my planned care and support.                     | 69%   | Outcome 3                           |
| Overall, are you satisfied with the service?                                     | 87%   | Outcome 4                           |

### *Carers Centres*

The Carers Centres also provide an Evaluation form to Carers who have been in recent contact with their service. This asks carers to rate the service they received in relation to several criteria including those linked to the Strategic Priority of Supporting People in their Communities. Feedback from the latest survey covering 2025/26 is included below:

| Question   | % Carers Responding Positively |
|--|--------------------------------|
| improved the quality of life for the person you look after?    | 89%                            |
| improved your quality of life?                                 | 95%                            |
| improved your ability to support the person that you care for? | 95%                            |

### 5.3 KEY ACHIEVEMENTS

Local KPI Indicators where performance has shown the greatest improvement over the past 12 months:

| INDICATOR  | YEAR END 2024/25             | YEAR END 2025/26                     |
|--|------------------------------|--------------------------------------|
| Number of Children in out of authority placements  | 24<br>                       | 21<br>                               |
| % service users who receive a reablement service following referral for home care: <i>i) from hospital</i> | 84.0%<br>                    | 84.2%<br>                            |
| Telecare referrals   | 3,313<br>                    | 3,441<br>                            |
| Unscheduled Hospital Bed Days - Acute (18+)  | 547,042<br><br>45,587/ month | 255,396<br><br>42,566/ month (To Q2) |
| Total Acute Delays   | 172<br>                      | 139<br>                              |

### 5.4 AREAS FOR IMPROVEMENT

Ongoing improvement is sought across all services. KPIs relating to this Strategic Priority which we would specifically like to improve within the next 12 months are:

| INDICATOR  | Performance Issues and Actions to Improve Performance  |
|--|--|
| <p>Bed Days Lost to Delays (All delays, all reasons 18+).</p> <p><b>Target:</b><br/>45,318<br/>3,776/ month</p> <p><b>Actual:</b> 66,357<br/>7,373/month<br/>(To Q3)</p> | <p><b>Performance Issues:</b></p> <ul style="list-style-type: none"> <li>Hospital inpatient capacity remains under significant pressure due to high service demand</li> <li>A high volume of complex cases, including patients under 65 and those with clinical complexity, is increasing the demand for social work assessment and intervention</li> <li>Delays associated with private Guardianship applications continue to impact discharge timescales</li> <li>There has been a further increase in longer-term delays, largely driven by case complexity and challenges in securing appropriate care provision</li> </ul> <p><b>Actions to Improve Performance include:</b></p> <ul style="list-style-type: none"> <li>Targeted funding is supporting service improvements aimed at reducing delays and associated bed days lost</li> <li>Additional qualified social workers have been recruited, alongside increased social work hours, to strengthen assessment capacity</li> </ul> |











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|  |   |
|--|---|
|  | <ul style="list-style-type: none"> <li>• Additional legal capacity has been secured to accelerate private Guardianship applications</li> <li>• Ongoing, targeted work on complex cases is being progressed, alongside strengthened links with commissioning and homelessness services to support discharge</li> <li>• Regular scrutiny and monitoring of delays is in place, with escalation routes to senior leadership including direct reporting to the Chief Officer</li> <li>• Joint commissioning activity is focusing on long-stay and complex patients to develop tailored care solutions.</li> <li>• Ongoing improvement activity is aligned with Scottish Government expectations and wider system improvement plans</li> </ul>   |
| <p>Total number of Mental Health delays (Adult &amp; Older People)</p> <p><b>Target:</b> 20</p> <p><b>Actual:</b> 68</p> | <p><b>Performance Issues</b></p> <ul style="list-style-type: none"> <li>• The main constraint affecting delays continues to be limited availability of appropriate community placements, including supported accommodation, specialist care home beds, and services able to support individuals with complex or high-risk needs</li> <li>• Complex cases involving legal processes, including Guardianship applications and multidisciplinary assessments, are extending discharge timescales and contributing to ongoing delays</li> <li>• As a result, sustained pressures on inpatient flow, ward capacity and length of stay continue to impact overall system performance</li> </ul> <p><b>Actions to Improve Performance include:</b></p> <ul style="list-style-type: none"> <li>• Recruitment of a dedicated Mental Health Bed Manager post is progressing and will strengthen real-time oversight of bed flow, escalation and discharge coordination</li> <li>• All delayed discharge cases are now actively allocated to social work staff to ensure consistent management and progression towards discharge</li> <li>• Regular joint working with commissioning and service managers continues to identify placements, unblock pathway barriers, and develop bespoke solutions for complex cases</li> <li>• Operational teams are improving the timeliness of assessments, exploring alternative housing options, and strengthening links with third sector and commissioned providers</li> </ul> |

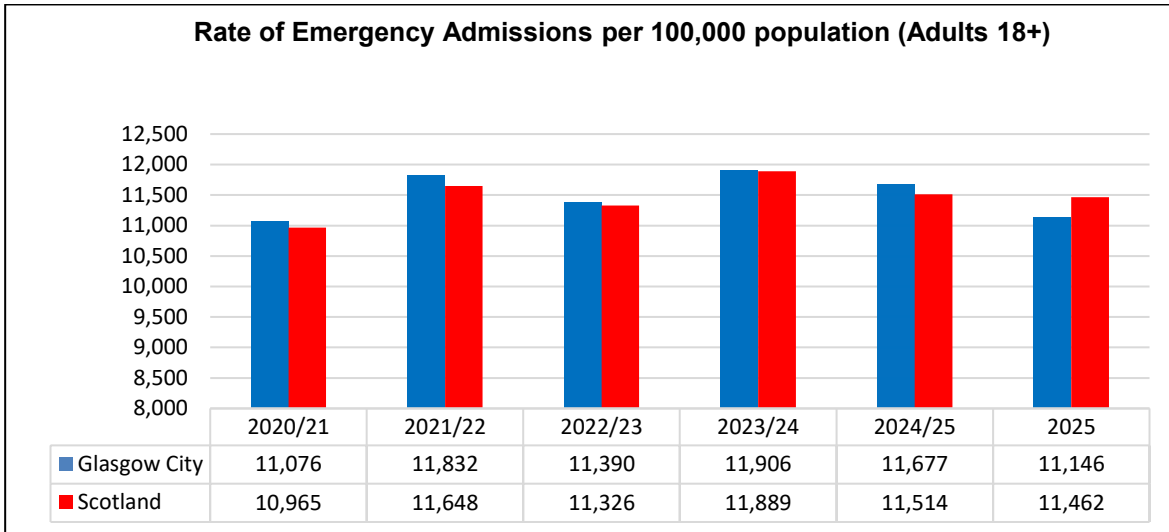
## 5.5 NATIONAL INTEGRATION INDICATORS

The majority of the National Integration Indicators relate to the Strategic Priority of Supporting People in their Communities. Data from the most recent [Public Health Scotland publication](#) in relation to these indicators is shown below, with a number of them covering the same aspects of performance as the Local KPIs set out in Section 5.2 above.

National Integration Indicators 1 to 9 are derived from the national [Health and Care Experience Survey \(HACE\)](#), which is a sample survey of people aged 17 and over registered with a GP in Scotland. Due to changes in the survey wording, only indicators 1, 6 and 8 can be compared to the last report in 2021/22.

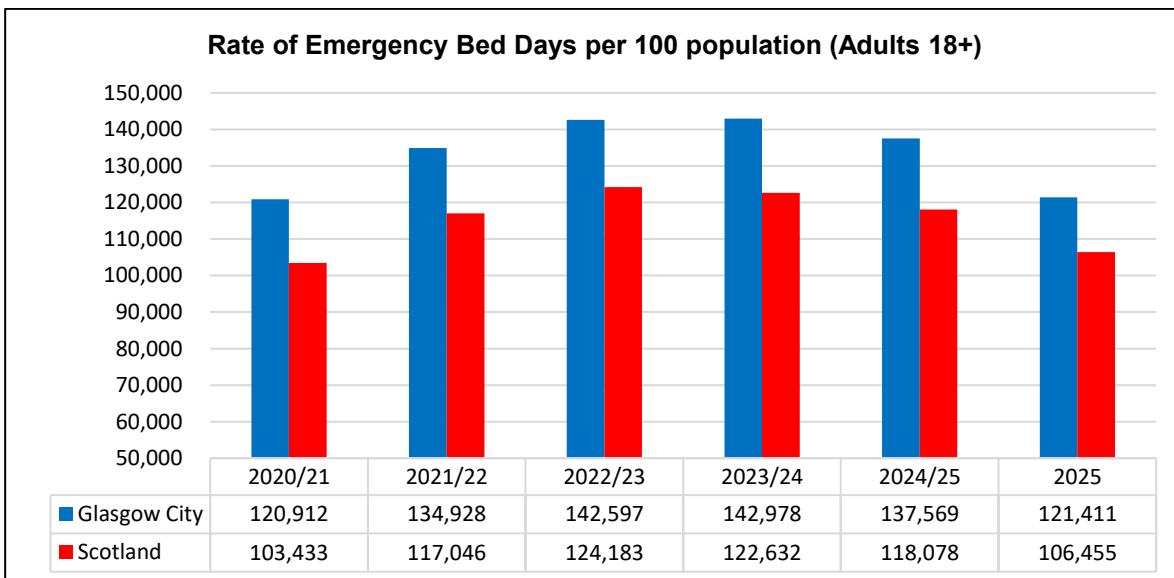
| National Integration Indicator  | 2023/24 Survey Results<br>(21/22 results shown in brackets if comparable) |                         |                         |  | Direction of Travel Since Last Survey (21/22) |
|---|---|-------------------------|-------------------------|--|---|
|   | Outcome   | Glasgow                 | Scotland                | Compared to Scottish average   |   |
|   |   |                         |                         | Above <br>Below  |   |
| 1. % adults able to look after their health very well or quite well   | 1   | <b>87.6%</b><br>(88.1%) | <b>90.7%</b><br>(90.9%) |   | ▼   |
| 2. % adults supported at home who agreed that they are supported to live as independently as possible                           | 2   | <b>72.3%</b>            | <b>72.4%</b>            |   | N/A   |
| 4. % adults supported at home who agree that their health and social care services seemed to be well co-ordinated               | 3   | <b>65.2%</b>            | <b>61.4%</b>            |   | N/A   |
| 5. % adults receiving any care or support who rate it as excellent/good   | 3   | <b>71.2%</b>            | <b>70%</b>              |   | N/A   |
| 6. % people with positive experience of the care provided by their GP practice  | 3   | <b>73.7%</b><br>(71.4%) | <b>68.5%</b><br>(66.5%) |   | ▲   |
| 7. % adults supported at home who agree that their services/support had impact on improving /maintaining their quality of life. | 4   | <b>69.7%</b>            | <b>69.8%</b>            |   | N/A   |
| 8. % carers who feel supported to continue in their caring role   | 6   | <b>34.5%</b><br>(33.7%) | <b>31.2%</b><br>(29.7%) |   | ▲   |
| 9. % adults supported at home who agreed they felt safe   | 7   | <b>72.6%</b>            | <b>72.7%</b>            |   | N/A   |

**National Integration Indicator 12**



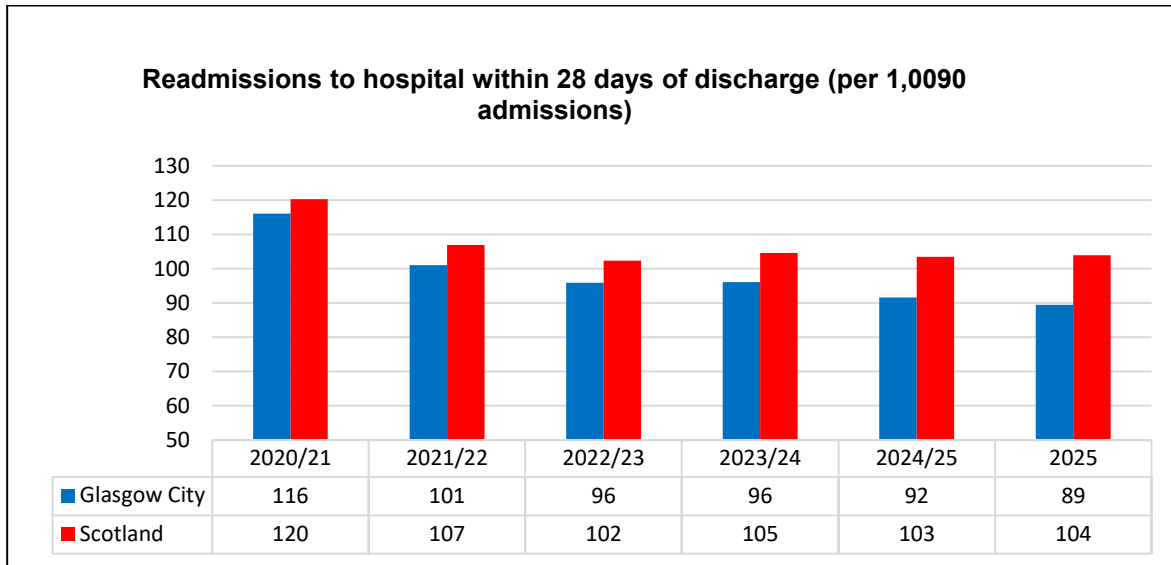
- Reduction in Glasgow over the last two years after increases prior to that, with the rate falling close to the 2020/21 rate
- Glasgow has fallen below the Scottish average during 2025 for the first time over the period shown

**National Integration Indicator 13**



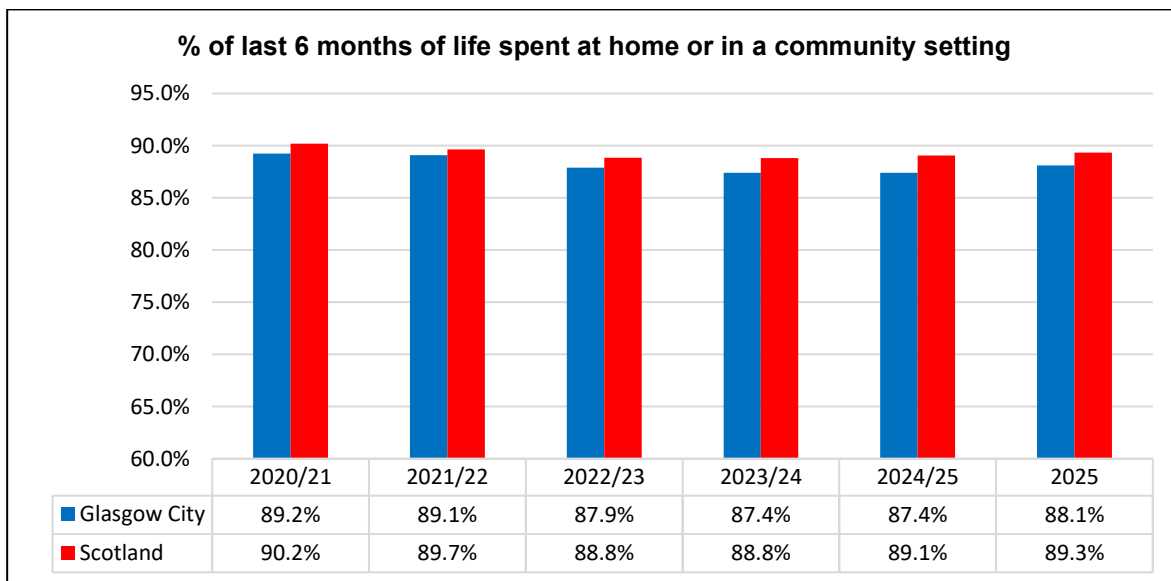
- Reduction in Glasgow over the last two years after increases prior to that, with the rate falling close to the 2020/21 rate
- Glasgow continues to be higher than the Scottish average although the gap reduced in 2025

**National Integration Indicator 14**



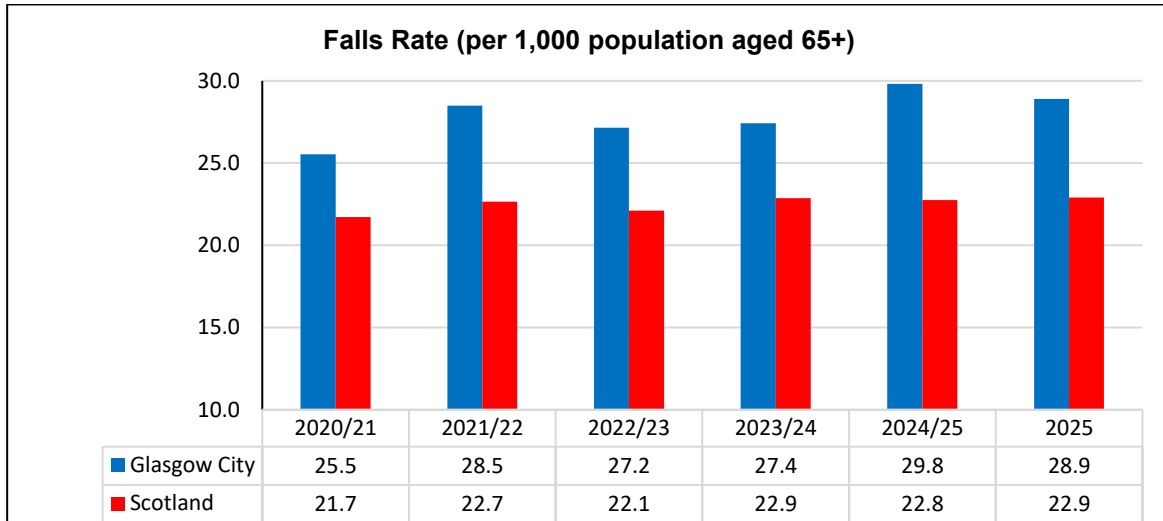
- Rate has been falling in Glasgow since 2020/21 and continued over the last year
- Glasgow has remained lower than the Scottish average over the period shown

**National Integration Indicator 15**



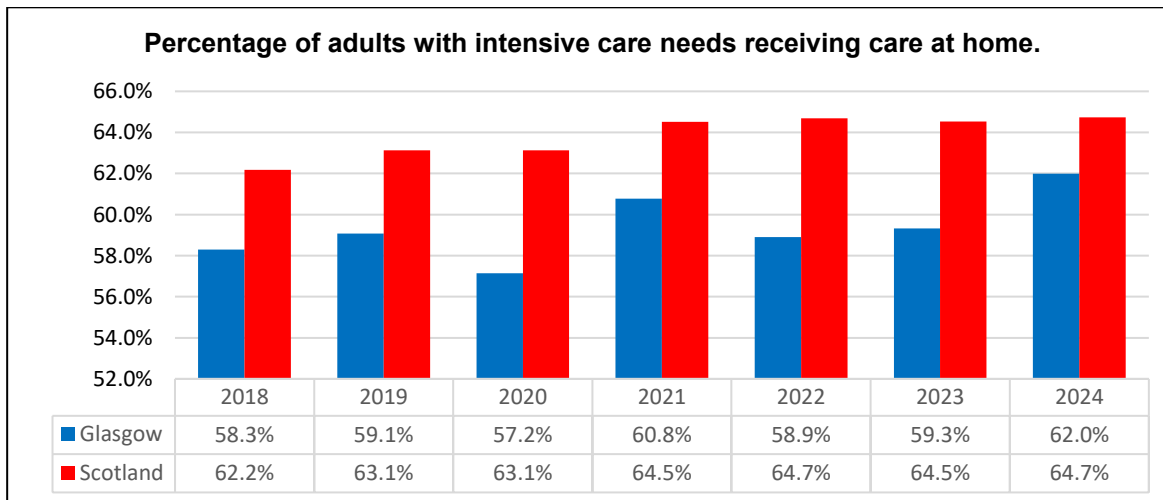
- Rate increased slightly in the last year in Glasgow after falling prior to that, but remains below the 2020/21 rate
- Glasgow has remained lower than the Scottish average over the period shown

**National Integration Indicator 16**



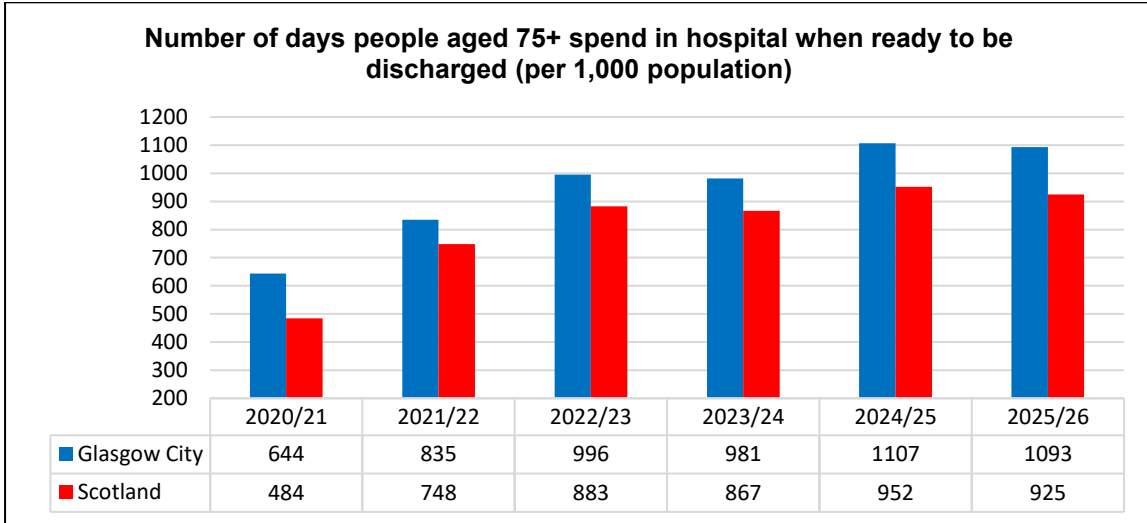
- Reduction over the last year in Glasgow, but the rate is higher than in 2020/21 & 2021/22
- Glasgow consistently higher than the Scottish average

**National Integration Indicator 18**



- Increase over the last two years in Glasgow and at highest in 2024 for the period shown
- Glasgow consistently lower than the Scottish average over the period shown
- No data currently available beyond 2024

National Integration Indicator 19



- Rates showed a slight reduction over the last year in Glasgow after significant increases since 2020/21
- Glasgow higher than the Scottish average over the period shown

**Notes**

Please note that calendar year 2025 is used for indicators 12-16 above as a proxy for 2025/26, due to the national data for 2025/26 being incomplete at this stage. This is in line with guidance issued by Public Health Scotland to all Health and Social Care Partnerships. Indicators 18 and 19 are reported as normal by calendar year (18) and financial year (19).



# 6. STRENGTHENING COMMUNITIES TO REDUCE HARM



## 6. STRENGTHENING COMMUNITIES TO REDUCE HARM

Within this section, we profile some of the key developments progressed in relation to our strategic priority of Strengthening Communities to Reduce Harm and consider performance in relation to KPIs associated with this theme. Activities undertaken have contributed to a range of the national Health and Wellbeing Outcomes, most notably the following:

|   |
|---|
| <b>Outcome 3</b>  |
| People who use health and social care services have positive experiences of those services, and have their dignity respected.       |
| <b>Outcome 4</b>  |
| Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services. |
| <b>Outcome 5</b>  |
| Health and social care services contribute to reducing health inequalities.   |
| <b>Outcome 7</b>  |
| People using health and social care services are safe from harm.  |

### 6.1 KEY DEVELOPMENTS/ACHIEVEMENTS

#### 6.1.1 Adult Support and Protection

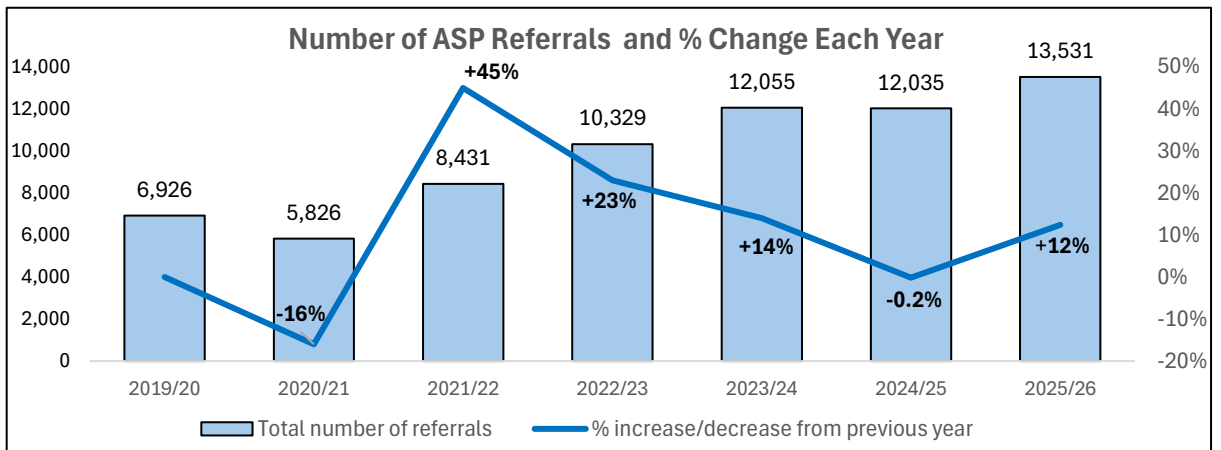
Glasgow City Adult Support and Protection (ASP) Committee and its sub-groups are the primary strategic planning mechanisms for overseeing multi-agency support and protection arrangements for adults at risk of harm. The centralised ASP Team provide a link between the Committee and the HSCP operational arrangements for delivering ASP interventions, as well as support ASP practice development and improvement. Activities progressed over the last year by them include the following:

- Working in partnership with Police and Health Colleagues, continued to implement the Tripartite Audit Improvement Plan following the last audit (2024), which now takes place every two years. Actions progressed by partners include police efforts to support improved referral quality and promote the Appropriate Adult scheme; and social work improvements to work undertaken at the Duty to Inquire stage and to the ASP Escalation protocol
- Implementation of the Adult Interagency Referral Discussion (IRD) pilot, which following initial positive feedback has been extended. It will be reviewed in July 2026 and if evaluated positively, will become an integral part of routine work. The IRD is triggered when partners have ASP concerns and believe there is significant risk of harm to the adult which would merit safety discussions being held as quickly as possible. To date, 1-4 referrals per week are being received with the majority of IRDs held within 2 days
- Rolling out of the Care Home Risk Matrix Tool to 14 care homes across Glasgow. Evaluation has shown that the tool has led to increased confidence in the reporting of ASP harm incidents and a clear improvement in consistency and accuracy of reporting. The tool will now be rolled out to the remaining 48 care homes by Autumn 2026, then potentially to all care providers in the city by the end of 2026

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- Improved ASP Management Information through full implementation of the new National Minimum Dataset, which helps partners identify trends and drive service improvements. A new ASP Performance Report has also been produced which provides information on referrals, ASP processes and timescales, as well as providing service user feedback. This is being used with localities to recognise areas of good practice and identify potential areas for improvement
- Working with the Learning and Development Team to strengthen training and development opportunities. A Chronology course was successfully delivered to front line staff, along with a new Council Officer refresher course, which were both positively evaluated. In line with the new National ASP Learning and Development Framework, the team are also now reviewing the full ASP training suite to ensure it continues to support practice and development for front line staff, with a survey issued to gather their views. Staff have also supported ASP Team Leader development sessions, local ASP Practitioner Forums and ASP Spotlight learning events that focus on areas of service complexity

### ASP Referrals



- There were 13,531 referrals in 2025/26, compared to 12,035 the previous year (an increase of 1,496 or 12%) This continues the steady increase in referral numbers seen since 2020/21 (apart from the small decrease in the 2024/25)
- Of the 13,531 referrals in 2025/26, 3,513 (26%) used Investigatory Powers, with 74% not requiring them
- Care Homes (31%), various NHS services (14%) and Police Scotland (13%) were the biggest referrers locally in 25/26, followed by Third Sector Organisations and Housing, which were 12% and 11% respectively



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### 6.1.2 Child Protection

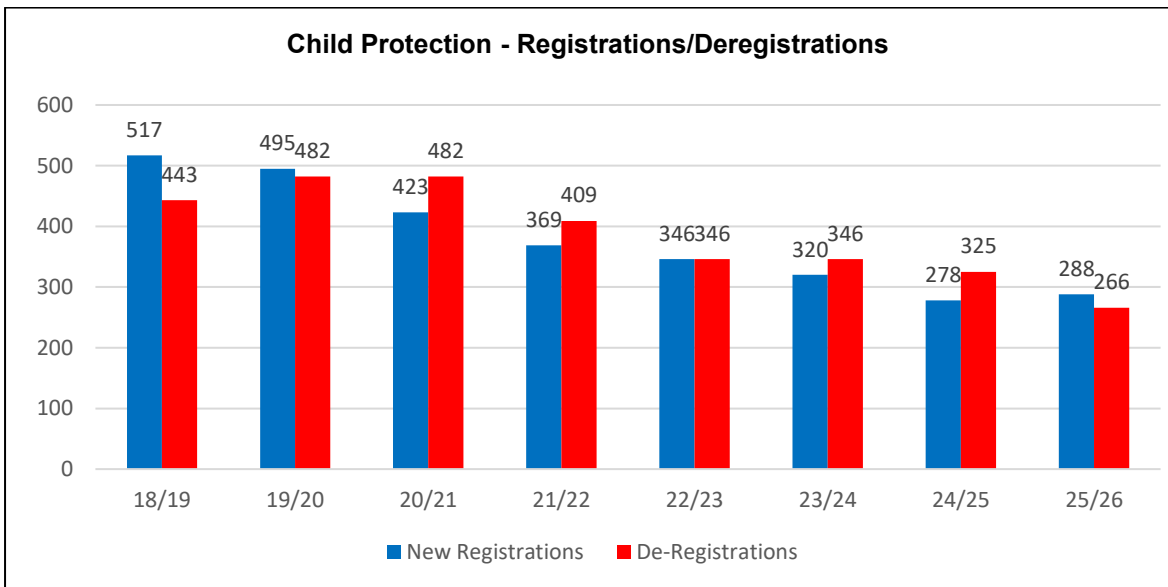
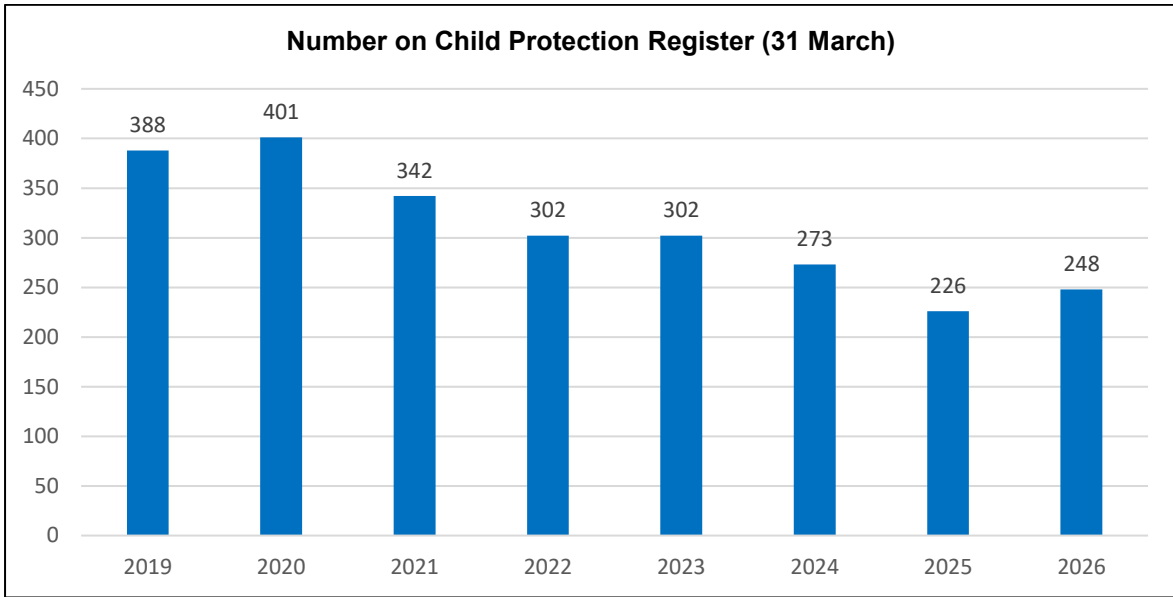
The centralised citywide Child Protection (CP) Team provides strategic leadership, policy development and practice oversight to support the protection of children and young people at potential risk of significant harm. The team coordinates governance arrangements across locality services; undertakes case reviews at the request of localities and the Child Protection Committee (CPC); and translates national child protection policy and legislation into local practice. Activities progressed over the last 12 months include the following:

- Following the Care Inspectorate joint inspection in 2025, Glasgow City received an overall evaluation of “Good”, with clear strengths and areas for improvement identified. The team continues to play a key role in progressing the resulting improvement plan, alongside engagement and communication with children, young people, and families involved in the inspection
- The Child Protection Framework for Practice was implemented across Children and Families, supported by updates to Carefirst recording arrangements; interactive workshops and briefing sessions; the production of guidance materials; and sessions with partners on resultant changes to child protection practice
- Undertaken a review of the Young Person Support and Protection (YPSP) Framework for Practice. Once implemented, this will include guidance on the introduction of Care and Risk Management (CARM) processes for children whose behaviour poses a serious risk to others or themselves, in line with the Scottish Government’s CARM framework
- Worked with Learning and Development to deliver a comprehensive suite of training including the relaunching of Child Protection Assessment training; and ongoing work on the Child Protection Training Pathway
- Contributed to the sub-groups set up by the Child Protection Committee in relation to: Neglect, Young Person’s Support and Protection (YPSP), and Interagency Referral Discussion (IRD). These have focused on improving child protection arrangements within the city by strengthening multi-agency collaboration; updating guidance, tools and training; and developing more consistent approaches to assessment, information sharing, and early intervention
- Supported several evaluations and audits in relation to reporting and referral systems/forms; cases with extended child protection involvement; and approaches to identifying and supporting children affected by exploitation and trafficking
- Developed a chronology tool which has been embedded within careFirst and has been communicated via briefings and Child Protection Assessment training
- Developed a Child Protection Performance Framework and interactive dashboard based upon identified key performance indicators

#### *Child Protection Trends*

Trends over time in respect of child protection data are shown below. These indicate that the numbers on the Child Protection Register have been on a downward trend, as have the number of Registrations/Deregistrations, although there has been a slight increase in the number in the last year.

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In terms of age breakdown, at the end of March 2026, 42% of children on the CP register were aged 0 to 4; 41% were 5 to 11; 14% were 12 to 15 while the remaining 3% were 16 and over. This compares to 49% (0-4), 34% (5-11), 15% (12-15), and 2% (16 and over) in March 2025.

### 6.1.3 Justice Services

#### *MAPPA Public Protection Arrangements*

In line with national guidance, Multi-Agency Public Protection Arrangements (MAPPA) are in place within the city with respect to the management of individuals who pose a risk of serious harm. These arrangements seek to reduce the risk of serious harm posed by registered sex offenders, mentally disordered restricted patients, and other 'risk of serious harm' offenders.

Glasgow MAPPA published its sixteenth [Annual Report \(2024-25\)](#) in November. This includes a range of related statistics and information upon Glasgow's performance in relation to the eight [National Performance Indicators](#) and it indicated all national targets were being met. A [national MAPPA report](#) was also published in November by the Scottish Government, which gave an overview of national performance and provided examples of cases illustrating good practice, including Glasgow. Work was also undertaken locally to prepare for the introduction of a new national IT system (MAPPS) for managing violent and sexual offenders under MAPPA, with Glasgow participating in system testing and engaging in national forums developing guidance and overseeing progress.

#### *Caledonian Domestic Abuse Project*

The Caledonian Project is a domestic abuse intervention that works with men convicted of domestic abuse with the aim of reducing repeat offending, while also supporting women and children affected by abuse. It lasts up to two years, and combines structured work with men to change their abusive behaviour; voluntary safety planning; and emotional support for women and children to protect their wellbeing. During the last year, the service was reviewed and a strategic plan produced. This seeks to develop the service to focus on enhanced risk assessment, interventions, and management of complex cases. Significant work is also underway to review operational processes and improve management information through the creation of data dashboards.

#### *Justice Social Work*

Justice Social Work are progressing a range of actions to improve community safety, reduce pressure on prisons, improve support for people returning from custody, and create more opportunities for reintegration and rehabilitation, in line with the [Community Justice Glasgow Outcomes Improvement Plan \(2023-28\)](#). An [Annual Overview Update](#) was provided to the IJB in November 2025, which included the following activities:

- Supported national early prison release schemes by strengthening throughcare planning, implementing updated national Risk Management Standards (2025) and improving alignment and collaboration between prison and community teams
- Increased capacity to support the shift towards community-based sentencing, including bail supervision, diversion from prosecution and structured deferred sentences
- Maintained a daily social work presence in custody courts, providing real-time advice to legal professionals on bail and alternatives to remand, following implementation of the Bail and Release from Custody (Scotland) Act 2023. Early feedback shows this has positively supported judicial decision-making

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- Enhanced the Drug Court Team, introducing Structured Deferred Sentences for individuals not suited to the more intensive Drug Treatment and Testing Orders (DTTOs), enabling assessment and tailored planning prior to sentencing
- Expanded unpaid work placements with local partners across all locality areas, strengthening community links and reinforcing the value of unpaid work as a restorative justice option



### 6.1.4 Alcohol and Drugs

#### *The Thistle Safer Drug Consumption Facility*

The UK's first safer drug consumption facility - the [Thistle](#) - marked its first year of operation in January 2026. As a three-year pilot, it provides a supervised, hygienic space for people to inject drugs obtained elsewhere, aiming to reduce overdoses, treat injection-related infections, and minimise the community impact of outdoor drug use. The service also offers access to basic amenities like washing facilities and clean clothes, health services, as well as referrals to housing, addiction and other services, including Blood Borne Virus (BBV) testing, as required. As the service has developed, it has identified growing demand from people who consume drugs via smoking or inhalation and plans have been progressed, following IJB approval, to develop a full [Business Case](#) for a dedicated inhalation space at the Centre. Since opening, 575 individuals (448 male 127 female) have registered, with over 11,000 visits and 7,800 injections. Ninety-three medical emergencies were safely managed on site and encouragingly, more people have accessed treatment and care for their drug use than expected at this stage.

#### **Service User Feedback**

*'I used the service for the first time today. It was really good. The staff were very nice. I felt safe and clean as I wasn't using outside in dirty lanes.'*

*'I want to thank all the staff who give up their time to work with us, you have no idea how many lives you are changing.'*

*'They are amazing staff. If it wasn't for them I wouldn't be clothed, I wouldn't be washed, I wouldn't have people to speak to. I get a wee bit of peace here.'*

#### *Recovery Communities*

[Recovery Groups](#) set up by lived experience peers have operated independently in each locality for more than 20 years. They have developed to become larger communities that promote and deliver peer-led recovery initiatives to people experiencing alcohol and drug harms. These communities were awarded charitable status in 2022 and became commissioned services, supported by their own outreach workers. Each has their own programme of activities ranging from drop-in information sessions, recovery cafes and support groups, to social events and educational courses. During the last year, the communities held their largest ever citywide event - [People Make Recovery](#) - to celebrate the achievements of individuals in recovery and raise awareness of the services supporting them. This brought together over 500 people and included a range of entertainment, as well as access to holistic therapies, a resources fair and opportunities for the sharing of personal recovery stories.

## 6.2 KPI PERFORMANCE

### 6.2.1 Local KPIs

|  |         |         |         |         |         |                |         |   |   |
|--|---------|---------|---------|---------|---------|----------------|---------|---|---|
| Number households reassessed as homeless/potentially homeless within 12 months.<br>(Outcome 7)                         | 420<br> | 526<br> | 406<br> | 312<br> | 414<br> | <480 per annum | 410<br> | ▲ | ▲ |
| Percentage of Community Payback Order (CPO) unpaid work placements commenced within 7 days of sentence.<br>(Outcome 4) | 76%<br> | 87%<br> | 89%<br> | 90%<br> | 83%<br> | 80%            | 88%<br> | ▲ | ▲ |
| % of Service Users with a Case Management Plan within 20 days*<br>(Outcome 4)  | 85%<br> | 93%<br> | 97%<br> | 93%<br> | 89%<br> | 85%            | 90%<br> | ▲ | ▲ |

#### Notes

- \*This includes Community Payback Orders, Drug Treatment and Testing Orders (Drug Court), and Throughcare Licenses (Clyde Quay, Sex Offender Criminal Justice Services)
- These targets may have been adjusted over the period shown, so RAG ratings for previous years may be against historical targets.

## 6.3 KEY ACHIEVEMENTS

Local KPI Indicators where performance has shown the greatest improvement over the past 12 months:

| INDICATOR  | YEAR END 2024/25 | YEAR END 2025/26 |
|--|------------------|------------------|
| Number of households reassessed as homeless/ potentially homeless within 12 months                     | 414<br>          | 410<br>          |
| Percentage of Community Payback Order (CPO) unpaid work placements commenced within 7 days of sentence | 83%<br>          | 88%<br>          |
| % of Service Users with a Case Management Plan within 20 days  | 89%<br>          | 90%<br>          |

## 6.4 AREAS FOR IMPROVEMENT

There are no specific KPIs relating to this Strategic Priority we would highlight as to be improved within the next 12 months, but ongoing improvement is sought across all service areas.



# 7. A HEALTHY, VALUED AND SUPPORTED WORKFORCE



## 7. A HEALTHY, VALUED AND SUPPORTED WORKFORCE

Within this section, we profile some of the key developments progressed in relation to our strategic priority of A Healthy, Valued and Supported Workforce and consider performance in relation to KPIs associated with this theme. Activities undertaken have contributed to a range of the national Health and Wellbeing Outcomes, most notably the following:

| Outcome 1  |
|--|
| People are able to look after and improve their own health and wellbeing and live in good health for longer.   |
| Outcome 8  |
| People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide. |

### 7.1 KEY DEVELOPMENTS/ACHIEVEMENTS

#### 7.1.1 Supporting Our Staff

##### *iMatter*

iMatter is a national staff engagement questionnaire that measures staff engagement and satisfaction. In 2025, the HSCP results showed an overall improvement, with the response rate rising from 54% to 57%; the overall Employee Engagement Index rising from 77 to 78 (remaining classified by iMatter as 'Strive and Celebrate'); and the percentage of teams completing an action plan in response to their team report increasing from 30% to 36%.

##### *Staff Mental Health and Wellbeing*

The Staff Mental Health and Wellbeing group has been refreshed and a clearer remit established. During the last year, a wellbeing survey was issued to all staff to assess their awareness of existing wellbeing support and the results will inform the future priorities of the Group. A specialised wellbeing webinar for managers has also been designed, with the aim of helping them to understand how they influence 'Good Days at Work'. As part of this, managers can access a Leadership Impact tool, which helps them reflect on their natural leadership style and the impact it may have upon those they manage. Access to Psychological Therapies for NHS staff was also established, enhancing early intervention for psychological concerns.

##### *Supporting Attendance*

During 2025–26, the HSCP's Supporting Attendance Action Plan strengthened attendance management efforts across NHS and Social Work services. Key improvements included clearer guidance and early access to resources for managing psychological and musculoskeletal absences. HR surgeries and dedicated HR advice were also provided with the aim of improving responsiveness and the consistency of short-term absence management across the HSCP. Long-term absence cases were also systematically reviewed and targeted interventions applied in known hotspot areas

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Governance and oversight was also improved through Performance Improvement Groups, which provide monthly oversight of absence activity. This is now an integrated approach to performance across the HSCP. Building upon a training needs analysis, HR briefings and training opportunities were also expanded for managers, with communications reminding them of the high priority of managing attendance and the requirement to complete mandatory training upon it.

### 7.1.2 Awards

In the last year, the HSCP have submitted nominations for a variety of internal and external awards, with winners or recognitions including the following:

- James McLean Project – Shift Team, Winner, Team of the Year, Glasgow City HSCP Staff Awards for Excellence 2026
- Balmore Children’s House, Commendation, Team of the Year, Glasgow City HSCP Staff Awards for Excellence 2026
- Sabine Gnauck, Service Manager, Winner, Employee of the Year, Glasgow City HSCP Staff Awards for Excellence 2026
- Mark O’Donnell, Therapeutic Activity Nurse, Commendation, Employee of the Year, Glasgow City HSCP Staff Awards for Excellence 2026
- Marie Brown, Service Manager, Winner, Leader of the Year, Glasgow City HSCP Staff Awards for Excellence 2026
- Sinead Mallon, Project Leader, Commendation, Leader of the Year, Glasgow City HSCP Staff Awards for Excellence 2026
- Stuart James, Engagement and Equalities Coordinator, Winner, Volunteer of the Year, Glasgow City HSCP Staff Awards for Excellence 2026
- The Young Persons Befriending Service – Volunteer Team, Commendation, Volunteer of the Year, Glasgow City HSCP Staff Awards for Excellence 2026
- Enhanced Care Service, Winner, Innovation of the Year, Glasgow City HSCP Staff Awards for Excellence 2026
- Making It Happen Project Team, Commendation, Innovation of the Year, Glasgow City HSCP Staff Awards for Excellence 2026
- Thistle Project Team, Overall Winner, Glasgow City HSCP Staff Awards for Excellence 2025
- HSCP North West Primary Care Pharmacy Team – Zendesk staff, Winner, Better Value, NHS Greater Glasgow and Clyde Celebrating Success Awards 2025
- HSCP Home Care Team, Winner, Top Team Award, Scottish Health Awards 2025
- Mark Mason, Biomedical Scientist, Sandyford Sexual Health Services, Winner, Healthcare Scientist of the Year, The Chief Scientific Officer’s Awards 2025
- The Thistle Centre Team (Safer Drug Consumption Facility), Winner, Community Mental Health Team, The Mental Health Nursing Forum (Scotland) Awards 2025
- HSCP Practice Development Nursing Team – Adult Services (Mental Health, Prison Health Care, Alcohol and Drug Recovery Service and Sexual Health Service), Highly Commended, Jonathan MacLennan Award for Practice Development, The Mental Health Nursing Forum Scotland Awards 2025

### 7.1.3 Communications

Effective communication enables the HSCP to engage with staff and other key stakeholders to increase awareness of its priorities and to involve them in the planning and delivery of services. This past year, Glasgow City HSCP’s communications activities have included:

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- Launched [Health and Social Care Information Glasgow](#), replacing *Your Support Your Way Glasgow*. This provides accessible information, advice and guidance on local and citywide health, social care and community supports across the statutory, independent and third sectors. This includes services, groups, networks and advice on topics such as health, wellbeing and money advice. As part of this work, the national [ALISS](#) information resource replaced the previous resource directory
- Redeveloped and launched the [Sandyford website](#) for NHSGGC sexual health services, informed by extensive user-journey work and feedback from patients, staff and stakeholders. The new site prioritises ease of access, clear language and digital accessibility, meeting NHS and global web standards
- Improved accessibility across the [HSCP Website](#) to meet national accessibility standards. Following an audit by UK Government Digital Services in Spring 2025, a programme of website improvements were undertaken. The site was subsequently reaudited and confirmed as compliant, reducing barriers for people with disabilities
- Developed and promoted additional accessibility guidance for internal and external communications, supporting more consistent best practice and accessible communications across the HSCP
- Expanded HSCP's social media presence, using a planned content calendar across [Facebook](#), [X \(formerly Twitter\)](#); [YouTube](#); and [Instagram](#) to support national and local campaigns. New social media channels were also launched for the Glasgow City Alcohol and Drug Partnership, including Facebook (public and service users) and LinkedIn (staff and partners)
- Published the [Partnership Matters](#) briefing to keep internal and external audiences informed of key partnership activity, alongside a range of service-specific newsletters (including Maximising Independence, Home Care, Primary Care and Foster Carers)
- Launched the [Chief Officer Catch Up](#), a regular video update to keep staff and partners informed of priorities, progress and service achievements, and to recognise workforce contributions
- Maintained and developed website content, including updates to IJB and committee pages, service information, news and major programmes and projects such as [The Thistle](#) or [Parkhead Hub](#). New online forms were also introduced, including Housing Options advice, BSL interpreter booking and staff safety roles
- Provided communications support to a wide range of programmes, services and campaigns, including service redesign, prevention and wellbeing campaigns, children's rights, mental health, substance use, fostering and adoption, suicide prevention, health improvement and cost-of-living activity at local and national levels.
- Delivered graphics and design support for print and digital publications, recruitment and training materials, performance and annual reports, locality plans, commissioning frameworks, service branding and workforce resources
- Produced a range of videos to promote HSCP services and partnership activity, including service awareness, lived experience, staff recognition and community initiatives, published mainly via the HSCP YouTube channel
- Supported and delivered key internal and external events, including the HSCP Staff Awards for Excellence, leadership events, STEP Forward programme engagement, recovery events and fostering recruitment activity

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*Activity*

- During 2025/26, 54,957 people visited the HSCP's website, with 204,754 page views
- At 31 March 2026, the HSCP's Facebook profile had 4,579 followers, with 695 posts made during 2025/26
- At 31 March 2026, the HSCP's X profile had 5,301 followers, with 611 posts made during 2025/26
- As at 31 March 2026, the HSCP's Instagram profile had 77 followers
- As at 31 March 2026, the HSCP's YouTube channel had 487 subscribers



7.2 PERFORMANCE

7.2.1 Local KPIs

| INDICATOR<br>(Health &<br>Wellbeing<br>Outcome)           | 2020/<br>21<br>YEAR<br>END  | 2021/<br>22<br>YEAR<br>END   | 2022/<br>23<br>YEAR<br>END   | 2023/<br>24<br>YEAR<br>END   | 2024/<br>25<br>YEAR<br>END   | 2025/26<br>TARGET | 2025/26<br>YEAR<br>END   | Direction<br>of Travel<br>since<br>2020/21 | Direction<br>of Travel<br>since<br>2024/25 |
|---|---|--|--|--|--|-------------------|--|--|--|
| NHS<br>Sickness<br>Absence rate<br>(Outcome 8)            | 5.1%<br> | 6.39%<br> | 7.01%<br> | 7.66%<br> | 8.11%<br> | <6%               | 8.11%<br> | ▼  | ▶  |
| Social Work<br>Sickness<br>Absence<br>Rate<br>(Outcome 8) | 8.4%<br> | 9.8%<br>  | 10.3%<br> | 11.5%<br> | 9.6%<br>  | <5%               | 9.6%<br>  | ▼  | ▶  |

### 7.3 AREAS FOR IMPROVEMENT

Ongoing improvement is sought across all services. KPIs relating to this Strategic Priority which we would specifically like to improve within the next 12 months are:

| INDICATOR  | Performance Issues and Actions to Improve Performance  |
|--|--|
| <p>NHS Sickness Absence rate (%)</p> <p><b>Target:</b> &lt;6%</p> <p><b>Actual:</b> 8.11%</p>        | <p><b>Performance Issues:</b></p> <ul style="list-style-type: none"> <li>• Seasonal illness, including flu-related absence, has remained a contributing factor during the winter period</li> <li>• Ongoing monitoring has identified variability in absence levels, with a need to distinguish between short-term seasonal impacts and sustained trends requiring intervention</li> <li>• While the overall position has improved, absence management remains a key priority to support service resilience and workforce wellbeing</li> </ul> <p><b>Actions to Improve Performance include:</b></p> <ul style="list-style-type: none"> <li>• Performance Improvement Groups remain in place across HSCP management teams, with absence continuing as a priority focus for Assistant Chief Officers and Heads of Service, supported through the Performance Review Group chaired by the Chief Officer.</li> <li>• The Wellbeing and Attendance Action Plan continues to be implemented, promoting a consistent approach to attendance management, including early intervention, reasonable adjustments and proactive wellbeing support.</li> <li>• A dedicated Attendance Management Team is being established on a permanent basis, with additional staffing resource to target areas requiring the greatest level of support</li> <li>• Management teams are being supported to make more effective use of attendance data, strengthening the ability to respond rapidly to emerging trends and seasonal pressures</li> <li>• Weekly monitoring of absence, alongside existing quarterly reporting, has been introduced to provide earlier visibility of trends and support more timely, targeted interventions</li> <li>• These combined actions are expected to support sustained and incremental improvement over time, although some seasonal fluctuation is anticipated, particularly during winter periods</li> </ul> |
| <p>Social Work Sickness Absence Rate (%)</p> <p><b>Target:</b> &lt;5%</p> <p><b>Actual:</b> 9.6%</p> | <p><b>Performance Issues:</b></p> <ul style="list-style-type: none"> <li>• The nature of work within social care involves sustained physical effort and emotional demands, both of which can impact staff wellbeing and contribute to higher levels of sickness absence</li> <li>• The age profile of the workforce is also a contributing factor, with a higher likelihood of age-related health conditions such as musculoskeletal issues and long-term illness</li> </ul>   |

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|  |   |
|--|---|
|  | <p><b>Actions to Improve Performance include:</b></p> <ul style="list-style-type: none"><li>• Performance Improvement Groups remain in place across HSCP management teams, with absence continuing as a priority focus for Assistant Chief Officers and Heads of Service, supported through the Performance Review Group chaired by the Chief Officer.</li><li>• The Supporting Attendance Action Plan 2025/26 has delivered measurable improvements, with lower absence levels recorded in each quarter compared to the previous year.</li><li>• A refreshed Supporting Attendance Action Plan for 2026/27 has been developed and will build on this progress, with a focus on sustaining and further improving attendance levels.</li><li>• The updated plan will continue to target the two leading causes of absence, i.e. psychological (including stress) and musculoskeletal conditions, alongside targeted wellbeing initiatives informed by the recent Staff Wellbeing Survey.</li><li>• These combined actions are expected to support continued, incremental improvement in attendance levels as the 2026/27 plan is implemented and embedded across services.</li></ul> |
|--|---|



# 8. BUILDING A SUSTAINABLE FUTURE

## 8. BUILDING A SUSTAINABLE FUTURE

Within this section, we profile some of the key developments progressed in relation to our strategic priority of Building a Sustainable Future. Activities undertaken have contributed to a range of the national Health and Wellbeing Outcomes, most notably the following:

| <b>Outcome 8</b>   |
|--|
| 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. |
| <b>Outcome 9</b>   |
| Resources are used effectively and efficiently in the provision of health and social care services.  |

### 8.1 Workforce Plan

Glasgow City HSCP is required by the Scottish Government to publish a workforce plan every three years. The new [HSCP Workforce Plan \(2025-2028\)](#) was approved by the IJB on January 2026 and is framed around the five pillars of the workforce journey - Plan, Attract, Employ, Train and Nurture. The plan takes account of the Scottish Government's requirements set out in the National Workforce Strategy for Health and Social Care in Scotland. Underpinning the Plan are commitments to promote GCHSCP and Glasgow as a great place to work; to support and nurture our workforce; to look after staff mental and physical wellbeing; and to offer rewarding and fulfilling roles and development opportunities.

### 8.2 Recruitment

Recruitment remained a key priority during 2025/26. HR continues to review workforce projections and plan recruitment needs for the year ahead, working closely with services to facilitate recruitment to frontline and high-turnover roles, as well as streamline overall recruitment processes.

Targeted advertising campaigns to reach specific audiences and attract candidates in a cost-effective way have been implemented, with a local campaign using TV and social media successfully run for Homecare Services in early 2026. Candidate events and screening have also proved useful for Care Services ahead of formal selection processes and have reduced the number of AI generated applications received. The HSCP is also using targeted social media posts to support wider employment initiatives and strengthen our employer brand across Glasgow. Engagement levels are continuing to grow, helping the HSCP to attract a broader and more diverse pool of applicants.

The recruitment team also work with local schools, colleges, and universities to promote careers within health and social care and have attended regular recruitment and job fairs throughout the year to provide information, guidance, and support to prospective applicants.

### 8.3 Succession Planning

A Succession Planning Programme Board is in place with a Succession Plan for the Executive Leadership Team submitted to them annually. Further work has also been planned for later in 2026 to ensure that a Succession Plan is in place for SMT and other critical posts. Succession planning is also part of any service change activity, with part of the recruitment vacancy approval process being a requirement to consider vacancies and ensure succession planning at Core Leadership Team meetings, prior to submission to the HSCP's Workforce Planning Subgroup.

### 8.4 Career Pathways

Examples of work to support career pathways within the HSCP during the last year include the following:

- The award-winning Care Intern Partnership Programme, co-designed with Glasgow Clyde College, combines an 18-week course with 12 hours of weekly paid work, leading to a guaranteed Social Care Assistant interview on completion
- The Modern Apprentice Programme recruits 10 young people (16–24) annually, who complete a 2–4 year programme, depending on their progression and are supported to apply for roles within our Day Care establishments
- The HSCP received approval by SSSC (Scottish Social Services Council) and SQA (Scottish Qualifications Authority) to deliver the [Professional Development Award in Practice Learning \(PDAPL\)](#) award in-house. This trains social workers to become practice educators for students and in 2025, 10 social workers qualified and a further 27 are in training, with around 75 students supported annually.
- The North East Rehabilitation Service introduced extended clinical roles (e.g. falls assessments) for Band 4 support workers, improving access and workforce sustainability. This approach has been adopted citywide and recognised nationally as good practice in multidisciplinary working and skill mix development. The Chartered Society of Physiotherapy produced a [short video](#) showcasing the approach in September 2025 to promote wider understanding and adoption

### 8.5 Management and Leadership Development

A number of management and leadership development opportunities have been provided over the last 12 months including the following:

- The Leading, Managing and Care Programme, provided by the Open University, saw 17 managers qualify in 2025, with a further 17 expected to do so by June 2026
- The Coaching Conversations for Leaders Programme, supporting managers to have effective performance discussions, was completed by 60 managers in 2025 with a similar number due to complete in 2026
- The Professional Development Award (PDA) in supervision (required for residential managers) was completed by 24 managers in 2025, with 14 more due to finish in 2026
- The Pilot Leadership Accelerator Management Development Programme was launched with 20 participants. This involved them attending a series of 5 workshops which aim to build leadership competencies, skills, and knowledge, to support effective performance and career progression. Learning from the pilot will inform future iterations, with further cohorts planned for 2026/27

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- The Coaching Conversations & Influencing for Performance and Change (CCIP) pilot commenced with 17 managers participating in 2 full day workshops, designed to develop coaching, feedback and influencing skills
- The Professional Coaching Service, hosted and led by the HSCP in collaboration with NHSGGC, supported 21 managers with 1-2-1 coaching during the last year
- A 6 day Scottish Coaching and Leading for Improvement Programme (SCLIP), focusing on quality improvement and leading change, was delivered to 19 middle and senior managers by the HSCP's Organisational Development team in collaboration with the Clinical Effectiveness Team,
- The Women's Leadership Development Programme pilot launched for both NHS and Council staff. This aims to address barriers faced by women when progressing into leadership roles. Learning from the pilot will inform future planned iterations. Work is also underway to develop a complementary suite of self-serve resources focusing on key themes from the pilot.

### 8.6 Staff Training and Development

A range of learning and development opportunities for the wider staff group have also been made available in 2025/26, including the following:

- GCHSCP continues to encourage and support social workers to gain a range of professional postgraduate qualifications, covering costs and study time (e.g. Certificate in Mental Health Social Work (MHO) and the Child Protection Diploma),
- Ongoing delivery of SVQ programmes for Care Services staff, ensuring SSSC (Scottish Social Services Council) requirements are met. Over 150 staff qualified in 2025 and 100 are in progress. 96% of Home Care staff are now registered, with the remainder progressing to registration within the agreed timelines
- Trauma training has been strengthened with a new e-learning module implemented last year, adding to the existing suite of trauma related resources developed by the HSCP's Trauma Lead
- A project team has implemented a training strategy to equip staff with the necessary skills and knowledge to apply 'strengths-based approaches' in their daily practice. Following a successful pilot, training will be rolled out across adult services during 2026
- The Learning and Development team in Care Services delivered [Intensive Autism Training](#) to develop staff knowledge, confidence, and skills to support families with a child with autism, or other related neurodiverse differences.
- Promoting Positive Behaviour (PPB) training, which is designed to help workers manage challenging behaviour, continued to be delivered to a range of staff groups, with a number of core courses and refresher programs ongoing
- A Dementia Skills program which was integrated into several Care Services Induction Programmes has continued to be implemented, with approximately 260 staff being trained by the end of 2025
- A Training Liaison Group has expanded face to face and online Public Protection learning opportunities, with 500 staff trained on a range of topics including Adult Support and Protection (ASP), Adults with Incapacity, Child Protection and Domestic Abuse. An ASP Digital Resource Library has also been made available
- General and role specific Induction Programmes continue, including a 9-day programme for Home Care staff covering topics such as moving and assisting, first aid, and dementia awareness. Bespoke inductions for 53 NQSW's (Newly Qualified Social Workers) were also organised in 2025.

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## 8.7 Strathclyde University Strategic Partnership

During the last year, the HSCP renewed its [Strategic Partnership \(SPA\) with the University of Strathclyde](#), which provides academic and research capacity to support evidence based innovation in health and social care. It has also provided a number of development opportunities for HSCP staff, including the following:

- 10 fully funded MPhil places for HSCP officers, enabling them to undertake advanced academic study focused on health and social care, while developing their analytical, research, and critical-thinking skills.
- Involvement of staff in university teaching activities, including delivering tutorials and supporting the development of academic content within the University's Healthy Ageing modules.
- Delivery of Joint PhD studentships focused on collaborative leadership and exploring how multidisciplinary teams can work together more effectively.





# 9. EQUALITIES

## 9. EQUALITIES

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

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

Glasgow City HSCP Equalities Working Group oversees the programmes of work related to the Equalities and [Fairer Scotland Duties](#), to further advance equalities practice across all our business areas.

During 2025/26, equalities activity has included:

- 22 [Equality Impact Assessments](#) (EQIA) were published. In addition, a report was produced summarising the equalities impact of each of the budget proposals for 2026/27, which included an overview of their cumulative impact. The EQIAs include considerations of equality, socio-economic circumstance, and human rights. Children's rights have also been added and are currently being considered on a pilot basis.
- Work has been undertaken to increase awareness and understanding of Equality Impact Assessments at all levels of the organisation. This included briefings for IJB members linked to the budget setting process; awareness raising sessions for the HSCP's Senior Management Team; as well as sessions with staff involved in reviews and service redesign. Promotion of access to the NHS GG&C Equality Impact Assessment training has also continued
- Work has continued to deliver the BSL (British Sign Language) (Scotland) Act. A programme of work is underway to pilot the use of BSL Video Remote Interpreting (VRI), with an initial focus on health centres. This enables real-time communication between deaf BSL users and people who can hear via a remote BSL interpreter accessed through a video link. This service does not replace face to face interpreters but aims to support communication for routine reception desk staff and in unscheduled or emergency situations, if no in-person interpreter is available
- A [Glasgow City HSCP British Sign Language Interpreting Pathway](#) has also been developed to support all staff to access interpreting support when and where it is needed. The pathway provides information on how to access BSL Interpreting services for both NHS and social work appointments, out of hours and emergency services, as well as upon the wider supports available for BSL users and staff.
- In partnership with NHS Greater Glasgow and Clyde, a boosted Health and Wellbeing survey was undertaken with the five largest ethnic minority communities in Glasgow. This research will be used to inform HSCP and wider community planning forums of the needs and issues faced by members of these communities. The [results of the survey were published](#) in October 2025 and a launch event was held to share the findings with partners and discuss next steps
- Regular equality training is important for all staff and in addition to promoting the equality and diversity e-learning modules, further work has been undertaken to promote uptake of training and awareness sessions. There have also been spotlight communications, pulling together information on a range of local and national resources and supports. Topics covered within these included Black History Month,

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Pride Month, British Sign Language, Neurodiversity, Staff Equality Peer Support Networks and Hate Crime Awareness Week

- Our latest [Equalities Progress report for 2024 to 2026](#) provides full details of the wider range of actions and progress to date against our agreed Equality Outcomes





# 10. INSPECTION AND PRACTICE AUDIT

## 10. INSPECTION AND PRACTICE AUDIT

### 10.1 HSCP REGISTERED SERVICES – CARE INSPECTORATE

Between April 2025 and March 2026, the [Care Inspectorate](#) undertook 26 inspections of HSCP provided services. The following tables detail the individual services inspected, the care grades achieved across the assessed standards, and the number of requirements specified by the Care Inspectorate. Full details of these inspections can be accessed from the [Care Inspectorate Website](#) and via the individual links provided in the tables below.

#### 10.1.1 Older People’s Residential Services

| UNIT/SERVICE                               | DATE OF INSPECTION | How well do we support people’s wellbeing? | How good is our leadership? | How good is our Staff Team? | How good is our setting? | How well is our care and support planned? | No. of Requirements |
|--|--------------------|--|-----------------------------|-----------------------------|--------------------------|---|---------------------|
| <a href="#">Riverside House</a>            | 25/06/25           | 5  |                             |                             | 5                        |   | 0                   |
| <a href="#">Victoria Gardens Care Home</a> | 10/07/25           | 5  | 5                           |                             | 5                        | 5   | 0                   |
| <a href="#">Orchard Grove Care Home</a>    | 01/10/25           | 5  |                             |                             | 5                        |   | 0                   |
| <a href="#">Hawthorn House</a>             | 05/02/26           | 5  | 5                           | 5                           | 5                        | 4   | 0                   |
| <a href="#">Meadowburn Care Home</a>       | 18/02/26           | 5  |                             |                             | 5                        |   | 0                   |

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

#### 10.1.2 Home Care and Community Support Services

| UNIT/SERVICE  | DATE OF INSPECTION | How well do we support people’s wellbeing? | How good is our leadership? | How good is our Staff Team? | How good is our setting? | How well is our care and support planned? | No. of Requirements |
|---|--------------------|--|-----------------------------|-----------------------------|--------------------------|---|---------------------|
| <a href="#">North West - HSCP Community Support Service</a> | 07/08/25           | 5  |                             |                             | Not applicable           | 5   | 0                   |
| <a href="#">Home Care Service – North West</a>              | 04/02/26           | 5  | 4                           | 4                           | Not applicable           | 4   | 0                   |
| <a href="#">Home Care Service – South</a>                   | 04/02/26           | 5  |                             | 4                           | Not applicable           | 4   | 0                   |
| <a href="#">Home Care Service – North East</a>              | 04/02/26           | 5  |                             | 4                           | Not applicable           | 4   | 0                   |
| <a href="#">South, HSCP Community Support Service</a>       | 12/02/26           | 5  |                             |                             | Not applicable           | 5   | 0                   |

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

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### 10.1.3 Families for Children Community Services

| UNIT/SERVICE  | DATE OF INSPECTION | How well do we support people's wellbeing? | How good is our leadership? | How good is our Staff Team? | How good is our setting? | How well is our care and support planned? | No. of Requirements |
|---|--------------------|--|-----------------------------|-----------------------------|--------------------------|---|---------------------|
| <a href="#">Adoption Service</a>                              | 02/10/25           | 5  |                             |                             | Not applicable           |   | 0                   |
| <a href="#">Fostering Service</a>                             | 02/10/25           | 3  | 3                           | 4                           | Not applicable           | 2   | 4                   |
| <a href="#">Families for Children Adult Placement Service</a> | 02/10/25           | 3  | 3                           | 4                           | Not applicable           | 2   | 4                   |

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

### 10.1.4 Children's Residential Services

#### *Key Question 7 Inspections*

Inspection of Children's Residential Services is underpinned by the [Quality Framework for Care Homes for Children and Young People](#). In April 2022, [Key Question 7](#), was introduced: *How well do we support children and young people's rights and wellbeing?* This question was introduced to produce a more regulatory footprint; to prioritise the quality of relationships experienced by children and young people, in line with the aspirations of [The Promise](#); and to support engagement with greater numbers of children and young people by enabling more services to be inspected. Key Question 7 has 2 quality indicators:

- Children and young people are safe, feel loved and get the most out of life
- Leaders and staff have the capacity and resources to meet and champion children and young people's needs and rights

From April 2025 to March 2026, the [Care Inspectorate](#) undertook 8 inspections of children's residential services using Key Question 7 as outlined in the table below:

| Children's House                   | Date of Inspection | <b>Key Question 7:<br/>How well do we support children and young people's rights and wellbeing?<br/>Grade Awarded</b> | No. of Requirements |
|------------------------------------|--------------------|---|---------------------|
| <a href="#">Newlands Road</a>      | 06/05/25           | 5   | 0                   |
| <a href="#">Hinshaw Street</a>     | 29/05/25           | 4   | 0                   |
| <a href="#">Norse Road</a>         | 17/06/25           | 4   | 0                   |
| <a href="#">Milncroft Road</a>     | 11/07/25           | 5   | 0                   |
| <a href="#">Wallacewell</a>        | 23/10/25           | 5   | 0                   |
| <a href="#">Crossbank Crescent</a> | 19/11/25           | 5   | 0                   |
| <a href="#">Balmore</a>            | 29/01/26           | 6   | 0                   |
| <a href="#">Kempsthorpe</a>        | 06/03/26           | 5   | 0                   |

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

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### *Promise Assurance Inspections*

In addition to the above 8 inspections, another 5 children's residential services were inspected using a new assessment model - *Promise Assurance Inspections* - which were piloted from April 2025. These are designed to provide assurance that higher-performing services continue to meet the ambitions of [The Promise](#). As part of this model, no new grades are awarded; instead, inspections confirm whether services continue to perform at previously assessed high levels. A Promise Assurance Inspection focuses on key areas essential to upholding children and young people's rights, particularly that they are safe and at the centre of their own care. Findings are reported under the Promise foundation headings of *Voice, Care, and People*. During 2025/26, Promise Assurance Inspections were used to assess services that had achieved grades of *Excellent (6)* or *Very Good (5)* within the previous two years, as shown in the table below. These inspections confirmed that the services have continued to place the rights and voices of children and young people at the heart of their care and continued to provide a very good standard of support.

| Children's House                | Grade Awarded Previously | Date of Inspection |
|---------------------------------|--------------------------|--------------------|
| <a href="#">Netherton</a>       | 5                        | 02/12/25           |
| <a href="#">Main Street</a>     | 5                        | 11/12/25           |
| <a href="#">Wellhouse</a>       | 5                        | 13/01/26           |
| <a href="#">Larkfield</a>       | 5                        | 28/01/26           |
| <a href="#">Crawford Street</a> | 6                        | 26/02/26           |

### **10.1.5 Finance Audit and Scrutiny Committee Reports**

Care Inspectorate grades are also regularly reported to and reviewed by the IJB Finance, Audit and Scrutiny Committee. The reports to this Committee provide details for each care group of inspections undertaken; requirements specified; areas for improvement; along with detailed improvement action plans where relevant. Reports for inspections carried out during 2025/26 can be accessed via the following links on the HSCP website:

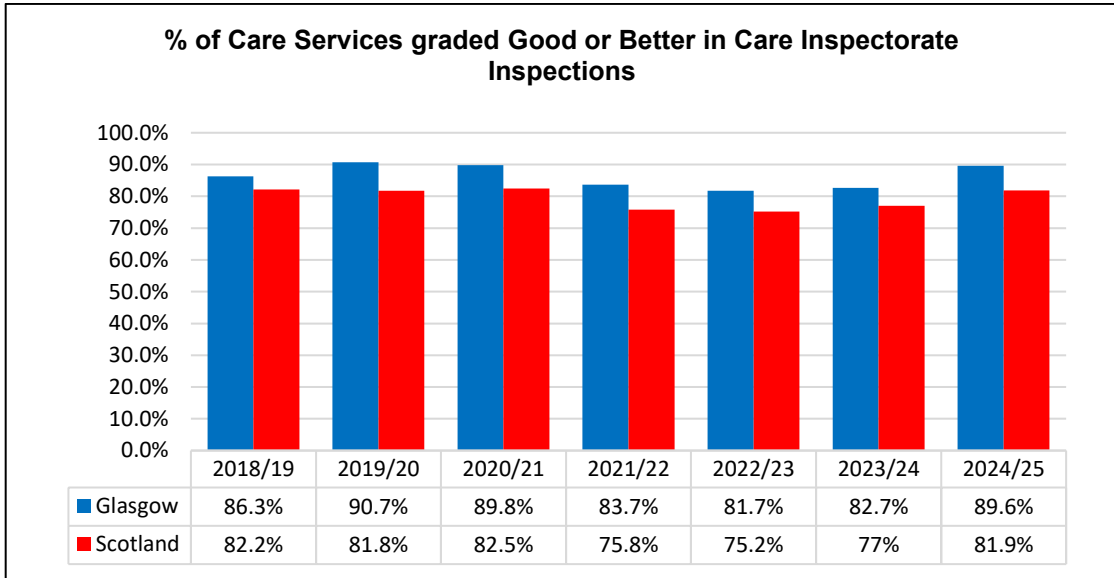
[Fostering and Adoption Services Care Inspectorate Activity](#)

[Children's Residential Services - Care Inspectorate Activity](#)

[Older Peoples Residential Services - Care Inspectorate Activity](#)

### 10.2 NATIONAL INTEGRATION INDICATOR

National Integration Indicator Number 17 (Care Inspectorate Grades) shows Glasgow’s performance over time and in comparison to the overall figure for Scotland in relation to Care Inspectorate Grades. This shows Glasgow is consistently higher than the Scottish average over the period shown, with grades improving over the last two years. The latest available information is shown below.



### 10.3 MENTAL WELFARE COMMISSION LOCAL VISITS

The [Mental Welfare Commission for Scotland](#) (MWCS) has a key role to protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions. The MWC undertake local visits, either announced or unannounced, to a group of people in a hospital, care home or prison service. In 2024 the MWC also began undertaking local visits to Community Mental Health Teams (CMHTs) across NHS Greater Glasgow & Clyde (NHSGGC). These local visits:

- identify whether individual care, treatment and support is in line with the law and good practice
- challenge service providers to deliver best practice in mental health, dementia and learning disability
- follow up on individual cases where the Commission have concerns and may investigate further
- provide information, advice and guidance to people they meet with.

Local Visits are not inspections, however the Commission’s report details findings from the visit and provides recommendations. The service is then required to produce an action plan to respond to these recommendations within three months. The MWC published a total of 17 local visit reports relating to Glasgow during the latest reporting period (1st January 2025 to 31st December 2025). All visits were to Glasgow city mental health hospital wards, with 11 announced and 6 unannounced. Details of the sites visited, and the recommendations and good practice noted during these visits, was presented to the IJB in [February 2026](#).

### 10.4 PRACTICE AUDIT AND EVALUATION ACTIVITY

In addition to external inspections, the Partnership has an ongoing planned programme of practice audit and self-evaluation to give quality assurance across all service areas. Practice Audit and Evaluation activity carried out by Social Work between April 2025 and March 2026 is listed in the following table.

| <b>Practice Audit and Evaluation Activity 2025/26</b>                          |
|--|
| Safe and Together (Domestic Abuse Training Programme) Evaluation Completed     |
| Social Work Out of Hours Services (Audit/Review) Completed                     |
| Abstinence Residential Service (Follow Up Audit Review) Completed              |
| Response to the Scottish Whistle Blowing Service Homeless GP Service Completed |
| Service Prioritisation Programme (Ongoing)                                     |
| Safeguarding into Bed & Breakfast Service user Accommodation Audit (Ongoing)   |



# 11. FINANCIAL PERFORMANCE

## 11. FINANCIAL PERFORMANCE

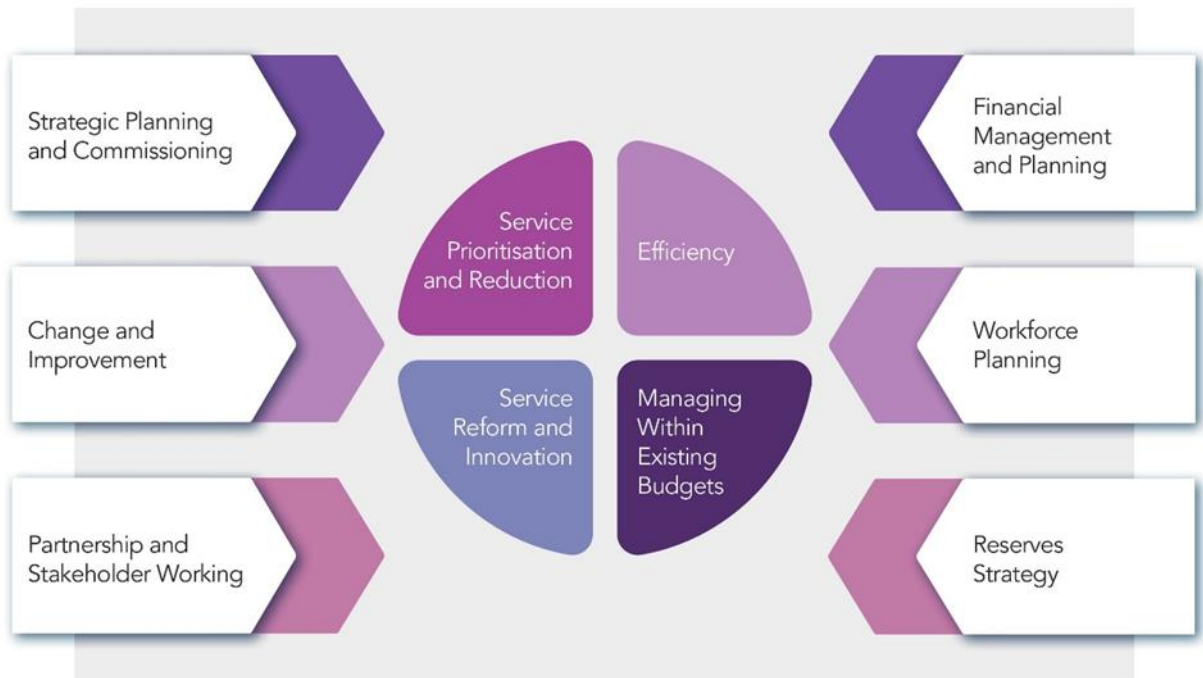
### 11.1 Introduction

National Health and Wellbeing Outcome 9 is set out below and within this chapter, we seek to demonstrate how we have achieved this. Firstly, we provide an overview of financial performance during 2025/26. We then describe the STEP Forward programme (formerly known as Service Prioritisation) and the key capital investments progressed during the last year, before briefly considering the financial outlook for 2026/27.

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

### 11.2 Best Value

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



**11.3 2025/26 Financial Planning**

The total financial resources available to the partnership for 2025/26 were around £1.6billion. This can be seen in the table below, along with trend information for previous financial years.

| Client Group          | 2023/24<br>£000's | 2024/25<br>£000's | 2025/26<br>£000's |
|-----------------------|-------------------|-------------------|-------------------|
| Children and Families | 173,189           | 167,471           | 174,299           |
| Adult Services        | 381,297           | 426,063           | 457,623           |
| Older People Services | 371,020           | 373,232           | 405,911           |
| Resources             | 67,561            | 107,607           | 106,425           |
| Criminal Justice      | (737)             | (808)             | 198               |
| Primary Care          | 421,962           | 450,873           | 478,725           |
| <b>TOTAL</b>          | <b>1,414,292</b>  | <b>1,524,438</b>  | <b>1,623,181</b>  |

**11.4 2025/26 Set Aside Budget**

In addition to the above, there is a set aside budget which is made available by the Health Board to the Integration Joint Board. This is in respect of those functions delegated by the Health Board which are carried out in a hospital within the Health Board area and provided for two or more Local Authority areas. The total set-aside budget for 2025/26 was £287.666m, which excludes the budget value for Adult Mental Health and Elderly Mental Health inpatient services.

**11.5 2025/26 Financial Management**

The IJB is operating in an increasingly challenging environment with funding not keeping pace with increasing demand for service and increasing costs linked to delivery. This requires the IJB to have robust financial management arrangements in place to deliver services within the funding available. The IJB reported a final operational underspend of £0.6m for 2025/26, as shown in the table below. These figures are subject to external audit over the coming months.

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|  | Note | £<br>million  |
|--|------|---------------|
| <b>Operational Service Delivery - Pressures</b>          |      |               |
| Mental Health Staffing Pressures                         | 1    | 9.4           |
| Health Visiting Staffing Pressures                       | 2    | 2.1           |
| Unfunded District Nursing Rebanding                      | 3    | 2.4           |
| Residential Pressures within Children and Families       | 4    | 1.0           |
| Increased Demand for Self Directed Support Payments      | 5    | 4.2           |
| Increased Homelessness Pressures                         | 6    | 3.6           |
| <b>Total Pressures in Operational Service Delivery</b>   |      | <b>22.7</b>   |
| <b>Operational Service Delivery - Underspends</b>        |      |               |
| Underspend as a Result of Vacancies and Staff Turnover   | 7    | (7.9)         |
| Underspend as a Result of Additional Income Recoveries   | 8    | (7.3)         |
| Underspend in Personalisation/Purchased Services         | 9    | (0.7)         |
| Underspend in Prescribing Costs                          | 10   | (7.4)         |
| <b>Total Underspends in Operational Service Delivery</b> |      | <b>(23.3)</b> |
| <b>Net Underspend in Operational Service Delivery</b>    |      | <b>(0.6)</b>  |

**Notes – Impact of Operational Service Delivery**

1. The overspend in Mental Health is mainly attributable to increased spend on bank nursing. This is due to increased contractual referrals, higher number of enhanced observations and spend required to provide sick leave and vacancy cover. Management continue to take actions to reduce the level of bank spending with specific focus on reduced observations and skills mix of the workforce.
2. The overspend in Health Visiting is due to lower than budgeted turnover and 79% of staff at the top of the salary scale.
3. Following a job evaluation review, Band 6 District Nursing staff were regraded to Band 7, backdated to 1<sup>st</sup> May 2002 at a total cost of £2.4m. This was not funded by the Scottish Government. A review of the staffing structure will take place during 2026/27 to ensure it is reflective of service need.
4. There is an overspend in residential services within Children and Families. This is linked to the use of overtime directly attributed to increased care needs and additional cover required to meet staff sickness levels and vacancies.
5. The increased demand for Self Directed Support Payments – Options 2 and 3 within Learning Disabilities and Mental Health has resulted in an overspend within Adult Services.
6. The overspend within Homelessness Services is largely due to increased property repairs, utility costs, legal expenses and interpreting costs.
7. Staffing pressures continue to be experienced across all services due to high turnover levels, high sickness levels and challenges in recruitment. This is not unique to Glasgow and is experienced in the wider UK. These challenges are not new to the IJB, however the scale of them is increasing. We continue to focus on the recruitment of staff utilising a range of measures such as advertising campaigns both at a local and

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national level, aligning recruitment timescales with the availability of newly qualified professionals and undertaking targeted recruitment and training strategies to develop existing and new staff to meet the skills requirements of our services.

8. Additional income was recovered mainly through recovery of financially assessed client contributions and additional income secured through service level agreements.
9. Commissioned services continue to face challenges to complete assessments and/or put services in place because of the staff pressures experienced across the sector. This is resulting in delayed start dates which mean in year costs are part year only and results in an underspend in personalisation and purchase services. These staffing pressures are not unique to Glasgow and are being experienced across the UK and include high turnover levels, high sickness levels and challenges in recruitment making it difficult to secure staffing levels to maintain services to meet demand.
10. Prescribing volumes have been lower than anticipated with an average volume growth of 1.5% against a budget of 3%. Price per item is also lower due to price tariff adjustments, lower costs of Dapagliflozin, aggressive market conditions and other global factors. In year savings delivered were £3.4m against a 2025/26 target of £4.6m. The net impact of price, volumes and saving delivery resulted in an overall prescribing underspend of £7.4m.

As part of the 2025/26 budget an additional £8.3m of savings were taken to smooth the impact of the 2026/27 increase in costs when employer superannuation rates are increased by Strathclyde Pension Fund for Council employees. This additional saving generated a planned underspend in 2025/26 which the IJB agreed would be taken to General Reserves.

In addition to this, there are a local and national priorities which will not be completed until future years and require funding to be carried forward (£22.8m). This relates to ring fenced funding which has been received or allocated to meet specific commitments and must be carried forward to meet the conditions attached to the receipt of this funding. Details can be found in our [Outturn Report 2025/26](#)

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## 11.6 Change and Improvement

The STEP Forward programme has recently been developed to ensure the HSPC is equipped to deliver on its strategic objectives in light of the significant financial challenge over the medium term. A new governance structure was created in 2025/26 and approved by the IJB Board to reflect the significance of this programme to the future of the organisation. This included a new Executive Structure, and the creation of an Executive Steering Group to oversee the recommendations coming from the programme reviews.

This is an innovative and new way to design the future services of the HSPC within the context of Public Sector Reform. The initial reviews commenced in quarter 4 of 2025/26 with the majority of the programme being delivered over the next three years. The governance arrangements are scheduled to be reviewed for ongoing effectiveness during 2026/27.

## 11.7 Capital Investment and Priorities

### Health and Care Centres

The North East Health and Social Care Hub at Parkhead is the largest health and social care hub in the UK. It became operational in January 2025 and the final phase of work to demolish the Parkhead Health Centre and create the remainder of the car park area was completed in December 2025. The Hub has won a number of national awards, including the Royal Institution of Chartered Surveyors UK's Best Public Sector Project in 2025 and the Architectural Excellence (Public) award at the 2026 Scottish Property Awards.

### Older People Residential Services

Major refurbishment works were progressed at the Riverside Care Home during 2025/26 and these were completed in April 2026.

Refresh works are also currently taking place at Hawthorn House and are expected to complete in October 2026.

### Homelessness Services

In Spring 2025, significant refurbishment work commenced on site at Brighton Place. This facility will provide accommodation for young homeless service users. Unfortunately, significant structural defects were uncovered during the early stages of the programme, which has necessitated the development and procurement of additional remedial works. These commenced on site in May 2026 and are due to complete by the end of the year. The main refurbishment works will follow on and are expected to complete in 2027/28.

### Other Sites

Options appraisal works are ongoing in relation to the refurbishment of the Church Street site and services contained therein, which include Children and Families Services, and Justice Services. The building is in need of significant investment, or alternatively other operational sites found from which to deliver these key frontline

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services. Capital resources have been earmarked and a final decision will be made during 2026/27.

A site has been identified in Bellahouston Park, adjacent to the Prince and Princess of Wales Hospice, for a new, purpose built, Learning Disability Daycare centre. A number of options have been identified, and a feasibility study is being developed to support a business case. This would ultimately result in the disposal of the current sites at Riddrie and Carlton. However, additional capital funding will be required to progress to full business case.

The purchase of a residential unit on Blackwood Street in Anniesland (Netherton), from the NHS, is currently being concluded, with the aim of developing a residential learning and disability service for young people transitioning from children's to adult services. This is being funded from IJB Earmarked Reserves and will enable high quality services to be provided within the City boundary, avoiding higher cost out-of-authority placements.

A number of other smaller capital or capital-related works supporting the wider strategic aim of maximising existing estate use were also undertaken including the relocation of the Restart Service to Parkview Resource Centre and the creation of additional clinical and GP capacity at Govan Health Centre. Work also commenced on the relocation of staff from Templeton Business Centre to Eastgate and the development of a vacant floor at Rowanpark to absorb staff displaced from the Adelphi Centre sale.

Work continues across our estate to rationalise our accommodation to ensure best value from the estate.

### 11.8 Financial Outlook for 2026/27 and Beyond

The financial position for public services is extremely challenging and the IJB must operate within significant budget restraints and pressures. On 18<sup>th</sup> March 2026, the IJB approved its budget for 2026/27. This budget assessed the demand and cost pressures which exist across services and presented a budget strategy with proposals on how these would be funded and managed in 2026/27. This budget identified a funding gap of £34m which will be addressed through a wide range of service reforms and efficiencies, the STEP Forward programme and the use of General Reserves. Progress on achievement of this programme will be reported during the year to the IJB and the IJB FASC and in the 2026/27 Annual Performance Report.

A [Medium Term Financial Outlook](#) was also reported to the IJB on the 18<sup>th</sup> March 2026. This considers a range of pressures and uncertainties to assess the likely impact on the IJB's financial position over the medium term. Examples include:

- Inflationary pressures linked to pay and contractual commitments and global markets for prescribing;
- National commitments such as uplifts for social care providers;
- Implications of the Home Office Asylum Seeking decisions;
- Local pressures linked to demand as a result of demographic, deprivation, and health; and
- Implication of changes to employer superannuation rates for Council employees from 2026/27.

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This looks forward to 2027/28 and identifies the need for a further £40m of savings to deliver a balanced budget in 2027/28 and £29m in 2028/29. In addition, it is estimated that unfunded costs relating to homelessness are set to increase to £73m and £91m in 2027/28 and 2028/29 if demand continues at the same levels. This is reflective of demand being higher than capacity within the city to offer permanent housing offers. These pressures are in addition to the budget gap identified in the Medium Term Financial Outlook.

It has been recognised for a number of years that funding settlements are not keeping pace with the demand and inflationary pressures which are being faced within the health and social care system. A financial strategy is proposed within this context.

The scale of the financial challenge in future years is such that a more fundamental review of service provision is required so that decisions can be taken on what the future shape of service provision looks like. In response, the IJB has agreed the development of the STEP Forward programme. A comprehensive model derived from the HM Treasury Green Book has been developed, coupled with a robust governance structure. The HSCP has restructured to reflect the importance of this programme and relevant teams have attended detailed training on the application of the model. The STEP Forward programme commenced the first tranche of reviews in quarter 4 2025/26 with the programme being subject of future updates to the IJB.

The IJB has a clear strategy to support delivery of the Strategic Plan and also to ensure the IJB remains financially sustainable over the medium term. The IJB also understands the key risks and uncertainties linked to delivery and has clear actions in place to mitigate these. We will continue to work closely with all our partners and stakeholders to secure a future which is sustainable and meets the needs of our communities and we remain committed to this as we move forward into 2026/27.

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**APPENDIX A - Glasgow City Profile – Additional Information**

|  |   |
|--|---|
| <a href="#">Department of Work and Pensions (DWP) Stat-Xplore</a>                      | Provides data on Department of Work and Pensions (DWP) benefits – regularly updated. See also 'Social Security Scotland Statistics' entry below.  |
| <a href="#">Glasgow Centre for Population Health (GCPH)</a>                            | Glasgow Centre for Population Health (GCPH) conducts research and collaborates with partners to support changes that will improve health and reduce inequality. Publications and outputs available include research reports, briefing papers, consultation responses, event reports, infographics and other digital outputs such as films and animations. |
| <a href="#">Glasgow City Council Area Partnership Dashboards</a>                       | This collection of dashboards provides a range of data at individual Area Partnership (Ward) level across Glasgow. The dashboard contains details about population, deprivation, planning, education, environment, as well as funding and local service provision.  |
| <a href="#">Glasgow City Council Factsheets Data and Statistics</a>                    | Information on demographic and socio-economic data, council factsheets, Glasgow Open Data Hub and links to statistical websites.  |
| <a href="#">Glasgow City HSCP Health Improvement Annual Report 2023/24</a>             | This report highlights the work that Health Improvement has led on or been involved in supporting in the last year.   |
| <a href="#">Glasgow City Youth Health Improvement Annual Report 2024/25</a>            | This report details the key highlights of work undertaken by the Glasgow City Child and Youth Health Improvement workforce in the last year.  |
| <a href="#">Glasgow City HSCP Strategies and Plans</a>                                 | This webpage provides links to the key strategies and plans of the Glasgow City Integration Joint Board and Glasgow City Health and Social Care Partnership.  |
| <a href="#">Glasgow Community Plan 2024</a>  | This Glasgow Community Plan 2024-2034 makes addressing poverty the overriding priority of the Glasgow Community Planning Partnership (the Partnership) and sets out how the partnership has agreed to act on poverty over the next ten years.   |
| <a href="#">Glasgow Health and Care Experience Survey</a>                              | This is used for measuring perceptions in relation to GP, care and carers services. It also measures progress against the national integration indicators.  |
| <a href="#">Glasgow City HSCP Demographics and Needs Profile</a>                       | Includes general population estimates and projections at HSCP locality, city and national level plus a profile of health in the city. Incorporating some data from Scotland's Census 2022.  |
| <a href="#">NHSGGC Adult Health and Wellbeing Survey 2022-23 - Glasgow City Report</a> | Survey information on adult health and behaviours in the city. A suite of reports for the 2022/23 survey for Glasgow City and each of the 3 localities within the city are available in addition  |

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|   |  |
|---|--|
| <p><a href="#">NHSGGC Adult Health and Wellbeing Survey 2022-23 Glasgow North East Locality Report</a></p> <p><a href="#">NHSGGC Adult Health and Wellbeing Survey 2022-23 - Glasgow North West Locality Report</a></p> <p><a href="#">NHSGGC Adult Health and Wellbeing Survey 2022-23 - South Locality Report</a></p> | <p>to reports for other local authority and HSCP areas.</p>  |
| <p><a href="#">National Records of Scotland (NRS)</a></p>   | <p>Official statistics on registrations of births, deaths, marriages, adoptions in Scotland. Annual population estimates and bi-annual projected population estimates.</p>   |
| <p><a href="#">NOMIS</a></p>  | <p>NOMIS is a service provided by the Office for National Statistics, ONS, which provides access to detailed and up-to-date UK labour market statistics from official sources.</p>   |
| <p><a href="#">Public Health Scotland</a></p>   | <p>Provides robust and extensive health information and health intelligence from data collected mostly from services provided through the NHS in Scotland.</p>   |
| <p><a href="#">Scotland's Census</a></p>  | <p>The Census is the official count of every person and household in the country that takes place every 10 years. Results from the 2022 Census are now available online.</p>   |
| <p><a href="#">Scottish Burden of Disease Study</a></p>   | <p>This is a ScotPHO hosted study of health inequalities comparable internationally. Local reports and interactive visual data dashboards available from 2019. Also report &amp; data forecasting the future burden of disease: Incorporating the impact of demographic transition over the next 20 years.</p>   |
| <p><a href="#">Scottish Government Health and Wellbeing Census (Schools) Scotland 2021/22</a></p>   | <p>The first of a national survey of secondary school pupils in Scotland covering all health &amp; wellbeing areas formerly addressed through the NHS Health Board school surveys. Also covers areas previously included in the Scottish Schools Adolescent and Lifestyle Substance Use Survey (SALSUS) national survey e.g. smoking, drinking, drug use and other lifestyle, health and social factors.</p> |
| <p><a href="#">Scottish Government Labour Market Statistics Publications</a></p>  | <p>Various labour market data including employment, unemployment and economic inactivity trends, sourced from the Labour Force Survey for Scotland and the UK.</p>   |
| <p><a href="#">Scottish Government Statistics</a></p>   | <p>Scottish Government statistics website that contains some national statistics publications or data not offered via other platforms e.g. homelessness data.</p>  |

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|  |  |
|--|--|
| <a href="#">Scottish Health Survey (dashboard)</a>                       | Summarises key statistics from the Scottish Health Survey providing information in relation to the health and health related behaviours of the population of Scotland, NHS health boards and local authority areas.  |
| <a href="#">Scottish House Condition Survey</a>                          | Annual national survey looking at the physical condition of homes and experiences of householders.   |
| <a href="#">Scottish Household Survey</a>                                | Annual national survey providing robust evidence on the composition, characteristics, attitudes and behaviour of private households and individuals as well as evidence on the physical condition of Scotland's homes.   |
| <a href="#">Scottish Index Multiple Deprivation (SIMD) 2020</a>          | Uses multiple indicators to provide comparative information on population deprivation at a small area level (data zones) within Scotland.  |
| <a href="#">Scottish Public Health Observatory profiles (ScotPHO)</a>    | Presents range of information from routine health statistics to survey data. Some data is available at small area level (e.g. intermediate zone of HSCP locality). Updated on an ongoing basis.  |
| <a href="#">Scottish Surveys Core Questions (SSCQ)</a>                   | An annual Official Statistics publication. SSCQ is a result of a harmonised design across the three major Scottish Government household surveys - the Scottish Household Survey, the Scottish Health Survey and the Scottish Crime and Justice Survey.   |
| <a href="#">Skills Development Scotland Annual Participation Measure</a> | Provides data on the learning, training and work activity of 16-19 year olds in Scotland.  |
| <a href="#">Social Security Scotland Statistics</a>                      | Social Security Scotland is an executive agency of the Scottish Government set up to deliver social security payments to the people of Scotland. Some payments are new e.g. the Scottish Child Payment and others are devolved from the DWP/UK e.g. Adult Disability Payment (formerly Personal Independence Payment (PIP)). See also 'DWP Stat-Xplore' entry above. |
| <a href="http://statistics.gov.scot">statistics.gov.scot</a>             | Scottish Government statistics website offering a wide range of official statistics from multiple sources including population, government statistics and survey data.   |
| <a href="#">UK Government</a>  | Provides access to many statistics at UK and local authority level inc. children in low income families statistics.  |
| <a href="#">Understanding Glasgow</a>                                    | Understanding Glasgow describes life circumstances and health in the city, showing data on trends and comparisons with other cities and areas. Includes health and wellbeing profiles for adults and children.   |

**APPENDIX B - National Health and Wellbeing Outcomes**

|                  |   |
|------------------|---|
| <b>Outcome 1</b> | People are able to look after and improve their own health and wellbeing and live in good health for longer.  |
| <b>Outcome 2</b> | 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. |
| <b>Outcome 3</b> | People who use health and social care services have positive experiences of those services, and have their dignity respected.   |
| <b>Outcome 4</b> | Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.   |
| <b>Outcome 5</b> | Health and social care services contribute to reducing health inequalities.   |
| <b>Outcome 6</b> | People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.                    |
| <b>Outcome 7</b> | People using health and social care services are safe from harm.  |
| <b>Outcome 8</b> | 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.                    |
| <b>Outcome 9</b> | Resources are used effectively and efficiently in the provision of health and social care services.   |

## APPENDIX C – National Integration Indicators

The [Core Suite of National Integration Indicators](#) are summarised below. These were published by the Scottish Government in March 2015, to provide the basis against which Health and Social Care Partnerships can measure their progress in relation to the National Health and Wellbeing outcomes. As these are derived from national data sources, the measurement approach is consistent across all Partnerships. The Integration Indicators are grouped into two types of measures. Numbers 1-9 are based on the biennial Scottish [Health and Care Experience Survey \(HACE\)](#). This is undertaken using random samples of approximately 15,000 patients identified from GP practice lists in the city and it asks about people's experiences of accessing and using services. Nine other operational indicators are derived from a range of sources including health activity, community and deaths information. In addition, there are five other indicators which cannot currently be reported as national data is not available, or for which there is not yet a nationally agreed definition. Public Health Scotland published the latest data relating to the available [National Integration Indicators in July 2024](#).

### Health and Care Experience Survey (HACE) Indicators

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

### Operational Indicators

11. Premature mortality rate per 100,000 population.
12. Rate of emergency admissions per 100,000 population for adults.
13. Rate of emergency bed days for adults per 100,000 population.
14. Rate of readmissions to hospital within 28 days of discharge per 1000 admissions.
15. Proportion of last 6 months of life spent at home or in community setting.
16. Falls rate per 1,000 population in over 65s.
17. % of care services graded 'good' (4) or better in Care Inspectorate Inspections.
18. % of adults with intensive needs receiving care at home.
19. Number of days people aged 75+ spend in hospital when they are ready to be discharged per 1,000 population.

### Indicators Not Currently Reported

10. % staff who say they would recommend their workplace as a good place to work.
20. % of health and care resource spent on hospital stays where the patient was admitted in an emergency.
21. % of people admitted from home to hospital, who are discharged to a care home.
22. % of people who are discharged from hospital within 72 hours of being ready.
23. Expenditure on end-of-life care.

# GLASGOW CITY HSCP ANNUAL PERFORMANCE REPORT 2025/26 SUMMARY

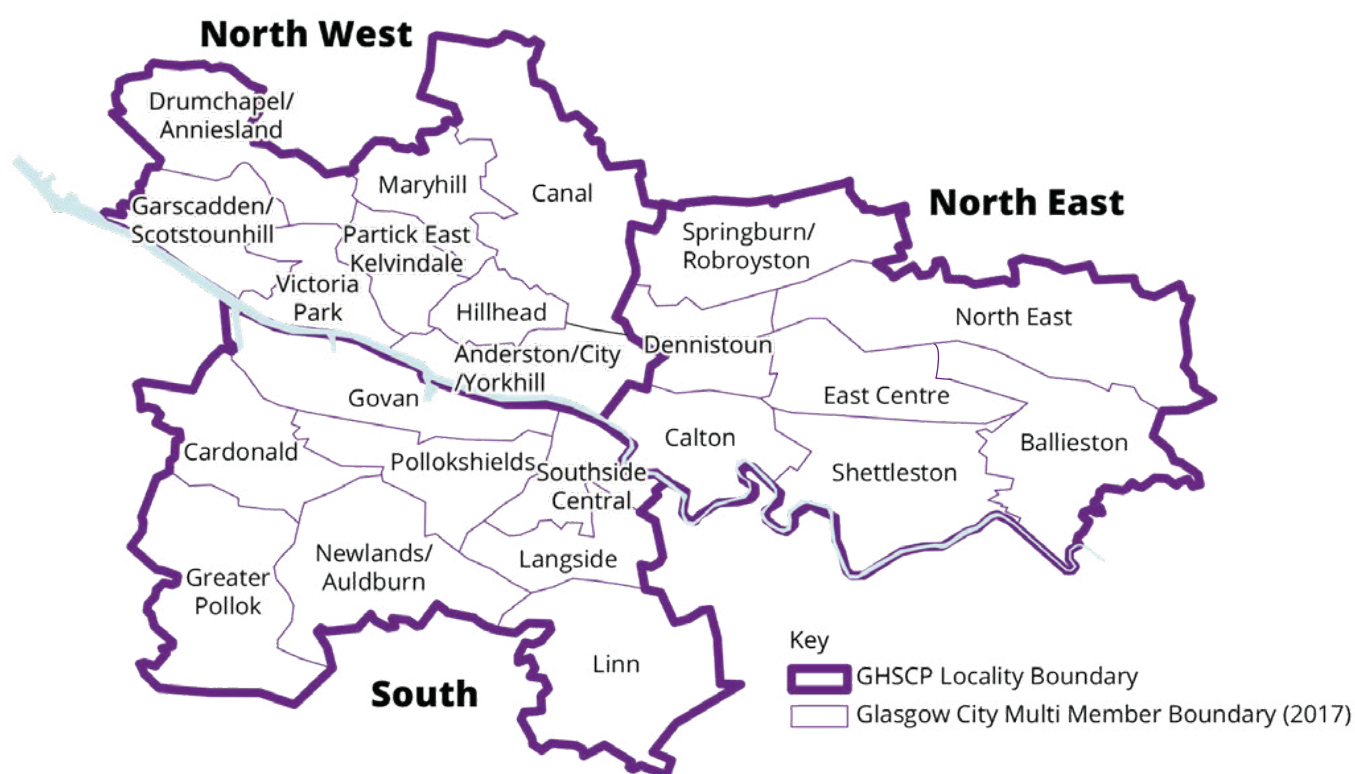
## Introduction

The Public Bodies (Joint Working) (Scotland) Act 2014 requires Integration Joint Boards to publish an Annual Performance Report (APR), setting out an assessment of performance in respect of those functions for which they are responsible. This Summary focuses on key highlights from the full [2025/26 APR](#).

## Partnership Overview

The [Glasgow City Integration Joint Board](#) (IJB) was established in February 2016 and provides strategic direction and leadership for community health and social care services in the city, which are jointly delivered through [Glasgow City Health and Social Care Partnership](#) (GCHSCP). The Partnership is divided into three areas, known as localities, with each area having a lead role for leading and co-ordinating different care group activities across the city. These are outlined below, along with a map showing Glasgow and the locality split:

- North East Locality: Children and Family Services
- North West Locality: Adult Services
- South Locality: Older People's Services



Each locality has a [Locality Engagement Forum](#) (LEF), made up of a range of local stakeholders, including service users and carers. These LEFs raise awareness of the governance arrangements of the IJB and GCHSCP, facilitate consultation on [Locality Plans](#) and help ensure services remain responsive to the views and needs of local communities.

## Our Vision and Priorities

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We believe that Glasgow'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. Our **Strategic Priorities** as set out within our **Strategic Plan** (2023-26) are:

- Prevention, early intervention and wellbeing
- Supporting greater self-determination and informed choice
- Supporting people in their communities
- Strengthening communities to reduce harm
- A healthy, valued and supported workforce
- Building a sustainable future



Image courtesy of © Glasgow Life / Paul Watt Photography

## Key Achievements in 2025/26

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Key achievements from the last year relating to our strategic priorities include the following:

### Prevention, Early Intervention, and Wellbeing

- Delivered a range of suicide prevention training and activities targeted at groups at higher risk of suicide, including justice services clients, students and **male construction workers** who were involved in building the Parkhead Hub.
- Led a youth engagement project on social media's impact on mental health and wellbeing and developed the **Digital Wellbeing Conversation Starters Toolkit** to support practitioners to have supportive conversations with young people about their online lives.
- Implemented a 'High Intensity Test and Treat (HITT)' programme in Barlinnie and Low Moss prisons, achieving a 90% screening uptake for hepatitis C and other blood borne viruses, with immediate treatment offered to all who tested positive.

### Supporting Greater Self Determination and Informed Choice

- Launched the **WAYfinder** outreach initiative. This was co-designed with people with lived experience of homelessness, with a **video** produced allowing potential providers to hear about what matters most to service users.
- Staff from all five GCHSCP care homes completed the University of Stirling's 'Effective Leadership for Dementia Care Services Programme', which embeds a person-led approach into dementia care, ensuring people with dementia can influence and shape the support they receive.
- Collaborated on the **Future Hospitals Initiative** which seeks to improve understanding of carers' needs and inform the design of innovative support for them and the people they care for.



## Supporting People in Their Communities

- Completed the Community Alarms and Telecare Service transition from analogue to a cloud-based digital platform ahead of the 2027 national deadline, improving reliability, response times and service user experience.
- Launched a **Scottish Government Pilot** with 30 short-term Advanced Care beds within two care homes, supporting the timely discharge of people with complex needs from acute care, where services work with patients to find the best long-term care solution for them, with emphasis on the principles of recovery, rehabilitation and independence.
- Produced an updated **Family Support Strategy (2024-2030)** which prioritises early intervention, strengths-based support and third sector partnerships to help families stay together safely within their communities and reduce the need for formal social work intervention.

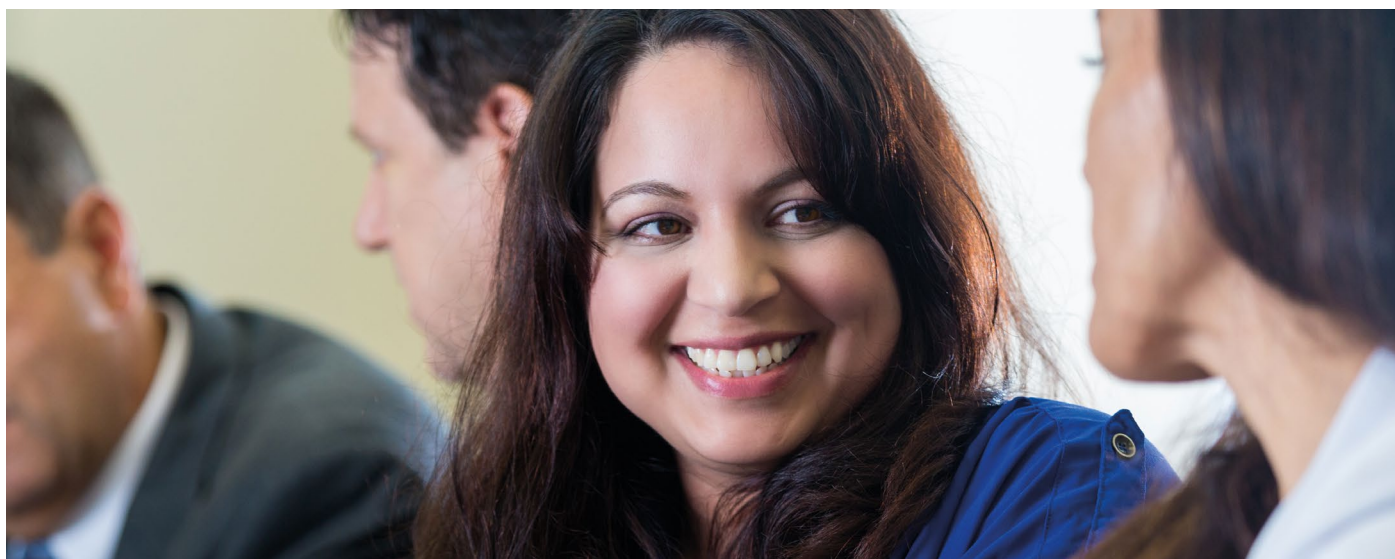
- Implemented an Adult Interagency Referral Discussion (IRD) pilot, which involves rapid multi-agency discussions when partners identify significant Adult Support and Protection (ASP) risks that require consideration and a potential response.
- Achieved a 'Good' rating in the Care Inspectorate's joint Child Protection Inspection, with clear strengths identified, along with some areas for improvement which are being taken forward by partners within a multi-agency improvement plan.
- Following the successful opening of the UK's first safer drug consumption facility - the **Thistle Centre** - a growing demand from people who consume drugs via smoking or inhalation was identified and a **Business Case** is now being developed for a dedicated inhalation space.



## A Healthy, Valued and Supported Workforce

- Launched a new **Workforce Plan (2025-28)** which commits to promoting the GCHSCP as a great place to work; supporting and nurturing our workforce; looking after staff mental and physical wellbeing; and offering rewarding and fulfilling roles and development.
- The Staff Mental Health and Wellbeing Group issued a survey to gather staff views and feedback, which will inform the Group's future priorities and workplan to enhance the health and wellbeing support made available to staff.
- Strengthened staff communication through the launching of the new **Chief Officer Catch Up**, a regular video update aimed at keeping staff and partners informed of priorities and progress, as well as recognising key staff achievements and contributions.

- Secured SSSC (Scottish Social Services Council) and SQA (Scottish Qualifications Authority) approval to deliver the **Professional Development Award in Practice Learning (PDAPL)** award in-house, enabling the GCHSCP to train social workers to become practice educators and support around 75 students annually.
- Piloted the Leadership Accelerator Management Development Programme and the Women's Leadership Development Programme, which both seek to build leadership skills and competencies, with the latter also seeking to address barriers faced by women when progressing into leadership roles.
- Renewed the **Strategic Partnership (SPA)** with the University of Strathclyde, offering GCHSCP staff development opportunities such as fully funded MPhil places, involvement in teaching activities, and joint PhD studentships.



## Equalities

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Our Equalities Working Group oversees programmes of work related to the duties set out in the [Equality Act 2010 \(Specific Duties\) \(Scotland\) Regulations 2012](#) and is responsible for developing equalities practice across GCHSCP services, supported by ongoing equality training and awareness raising. Key activities undertaken during the last 12 months include:

- Publishing of 22 [Equality Impact Assessments](#) (EQIAs) and raising awareness of the EQIA process across all levels of the organisation, including IJB members.
- Development of a British Sign Language (BSL) [Interpreting Pathway](#) to support staff to access interpreting support and piloting of a Remote Video Interpreting service (VRI).
- Supported research into the health and wellbeing needs of the five largest Ethnic Minority communities in Glasgow

Our latest [Equalities Progress Report for 2024 to 2026](#) provides details of these and other actions being progressed to meet our agreed Equality Outcomes.













## Key Performance Improvements in 2025/26

Indicators where performance has shown improvement over the past 12 months:

| Indicator  |                    | Target          | Year end 2024/25 | Year end 2025/26        |
|--|--------------------|-----------------|------------------|-------------------------|
| % of HPIs (Health Plan Indicators) allocated by Health Visitors by 24 weeks                            | North East         | 95%             | 96%<br>          | 99%<br><br>(Dec 25)     |
|  | North West         | 95%             | 94%<br>          | 96%<br><br>(Dec 25)     |
| Psychological Therapies: % of people who started treatment within 18 weeks of referral                 | South              | 90%             | 80.9%<br>        | 81.9%<br>               |
| % service users commencing alcohol or drug treatment within 3 weeks of referral                        |                    | 90%             | 88%<br>          | 92%<br><br>(Q3)         |
| Alcohol Brief Intervention Delivery  |                    | 5,066 per annum | 10,376<br>       | 10,929<br>              |
| Women smoking in pregnancy   | General population | <10%            | 5.5%<br>         | 5.3%<br>                |
| No. Future Care Plan summaries completed and shared with the patient's GP                              |                    | 360             | 605<br>          | 903<br>                 |
| % young people currently receiving aftercare service known to be in employment, education or training. |                    | 75%             | 72%<br>          | 73%<br>                 |
| Number of Children in out of authority placements  |                    | 25 or fewer     | 24<br>           | 21<br>                  |
| % service users who receive a reablement service following referral for home care: i) from hospital    |                    | 75%             | 84.0%<br>        | 84.2%<br>               |
| Telecare referrals   |                    | 1,310           | 3,313<br>        | 3,441<br>               |
| Unscheduled Hospital Bed Days - Acute (18+)  |                    | 507,633         | 547,042<br>      | 255,396<br>             |
|  |                    | 42,303/month    | 45,587/month     | 42,566/month<br>(To Q2) |
| Total Acute Delays   |                    | 160             | 172<br>          | 139<br>                 |
| Number of households reassessed as homeless/potentially homeless within 12 months                      |                    | <480 per annum  | 414<br>          | 410<br>                 |
| Percentage of Community Payback Order (CPO) unpaid work placements commenced within 7 days of sentence |                    | 80%             | 83%<br>          | 88%<br>                 |
| % of service users with a Case Management Plan within 20 days  |                    | 85%             | 89%<br>          | 90%<br>                 |

## Areas for Improvement in 2026/27

Specific areas where we would like to improve performance over the next 12 months include the following:

| Indicator  | Target                             | Year End 25/26   |
|--|------------------------------------|--|
| Mumps, Measles & Rubella (MMR) Vaccinations: (% uptake at 24 months)                                   | 95%                                | 89.6% (at Q3)<br>                       |
| Smoking Quit Rates at 3 months from 40% most deprived areas  | 845 (to Q3)<br>1,190 for year      | 710 (to Q3)<br>                         |
| Psychological Therapies: % of people who started treatment within 18 weeks of referral                 | 90%                                | 75.9% (NE)<br>                          |
|  |                                    | 74.6% (NW)<br>                          |
|  |                                    | 81.9% (S)<br>                           |
| % young people currently receiving aftercare service known to be in employment, education or training. | 75%                                | 73%<br>                                |
| Bed Days Lost to Delays (All delays, all reasons 18+).   | 3,776 per month<br>45,318 for year | 7,373 per month<br>66,357 (to Q3)<br> |
| Total number of Mental Health delays (Adult & Older People)  | 20                                 | 68<br>                                |
| NHS Sickness Absence Rate (%)  | <6%                                | 8.11%<br>                             |
| Social Work Sickness Absence Rate (%)  | <5%                                | 9.6%<br>                              |

More detailed performance information and updates on actions being progressed to improve performance can be accessed in our full [Annual](#) and [Quarterly](#) Performance Reports.

## Inspection

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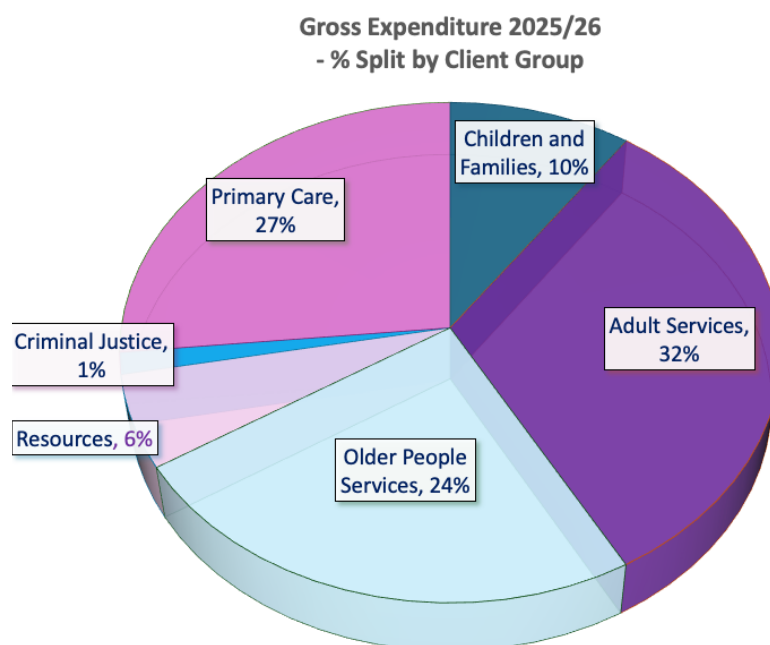
GCHSCP services are subject to regular inspection activity by the [Care Inspectorate](#) who inspected 26 community and residential services during 2025/26. In addition, the [Mental Welfare Commission for Scotland](#) (MWCS) undertook 17 local visits to mental health wards. Reports summarising the results of these inspections and visits were presented to the IJB Finance, Audit and Scrutiny Committee (FASC) and can be accessed at the links below:

- [Older Peoples Residential Services](#) (Care Inspectorate)
- [Fostering and Adoption Services](#) (Care Inspectorate)
- [Children’s Residential Services](#) (Care Inspectorate)
- [Mental Health Wards](#) (MWCS)

## Managing Our Resources

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The total financial resources available to the partnership for 2025/26 were around £1.6 billion. These were allocated across service areas as shown below.



The IJB is operating in an increasingly challenging environment with funding not keeping pace with increasing demand for service and increasing costs linked to delivery. This requires the IJB to have robust financial management arrangements in place to deliver services within the funding available. The IJB reported a final operational underspend of £0.6m for 2025/26.

