Glasgow City
HSCP
Health and Social Care Partnership

Glasgow City Health & Social Care Partnership North West Locality Plan 2017/18

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FOREWORD

I am pleased to introduce the second Locality Plan for the North West since the establishment of Glasgow City Health and Social Care Partnership. The aim is to provide a review of progress during 2016/17 and to identify priorities for 2017/18.

As well as progressing ongoing work, within the plan you will see some ambitious and exciting new projects which we hope to implement in the year ahead that will help to improve lives and reduce inequalities. That said, there are some challenging times ahead both in financial terms and in continuing to deliver improvements in performance.

This plan for 2017/18 highlights the priorities and actions that will be progressed in North West to address local need and contribute to the wider strategic agenda set out in the HSCP's Strategic Plan. These will be progressed in partnership with our stakeholders, including service users and carers, 3rd sector organisations and community planning partners. We are keen to build on the successes achieved in the first year of our status as an integrated organisation. These successes include the opening of a new health and care centre at Maryhill along with commencing work on site for a new Woodside health and care centre; the establishment of GP clusters and developing neighbourhood team approaches for our older people's community services; meeting or improving upon the majority of access and waiting time targets across a range of services; and overall, promoting better integrated working for the benefit of our service users, carers and communities.

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

Jackie Kerr
Head of Operations
North West Locality
Glasgow City Health and Social Care Partnership

1. INTRODUCTION

Glasgow City is the largest HSCP in Scotland by population and budget and is responsible for health and social care provision across 3 Localities in the City; North West, North East and South Glasgow. North West locality covers a population of 206,483 across 8 Local Community Area Partnership areas, set out in the map below. A significant feature of North West locality is the very marked difference in the social and economic circumstances of people living in different areas in the locality, ranging from some of the most affluent areas in Scotland to some of the most deprived. A key responsibility of localities is to produce a locality plan for the area they serve. This document is the locality plan for North West Glasgow and is guided by the overarching priorities set out in the HSCP's Strategic Plan.

2. HSCP KEY PRIORITIES

Glasgow City Integration Joint Board (IJB) came into being in February 2016 and in March 2016 the IJB endorsed a three year Strategic Plan for the period up to 2019 (see https://www.glasgow.gov.uk/index.aspx?articleid=19044). In that plan, the IJB set out its vision for health and social care services - *that the City's people can flourish, with access to health and social care support when they need it.* It also recognised that delivering 'more of the same' will not be enough to meet the challenges of rising demand, budget pressures and inequalities. Transformational change is therefore needed to the way health and social care services are planned, delivered and accessed in the city, with a greater focus on:

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

Within Glasgow City HSCP, localities play a vital role in delivering better, integrated health and social care services for the people of Glasgow. A key responsibility of localities is to produce a locality plan for the area they serve.

The purpose of this locality plan is to:

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

The plan is a one year plan covering the period April 2017 to March 2018. The plan is based on:

- what we know about health and social care needs and demands and any changes from our 16/17 locality plan;
- our current performance against key targets;
- our key service priorities, informed by the HSCP's Strategic Plan
- the resources we have available including staffing, finance and accommodation.

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

3. COMMUNITY ENGAGEMENT – LOCALITY ENGAGEMENT FORUM

Glasgow City Health and Social Care Partnership recently completed a consultation on how best to engage with people about health and social care issues. The consultation responses were extremely valuable and helped us to understand what we need to do to ensure we have the very best community engagement possible. We are taking forward a key recommendation to have stronger engagement at a local level by establishing a Locality Engagement Forum. This forum will act as a hub for information, communication and participation and will be supported by the North West Locality management team. Local people, community groups and organisations will have an opportunity to get involved in a range of ways.

NW Locality will also make use of established networks and forums in North West Glasgow (including the Recovery Network, Carers Forum, the Youth Network and Youth Committee, Voluntary Sector Network, Essential Connections Forum, Childcare Forums, Knightswood Connects and Mental Health Network) to gather feedback on services and work with Community Planning partners to encourage participation and involvement from the wider community. Plans will be developed to support increased representation within local networks from equalities and vulnerable people groups, which have historically been less well represented within engagement networks. In addition, services and teams will continue to engage and gather comments at point of service delivery and a programme of city-wide events, focusing on particular topics or care groups, will be delivered throughout 2017/18.

To find out more about the Locality Engagement Forum please contact:

May Simpson, Community Engagement & Development Officer (North West Locality) 0141 314 6250

4. PERFORMANCE INFORMATION

This section summaries our performance against key targets and indicators

Where we are performing well
Access to specialist children's services
Percentage of children 'looked after' away from home with a Primary worker
Breastfeeding rates, including in deprived areas
Access targets for alcohol and drug treatments
Meeting the target timescales for assessing all unintentionally homeless applications
Reducing the duration pregnant women or dependent children stay in bed & breakfast accommodation
Percentage of criminal justice community placement orders (CPO) with a 3 month review within agreed timescale
Alcohol Brief Interventions undertaken
The number of 3 – 5 year olds registered with a dentist
Target rates for MMR vaccinations
Referrals to financial inclusion and employability advice services
The number of carer assessments being undertaken
Improved uptake of sexual health services by men who have sex with men (MSM)
Percentage of service users who receive reablement service following referral from homecare
Percentage of service users leaving the service following reablement with no further period of homecare
Percentage of service users with an initiated recovery plan following assessment

Where improvement is required
Percentage of children receiving health visitor assessment within 30 months
Percentage of young people receiving a leaving care service who are known to be in employment, education or training
Meeting delayed discharge targets for people (i.e. discharge within 72 hours of being assessed as ready for discharge)
Increase the number of offers of permanent accommodation secured from Registered Social Landlords
Percentage of criminal justice community placement order (CPO) work placements commencing within 7 days of sentence
Bowel screening uptake rates
Cervical screening uptake rates
Increase attendance rate by young people across the range of Sandyford sexual health services
MSK Physiotherapy waiting times

5. SERVICE PRIORITIES

Primary Care

Priorities	Key Actions	Progress in 16/17	Target for 17/18
Working with GPs and the wider primary care team to develop 'clusters' to improve quality and integrated working	• Agree configuration of clusters within NW • Development of initial infrastructure to support clusters (which will continue to evolve in response to cluster needs) • Identifying key points of contact between clusters and service groups as precursor to exploring potential to align other services with cluster model	Achieved. (7 GP clusters in place) NW Primary Care Implementation Group established, with membership including cluster leads.	To continue to support the development and consolidation of GP clusters, including their work to develop quality improvement plans and identifying service priorities. Areas of work that clusters have indicated they wish to take forward include primary / secondary care interface; frailty; early detection of cancer; use of blood tests Embed Older People's 'neighbourhood' team approaches to align broadly with GP clusters where practical
Improve the unscheduled care pathway across primary and secondary care services	• Further develop Anticipatory Care Plans (ACPs) and Intermediate Care approaches • Work to improve primary care / acute care interface issues, including discharge planning and reducing DNAs (Did Not Attend hospital outpatient appointment) • Review learning from evaluation of joint Deep End GP and Community Addiction	Guidance on ACPs produced for practitioners. ACPs launched within mainstream Older People's services. On recommendation from	Continue roll-out and increase number of ACPs in place. Refine as necessary when national guidance released. Contribute to the implementation of unscheduled care strategic

	Team pilot work to improve pathways for people attending A&E for alcohol related issues	Deep End Pilot Report, close working partnerships with Deep End GPs continues.	commissioning plan and attainment of targets contained within it
Improving Access and Supporting Primary Care Capacity	• Promote greater use of the community pharmacy Minor Ailment Service and Optometry services (incl Low-Vision Aids dispensing - raising public awareness on appropriate access and use of health services • Support primary care capacity and patient access to other services • Progress primary care investment fund pilot to explore opportunities for pharmacists to work directly with GPs to undertake additional responsibilities to support patients with long term conditions • Review the use of treatment rooms	Poster/ leaflet campaign undertaken in GP practices to highlight to patients how and when it is appropriate to access Optometry services. Leaflet developed for patients – making the most of your practice including information about alternative services. Link Workers attached to deep end practices (national funding). Awaiting national recommendations. Additional resource in place Sept 2016 Existing capacity assessed	Access and capacity requirements will be considered as part of prioritisation for inclusion in a local primary care implementation group action plan to be developed for 17/18 Provide posters for independent contractors' practices and for other premises to highlight to patients how and when it is appropriate to access Optometry services. Review roles of different workers engaging with primary care to reduce duplication / maximise efficient use of resources. Evaluation ongoing for completion March 2018 Identify future capacity and resource requirements by

	• Identify permanent location for Challenging Behaviour Service (CBS) • Explore GP rapid access to certain investigations • Arrange a meeting for smaller practices to consider resilience issues	CBS relocated, temporarily to Kershaw unit, Gartnavel Royal In progress	August 2017 Recommendation by July 2017 Consider as part of primary care implementation group action plan Take forward any identified local actions from that meeting and contribute to Board- wide actions in relation to recruitment, retention and other issues which impact on resilience
Developing the role of pharmacy profession within North West	• Extend prescribing role of pharmacists in line with implementation of 'Prescription for Excellence' national strategy	Achieved increase in pharmacy led clinics in 16/17	Further increase the number of pharmacy led clinics by March 2018

Carers

Priorities	Key Actions	Progress in 16/17	Target for 17/18
Continue to raise awareness of adult carers and promote the single point of access within the health and social care teams	• Build increased links with all older people, primary care and adult teams to promote carer pathways • Ensure all staff are aware of their roles and responsibilities in identifying and	Target: 300 adult carers per locality and 100 young carers Training was delivered to all social work and voluntary	Performance Indicators will be available in May 2017 following consideration by carer's strategic planning group. Priority to increase referrals from Primary Care.

	supporting carers.	sector staff	
Continue to identify and support young carers through a family based approach	• Ensure all staff are aware of their roles and responsibilities in identifying and supporting young carers. • Continue to work in partnership with Education Services to develop pathway from schools to young carers' services. • Support education services to develop a schools pack for identifying young carers	Outcome Star training has been delivered and this is now embedded within young carers assessment process Recruitment exercise for CIS Education worker	Family Based approaches training is being delivered in May 2017 to all YC staff Young Carers Education CIS worker is now in post and is working in partnership with Education Services to develop resources and promote Young Carers pathway and support services

Children & Families and Criminal Justice

Priorities	Key Actions	Progress in 16/17	Target for 17/18
Support the Wellbeing of Children and Young People through Prevention	• Continue to improve breastfeeding rates in NW Locality particularly in deprived areas. • Implement programs to deliver on Child Healthy Weight. • Increase population awareness of parenting support programmes	At quarter 3, NW performance showing 65.6% compliance against a target of 70%. Delivery of 'Weigh to Go' Programme (for 12-18 year olds) - Board wide service managed by NW. 33 young people by March 2017 in line with target. 17 completed interventions at	Target remains 70% all measures against UNICEF Practice Standards. - in line with targets set out in contract - 30 young people (NW) by March 2018 (100 young people across Board wide service) Increase number of

	• Promote income maximisation and financial inclusion to have positive impact on addressing child poverty. • Carry out 3monthly UNICEF Practice Audits • Implement Assist Smoking pilot programme • Increased awareness of harm associated with alcohol and drugs	January 2017 At quarter 3,400 referrals from NW health visiting and midwifery staff. To be confirmed 18% of S2 year group per school, recruited as peer mentors in following schools Cleveden - 22 mentors Knightswood- 41 mentors Drumchapel – 16 mentors Hillhead – 35 mentors Delivery booze busters P6/7 in 26 schools S1 transition input on Multiple risk – all secondary schools S4/5 – input drugs & alcohol – all secondary schools	completed interventions by 20% by April 2018 Continue to increase the number of referrals to Financial Inclusion Services Target remains 70% all measures against UNICEF Practice Standard N/A – pilot completed New contract to commence in 2017/18
Early identification of children and families who need support	• Health Plan Indicators (HPI) allocated by health visitors to identify children requiring additional services beyond the universal child health pathway • Improve 30 month assessment uptake in NW Locality	At October 2016, NW achieving 92% HPI allocation within 24 weeks against a target of 95%. 66% achievement rate at March 2017 in NW against a target of 95%	Increase number of HPI care plans for children with additional needs in line with target. Ongoing review to improve uptake in line with target

	• Evidence increased referral to the 3 Early Years Joint Support Teams (JST) in NW Locality. • Continue to improve service access across specialist children's services	JSTs self evaluation process was ongoing in 2016/17. Action Plan being developed for 2017/18 Met waiting time target of maximum 18 week referral to treatment (RTT)	Baseline and targets to be confirmed Maximum 18 week RTT
Keeping Children Safe	• Identify and respond to children and young people affected by Domestic Violence • Contribute to awareness raising and implementation of unintentional injuries strategy • Support looked after children, including those in kinship care and promote permanency plans where appropriate • Review the potential for children placed in high cost specialist provision to be supported more locally • Specialist Children's Service vulnerability team to offer a health assessment to looked after children, including those in kinship care • Identifying and support children in need of protection with particular focus on reducing neglect	There has been an increased uptake in the Save Lives training by Health Visitors and School Nurses Variety of campaigns have been promoted including avoiding burns, dishwasher tablet storage and safe sleeping 72% of looked after children (aged <5 years and looked after for >6months) have a permanency review. Target 90%. 85 Child Health Assessments for children and young people currently looked after at home / Kinships have been carried out at April 2017. Training on use of neglect tool being rolled out across NW Team leads	Target to be confirmed Ongoing Increased number of permanency plans in place and meet review target All children 5-18 years newly looked after at home and or in Kinship Care a Comprehensive Health Assessment within 28 days of receipt of referral. Developing a monitoring Tool and will set baselines and targets for 2017/18.
Raising attainment	• Every school/establishment has a named	All Secondary establishment	All establishments will

and achievement	co-ordinator for looked after children (LAC), named officer at centre and Glasgow Psychological Service has existing workstreams in place for young people who are looked after	LAC co-ordinators attend quarterly, Education Services' LAC co-ordinator meetings, to share information and practice, ensuring consistency of approaches to improve outcomes	undertake training in new Health and Wellbeing Planning Tool
Building mental well-being and resilience across the Northwest via direct service delivery and capacity building	• Delivery of mental health improvement service for young people aged 11-18 • Commissioned Service to Improve the Mental Health and Wellbeing of Young People	Commissioned contract began in July 2016. Two quarters data: 260 appointments with 104 young people; mentoring just beginning; 68 young people accessed group work/wellbeing awareness sessions; Youth Health Service 434 appointments with 138 young people accessing service. High demand at Youth Health Service and have invested temporary additional support.	Schools Offering: • 1,000 one to one appointments in schools (260 young people) • Mentoring 220 appts (55 young people) • 8 Groups (64 young people) • 73 appts (inequality groups) (16 young people) Youth Health Service Offering: 600 one to one appts (150 young people)

Criminal Justice

Priorities	Key Actions	Progress in 16/17	Target for 17/18
The efficient processing of community payback orders (CPOs) and	• Ensure all CPOs are reviewed by a Team Leader at the 3 month stage and throughout the order. • Improve percentage of CPOs work placements commencing within 7 days of sentence	NW achieving 78% of 3 month reviews within timescale. Target 75%. NW showing 58% compliance against a target of 80%	75% of CPOs 3 month Reviews held within timescale 100% compliance (evidence through sample

criminal justice social work reports	• Ensure service users are given the opportunity to contribute to the review process.	Ongoing	audit)
The safe management of high risk offenders	• Ensure managerial oversight of risk assessment and risk management planning.	NW recorded at 98% compliance (target 100%)	100% compliance (evidenced through team leader counter signature)

Adult Services

Adult Mental Health

Priorities	Key Actions	Progress in 16/17	Target for 17/18
Delivery of inpatient redesign and ward improvement programme	• Improve the standard of ward accommodation for continuing care patients at Gartnavel Royal Hospital. • Progress plans that will lead to those NW patients who currently access Stobhill Hospital for acute care to instead access Gartnavel Royal Hospital.	Ongoing Ongoing	Progress in accordance with agreed project plan. Estimated timescale for completion: late 2018
Improve access to psychological therapies	• Reduce waiting times for treatment through improved appointment / call-back processes	Significant improvement in performance. Waiting times being met at March 2017.	Ongoing monitoring to ensure performance maintained: 90% RTT < 18 weeks. 100% referral to 1st PCMHT appointment < 28 days
Support people with a mental health to live as independently as possible in the	• Implement findings of community mental health team review to develop consistent, outcome focussed standards and practice	Implementation on target for completion. Development of performance indicators ongoing	Ongoing monitoring

community with access to support and care as necessary	• Support Personalisation of social care for appropriate individuals and ensure outcome focussed assessments are in place. • Improving care pathways between community and inpatient services to maximise the efficient and effective use of resources and opportunities to support people moving through services • Refresh multidisciplinary discharge planning arrangements to explore opportunities for more integrated practice and processes.	Personalisation assessments ongoing for those requiring a service response through this route and ensuring multi-disciplinary input to assessment as required. NW had 9 mental health delayed discharges breaching target at January 2017. As above	Meet personalisation targets Achieve all hospital discharges < 72 hours from treatment completion date ('included codes') As above
Improve the quality of care for people with dementia	• Progress initiative with Alzheimer's Scotland to involve patients and carers in the development of a patient –centred ward environment	Staff and patients, along with designers affiliated to Alzheimer's Scotland, are developing approach and are currently running a pilot in one ward. Using conversation and photographic representations of specific places of meaning for patients, they aim to provide a familiar and welcoming quality to the physical environment as well as using these visual reminiscence cues to promote increased communication	Review September 2017

		between patients, visitors and staff	
Building mental well-being and resilience across the NW via direct service delivery and capacity building	• Delivery of community based stress service for adults	By quarter 3, 3803 appointments with 1504 people accessing counselling service	5267 1:1 counselling appointments 1800 beneficiaries

Alcohol and Drugs

Priorities	Key Actions	Progress in 16/17	Target for 17/18
Improve access to addiction treatment and care	• Introduce 'Access Teams' within existing alcohol and drugs community services to improve assessment and access to appropriate services. • A focus on more intensive, shorter-term interventions to maximise the opportunities for recovery. • Establish presence of "lived experience" representation along with recovery hubs within Access Teams to support individuals not requiring/eligible for formal Care and Treatment provision. • Implement eligibility criteria consistently • Engage with service users and communities over proposals to locate all NHSGGC addiction inpatient beds and	Access Team staffing agreed and formalised Achieved 90% of clients commencing alcohol or drug treatment within 3 weeks of referral In progress In progress Decision deferred on inpatient redesign pending availability of capital funding. Implementation plans being	Access Teams to be operational by June 2017 90% of clients commencing alcohol or drug treatment within 3 weeks of referral Recovery plans in place within 21 days of commencing treatment By September 2017 Review September 2017 Achieve day hospital redesign by September 2017

	'Greater Glasgow' NHS day services at Gartnavel Royal Hospital, with enhanced outreach provision. • Development of community based Recovery Clinics	developed for single day service at Gartnavel within existing accommodation. Recovery hub in pace	Increase the numbers of people achieving abstinence based recovery from ORT
Continue to shift the balance of care from the community alcohol and drug teams to GPs, where appropriate (via 'Shared Care Scheme')	• Work closely with GP colleagues to review all patients and identify how best to meet the needs of patients who are prescribed Opiate Replacement Treatment (ORT) • Implement new Shared Care Team support arrangements • Widen opportunities for women to access women only ORT provision, linked to quality recovery opportunities and childcare/crèche support • More effectively understand the impact of parental substance use for the Shared Care client group and to improve response and outcomes for children	Ongoing Shared Care Team staffing agreed and formalised. Transfer of clinics/patients to team members underway Refreshed guidance in place for staff on Children Affected by Parental Substance Misuse	Increase in the number of people supported in shared care (and reduction in community addiction team activity)
Embed 3rd sector Recovery Hubs	• Work closely with existing 3rd sector providers to ensure a smooth transition for individuals into the new recovery hub service • Increase staff knowledge, skills and experience in respect of Recovery Orientated System of Care and ensure joined up pathways within a ROSC model.	NW Recovery Hub formalised launch in August 2016. Transition of service users completed December 2016 So far 400 referrals made to NW Recovery Hub Developments underway to develop Recovery Orientated System of Care (ROSC). Sainsbury Recovery Model	Hub performance measures in place including to increase the number of people entering and completing recovery programmes Recovery communities targets for participation to be set Staff Training in place June 2017

		launch 2016 with North West Alcohol and Drugs Recovery Service (ADRS) partners with action plan established	
Support the NW Recovery Communities to establish their new base and develop new services	• Support the new Recovery Volunteers Well-being Initiative • Establish a robust interface between the Recovery Communities and the new Recovery Hub Service to increase support to individuals in NW, particularly in the evening and at weekends.	Premises secured and operational Formalised training programme underway for Volunteers. 20+ individuals linked in Regular meetings underway to develop ROSC involving care and treatment services; recovery hubs and recovery communities. Joint funding bid with GCA successful to establish: Recovery Administrator post to support NWRC AFFIT co-ordinator (alcohol free events, social networking, community networks). 8 x Events delivered 2016/2017 with a further 12 on schedule for 17/18 Recovery Liaison Worker to support individuals who are isolated into positive recovery settings and recovery	Develop sustainability plan and funding strategy to support continued growth within NW Recovery Communities Expand involvement to other key partners eg. Homelessness providers, employability services

		meetings All commenced employment Jan/Feb 2017, induction and action planning underway	
Reduce Alcohol Related A&E admissions/ presentations	• Roll out the Assertive Outreach approach for those hard to reach individuals who do not use service or present to their GPs, but use A&E frequently • Work closely with GPs to identify our most vulnerable individuals	Working in partnership with Acute Liaison to identify individuals with 4 or more hospital admissions within a 12 month period. Weekly Complex Case Review Meeting to discuss individuals with 4 or more hospital admissions within a 12 month period. ADRS link nurses providing assertive outreach to all new Acute Liaison referrals. Alcohol related admissions (crude rate per 1000) increased between April 2015 and September 2016. However, Jan –Dec 2016 shows a reducing trend.	Reduction in rate of alcohol related A&E attendances from 2016/17 levels
Work with community planning partners and the Alcohol and Drugs Partnership to reduce	• NW Health Improvement Team to host the Health Improvement Lead (Alcohol Licensing) post on behalf of the city. • Continue to co-ordinate a Glasgow City /	Responded to alcohol licence applications in localities where alcohol related health impacts are in evidence. 2 off sales	Reduction in alcohol availability and consumption levels – measured through health & wellbeing survey

alcohol consumption	NHSGGC contribution to the licensing Forum and Board.	licence applications in NW Glasgow were refused in 2016 as a result of 'public health evidence'	results Continue to provide alcohol related health evidence to relevant licence applications. Ensure health evidence is considered in preparation of next local licensing policy.

Learning Disability

Priorities	Key Actions	Progress in 16/17	Target for 17/18
Undertake a review of health and social care learning disability provision to maximise the opportunities for people with a learning disability to live in the community with appropriate levels of support.	• Scope current practice and develop more integrated approaches between social work and health service teams • Improve access to mainstream services • Identify appropriate models of care and future accommodation requirements, including consideration of: - NHS long stay and assessment / treatments beds provision - Respite facilities - Day Services - Community provision and potential commissioning options • Review of all clients who have personalised packages to better align need with available resources	In progress. NW contributing to citywide review of integrated LD teams Ongoing Ongoing Personalisation plans in place. Ongoing review of current care packages	Recommendations by August 2017 Identify priorities / improve patient pathways to mainstream services Will be considered in 17/18 as part of developing a City-wide 5 year LD strategy Ongoing. Will inform the above

Older People's Services and Physical Disabilities

Priorities	Key Actions	Progress in 16/17	Target for 17/18
Deliver Dementia Local Delivery Plan target and local implementation of national and Glasgow City Dementia Strategy	• Deliver post diagnosis support (PDS) to everyone with a new diagnosis of Dementia. • Provide Board-wide leadership for early onset dementia, ensuring Young Onset Dementia Services are integral to implementation of dementia strategy and targets	Pilot proposal developed for GP initiative Continuing to develop young onset dementia service, which is now led by a Clinical Psychologist. Work ongoing includes developing a referral pathway from neurology services. Developed training for housing providers; and the setting up of two dementia cafes.	The focus of the LDP standard is now the numbers diagnosed and referred for PDS (incidence) rather than prevalence. Targets to follow.
Deliver Psychological Therapies Local Delivery Plan target (primarily OPMH community	• Develop plan for local delivery of psychological therapies including low level & high level interventions, and ensure staff are trained appropriately to deliver. • Provide Board-wide leadership for older adults psychology services ensuring	Action plan in place to increase access to psychological therapies for older people. Some of the work includes sharing information on services and groups available/suitable for older people; and developing referral pathways between CMHT for Older People and the Primary Care MHT. NW continues to lead on	90% RTT < 18weeks Ongoing

	effective links with 'increasing access to psychological therapies' agenda.	Boardwide Older Adult services and have organised two development sessions for relevant staff across the organisation.	
Implementation of the recommendations from NHSGGC District Nursing Review and the national review of district nursing	• Contribute to city-wide flexible working plan to provide 24 hr service availability. • Implement a Single Point of Access for Nursing Services, (based at Plean St Clinic and delivering city-wide)	Pilot undertaken. Priority to be single point of access. Fully rolled out Mon-Fri, with partial access at weekends.	Revisit potential benefits of extending weekend access. Awaiting national recommendations for district nursing services
Deliver timely Speech & Language Therapy interventions within residential settings (care homes/inpatients)	• Complete city-wide review of speech and language therapy partnership services . • Develop protocols to ensure robust management of referrals.	An initial review has been completed. An additional 1 wte post has been funded permanently for the SLT Care Homes service. A new email protocol for referrals for Care Homes & mental health referrals has been implemented.	Review of Adult SLT services within Glasgow City to be completed by September 2017
Supporting people to live for longer at home, independently	• Implementation of Accommodation Based Strategy (ABS) • Continued development of intermediate care approaches	Providers' Tender Framework in place. Cordia providing ABS multi-disciplinary groups in place targeting high cost care packages involving 2 or more Acute admissions 2 x 15 intermediate care bed	Target of 2 referrals per week to Cordia supported living service. Roll-out implementation of Assisted Technology strategy Review future HSCP bed capacity requirements,

	• Contributing to review of residential care provision • Local implementation of service changes arsing from City-wide review of Occupational Therapy services	commissioned. Reconfigured residential beds into intermediate and complex palliative care beds Work progressing to integrate health and social care OT roles and responsibilities	including intermediate care, step-up and HBCC (hospital based complex care) Progress development of new 70 bed care home at Blawarthill. Full implementation of integrated arrangements by September 2017
Focus on and develop service capacity particularly in relation to prevention and early support	• Develop anticipatory care and enabling approaches across services and reduce unscheduled admissions to hospital. • Support early discharge from hospital, contributing to the ongoing development of Intermediate Care approaches and an accommodation based strategy, along with input from community rehabilitation services. • Develop a more integrated approach across older people's services, including close links with GP clusters. • Further develop 'Knightswood Connects' project to build community networks and capacity	Guidance on ACPs produced for practitioners. ACPs launched within mainstream Older People's services. Contributed to city-wide 'home is best approach' to develop multi-disciplinary team approach across hospital and community service NW had 10 delayed discharge breaches of target at January 2017 (for patients over 65 years, excluding mental health and learning disability patients) Develop neighbourhood team approach for older peoples services with close links to GP clusters Ongoing	Continue roll-out and increase number of ACPs in place. Refine as necessary when national guidance released. Contribute to the implementation of unscheduled care strategic commissioning plan and attainment of targets contained within it Achieve all hospital discharges < 72 hours from treatment completion date ('included codes') Neighbourhood Team approach fully implemented by September 2017 Develop and roll-out well-being questionnaire

	• Oversee the development of the city-wide Respiratory Service, hosted in NW locality	Interim evaluation completed that has demonstrated the service has contributed to a reduction in hospital admissions and bed days. Permanent funding secured.	Performance indicators to be developed.
Improve the quality of life of patients and their families facing the problem of life-threatening illness	• Progress implementation of recommendations and actions arising from multi-agency palliative care learning event	Stocktake undertaken of current service provision and knowledge against the national strategic framework for action	Reconvene NW palliative care group by June 2017. Workplan with outcomes to be in place by October 2017.
Support the Provision of community based Health Improvement programmes	• Co-ordinate a review and support a programme of lunch clubs for older people	In progress	Complete June 2017
Improve access to services and outcomes for **people with a physical disability**	• Support Personalisation of social care for appropriate individuals and ensure outcome focussed assessments are in place • Develop more integrated service approaches for managing long terms conditions • Work with housing providers to support tenancy sustainment and early intervention	Personalisation plans in place Co-location of teams at new Maryhill Health & Care Centre	Reduce waiting times for assessments. Improve care pathways for people under 65 years with a physical disability Formalise multi-disciplinary forum for review of complex cases Introduce process to notify availability of barrier-free properties and match to assessed need

Homelessness

Priorities	Key Actions	Progress in 16/17	Target for 17/18
Improve interfaces with Housing Providers to increase access to settled accommodation	• Working with Housing Access Team, lead and coordinate citywide casework input to the 3 NW Local Letting Communities (Drumchapel, North West & West) to achieve targets on settled accommodation • Monitor number and duration of homelessness applications	From 1/4/16 to 31/12/17 the following lets were achieved: Drumchapel: 24 lets (-16 against annual target) North West: 119 lets (-276 against annual target) West: 110 lets (-85 against annual target) Wheatley Group (to 23/12/16): 249 lets (27% of all lets in area – target 40%) As at 20 March 2017: Total Live Cases: 584 Total Live cases over 6 months duration: 264 (45% - target 20%)	Targets: Drumchapel: RSLs - 40 units p.a. North West: RSLs - 395 units p.a. West: RSLs - 195 units p.a. + share of Wheatley Group citywide target % live homeless applications >6 months duration Additional capacity requirements to support asylum seekers to be determined
Increase throughput in temporary and emergency accommodation to	• Work to agreed citywide targets for provision of initial decision, prospects / resettlement plans and accommodation outcome	From 1st April to 31st Dec 16, 93% of decisions (based on Audit Scotland guidelines) were made within 28 days.	Targets: Provision of 95% of decisions made within 28 days; Completion of Prospects / Resettlement Plan within 14

settled accommodation	• Continue to contribute to citywide B&B Monitoring Meeting and development of IT based locality reports to monitor lengths of stay	At 20 March 2017 there were 51 cases awaiting resettlement plan of which 26 were over 14 days from decision date (51%). As at 20 March 2017 – 55% of live applications were of 6 months or less duration (target 80%). At 20 March 2017 North West CHT had 43 cases in B&B, of which 11 (26%) had been in for 60 days or more.	days ; 80% of live applications are 6 months or less duration Locality reports available by March 2017
Develop a sustainable, holistic response to homelessness by ensuring collaboration across housing, health, social work, third and independent sectors	• Develop and improve Housing Options approach by Community Homelessness Team and RSL partners • Continue to promote integrated working with money advice, mediation, and housing support services	From 1/4/16 to 20/3/17 there were 1,934 new Housing Options approaches to North West CHT. Of these, 1,123 were closed to 'Made Homeless Application' (58%). This indicator continues to be monitored on a quarterly basis. Referrals continue to be monitored on an ongoing basis. Referrals to Mediation Services have not increased to date. Funding for Money and	Monitor quarterly: % of closed housing options approaches which progress to homeless application Maintain / improve referrals to money advice / mediation services – quarterly monitoring

		Debt Advices Services will end on 31st March 2017, and provision of an interim service has been discussed with Locality based Welfare Rights Team as there has been high demand for this service.	
		New Flexible Homeless Outreach Support Service contract was awarded to Turning Point (Scotland) for NW area. Arrangements for colocation of Casework and Flexible Outreach staff being progressed through NW Planning Group.	Enhanced role for housing support embedded in NW from March 2017
	• Facilitate broader involvement from HSCP services in Housing Options approaches through awareness raising events	This will be developed through 2017/18.	Events /dates to be confirmed

Essential Connections Forum

Priorities	Key Actions	Progress in 16/17	Target for 17/18
Promote greater partnership working between NW Locality and Housing Providers	• Refresh the NW Essential Connections Forum and Vulnerable Households Forum to ensure membership and remit that reflects shared priorities	ECF in place with wider membership (including local letting community leads) and refreshed terms of reference.	Ongoing development of ECF and HPF – reviewing membership as necessary

	• Develop a multi-agency training plan • Refine statements of best practice and agree information sharing protocols • Continued development of Housing Options tenancy sustainment activities, working with partners across NW area	New Housing Providers Forum in place (replacing VHF). Draft training plan produced. Achieved Housing Options for Older People (HOOP) has pioneered new ways of working works with HSCP and Acute colleagues to offer advice, support and practical solutions regarding housing issues affecting older people being discharged from hospital or moving on from Intermediate Care.	Engage with RLS on final training plan and monitor uptake Roll-out new statements of best practice supported by awareness raising. Embed existing joint work and continue to maximise opportunities to facilitate case referral to HOOP. Promote early identification of patient housing status and develop closer joint work with OTs, Physiotherapists, Discharge Coordinators and ward staff. Awareness raising programme across all NW RSLs will be implemented
A greater focus on prevention and early intervention, supporting housing providers to identify potential need and access appropriate services quickly	• Progress development and implementation of the Housing Contributions Statement • Ensure housing providers are an integral partner in anticipatory care planning (ACPs) and discharge planning • Develop a co-ordinated person centred approach to the provision of aids and adaptations across tenures.	Ongoing Progressed through Housing Options (incl HOOPs) and Housing input at Older People's Planning Group	Review City-wide implementation Promote use of ACPs with housing providers Ongoing

Sexual Health Services

Priorities	Key Actions	Progress in 16/17	Target for 17/18
Fewer newly acquired HIV and sexually transmitted infections	• Improve access to testing at current clinics, and introduce some test-only walk-in clinics and targeted home or self-testing	The waiting time for Urgent Care clinics (for symptomatic and people at higher risk) within NW sector was less than 2 days, and across all Sandyford clinics was 2 days.	Waiting times for Urgent care appointment - 2 working days. Waiting times for Test-only appointments – 15 working days
	• Ensure increase in Partner Notification undertaken for people diagnosed with a sexually transmitted infection.	In progress	Proportion of clients with a diagnosed STI who have PN – target to be confirmed
	• Ensure HIV testing is being targeted appropriately at groups who are most at risk	In GC HSCP the proportion of males who are MSM (men who have sex with men) has risen from 18% in 2010 to 23% 2016, and in NW sector it has risen each year from 19% in 2010 to 24% in 2016.	HIV test uptake within priority groups increases *(target tbc)* Social marketing undertaken to promote HIV testing to those who have never been tested
	• Improve access to Free Condoms	The number of Free Condoms sites increased by 13% across North West sector, from 97 in 2015 to 110 in 2016.	Increase in number of FC sites across GGC. Increase in number of condoms available across GGC
Fewer unintended pregnancies	• Increase the uptake of very long acting reversible contraception across Sandyford services	Numbers of IUD and IUS fitted across Sandyford services in NW sector has remained at the same level in 2016 as in 2015, ie 2,042 in total. Numbers of implants has decreased from 1,782 in 2015 to 1,535 in 2016	Increase on previous years. Waiting times for vLARC appointment – 10 working days

	• Increase the uptake of vLARC in women who have undergone a termination of pregnancy procedure	.	Proportion of women receiving post-abortion LARC (immediate prescriptions and bridging contraception) within 6 weeks – 40%
	• Work with partners in the acute sector to increase access to the Termination of Pregnancy assessment services for all women from outside Glasgow City		Number of women accessing the service from outwith Glasgow city increases
	• Improve access to Free Condoms	The number of Free Condoms sites increased by 13% across North West sector, from 97 in 2015 to 110 in 2016.	Increase in number of FC sites across GGC. Increase in number of condoms available across GGC
Sandyford specialist sexual health services are accessible to all – including people and population groups who are more likely to experience poor sexual health	• Improve service access: - reviewing opening hours and locations (as part of the Service Review) - establish a call-centre model to improve telephone access - improve electronic access through the introduction of self-arrival kiosks, self-registration, and online booking of appointments	In progress	Target to be confirmed
	• Explore outreach provision to the most marginalised people with third sector and other partners	Building Relationships engagement event in summer 2016 which opened up wider discussion with community organisations about the particular issues and needs of their clients. It will also allow us to start a dialogue with partners (as part of the Service Review) to develop	Outreach models developed and plans in place to implement these where appropriate

		appropriate forms of outreach.	
	• Review the Steve Retson Project for men who have sex with men, and all Sandyford services, to ensure the most vulnerable men are offered the right services at the right times	133 men were referred to SRP Choices, the majority of whom (89%) were referred from a Sandyford service. • 53% of 133 men referred to SRP Choices engaged with the assessment. • 60% of 71 men who engaged with the assessment then also engaged with an intervention. • 72% of 54 men placed on the CBT waiting list went on to engage in CBT counselling. • 66% of 6 men placed on the low tier intervention list went on to engage in this intervention Work continued to identify suitable premises for the future location of the SRP. Options have progressed to design stage, but have not yet delivered a workable solution.	SRP community hub developed Proportion MSM of all male attendances at all Sandyford services – 10% .
Improved service	• Increase the rate of attendance at all Sandyford services of sexually active young people aged under 20	Numbers of young people aged under 20 have reduced across all Sandyford services from 7,096 in 2015 to 6,543 in	ages 13-15 male 5%, female 58%; ages 16-17 male 10%, female 64%

access across all Sandyford services for young people aged under 20		2016. In clinics within NW sector (Central at Charing Cross and Drumchapel), the numbers have increased from 3,500 to 4,008. The Youngpeople@sandyford website was launched in the autumn of 2016 and has been widely promoted using social media.	
	• Plan and Implement pilot to extend young people's clinic opening hours into late afternoon and early evening	Sandyford has completed a review of young people's service opening times and locations alongside a range of broader accessibility issues for young people. This review process included the lead officer from the YHS Service. A recommendations paper has been drafted for the Sandyford Service Review Programme Board. A pilot of extended young people's clinic opening hours is at the planning stages for one of Sandyford's Hubs in Northeast.	Increased attendance of all young people, young males, and young MSM. Increased uptake of LARC in young women. Increased uptake of STI testing in young people.
	• Assess training needs for staff working with young people and address where necessary	402 staff who work directly with young people across GGC were trained by Sandyford staff in sexual health and wellbeing issues in	Increase in the number of staff trained in sexual health and wellbeing who work directly with young people, particularly targeting third

		the business year 2016/17. Only 49 of these were in Glasgow City where this training is predominantly delivered by dedicated social work trainers.	sector addictions and homelessness staff
	• Strengthen links with Youth Health Service across North west and Glasgow city by responding to the outcome of the city-wide review as appropriate	Sandyford has engaged with and contributed to the City-wide review of youth health services, and will respond to the outcome of this review as appropriate.	Target to be confirmed

Health Improvement

Priorities	Key Actions	Progress in 16/17	Target for 17/18
Building mental well-being and resilience across the Northwest via direct service delivery and capacity building	• Provision of range of mental health training programmes to build capacity of local communities, groups and organisations • co-ordinate NW Mental Health & Wellbeing Forum • Co-ordinate NW Suicide Safer Communities Forum	Training Courses Delivered: • Scottish Mental Health First Aid training x 4 • Scottish Mental Health and Wellbeing Training -Young People (SMHFA:YP) x 3 • Safetalk x 7 • Assist x 5 • Mental Health & Wellbeing Forum x 6 6 meetings of communities forum held	Training Courses Offered: - Scottish Mental Health First Aid training x 4 -Scottish Mental Health and Wellbeing Training -Young People (SMHFA:YP) x 2 Safetalk x 6 Assist x 4 Amaan Communities Training x 2 - Mental Health & Wellbeing Forum x 4 sessions p.a. - NW SSCF x 6
Tackling poverty and	• Delivery of financial inclusion &	Financial Inclusion services	- Implement a neighbourhood

health inequalities	employability services including income maximisation, debt management and building financial capability. Work to increase referrals across service areas. • Delivery of mentoring programmes for young people • Lead the delivery of programmes to address Gender Based Violence in NW, including training, capacity building and inter-agency responses.	continue to grow and deliver good outcomes. By quarter 3, 970 people referred by NHS to financial inclusion services. Funding extended for the SLAB project in Possilpark. Making better progress after the employability Bridging Service transferred to a new supplier MIDAS – working with 21 new young people with particularly complex needs plus continued to work with 11 young people from 2015/16. . Nature of complexity impacted on target figure. Assisted Pilot – 2 young people (lack of uptake by pilot GP practices) Plusone – 24 young people recruited to the programme in 2016/17 Local delivery groups continue to develop and adapt in relation to neighbourhood need. Each group prioritised	approach to employability and financial inclusion. Embed money advice service model within Possilpark - Midas - 21 new young people + 10 existing + young people via Lifelink Youth Contract - Equally Safe local delivery groups x 5 (1 group per multi member ward area) - Gender Based Violence Youth Guideline training for trainers x 1 session (16 participants 6 ½ day training sessions (April 2017 – March 2018) FGM x 2, Childhood sexual abuse, domestic abuse & coercive control, commercial sexual exploitation.

	• Support the implementation/ delivery of the Violence against Women awareness raising campaigns:	their funding streams which reflected the Equally Safe priorities. Kelvin College agreed to develop trainer for trainers in order for it be recognised as a credited youth work module. Ongoing	Violence Against Women ½ day workshop x 2. - Child Sexual Abuse Awareness Month (Sept 2017) - 16 Days of Action (November 2017) - International Women's Day (March 2017) North West Women's Festival (25th November) Monthly neighbourhood event leading up to the festival.
Creating a culture for health – reducing alcohol , drugs and tobacco use and obesity	• Continue roll-out of targeted area based approach to smoking cessation services • Establish Action Plan for reformed NW prevention Education Group. • Delivery of community based Prevention and Education contracts	In 2016 the NW had the top three quit rates services in the whole of the health board, Possilpark, Drumchapel and Maryhill. Early 2017 returns suggest continued growth Completed across the Thriving Places area. Responses being collated and action plans being produced via local P&E subgroup. Delivered in Dumbarton Road Corridor. Completed Feb 2017. Evaluation of campaign and diversionary programme	- <15% women smoking during pregnancy (<20% in most deprived quintile) - From 40% most deprived (TBC quits at 12 weeks) - Facilitate a series of workshops x4 to identify priority actions in 4 neighbourhoods. Scope potential deliver a Local Community Alcohol Campaign in 1 priority neighbourhood linked to

		underway.	localised Ripple Effect action Plan
Taking a place-based approach to community health and wellbeing	• Use a variety of asset based methods and tools to work with local communities to identify their priorities • Support community based capacity building through the delivery of community based health contracts	Utilised the Place Standard tool to have conversations with more than 6 groups in Drumchapel to talk about their community and identify priority areas for action which were shared and discussed at a Drumchapel Blether. Worked in partnership with connecting Milton group to gather communities' wishes for Milton and further discussed these at regular community breakfasts. Facilitated visioning and planning workshops with Ruchill and Possilpark Thriving Places development groups to create local action plan and priorities. By end of quarter 3, AXIS engaged with 1618 people including delivery of community cooking, HIIC courses and capacity building	- Drumchapel - Continue work of the Breakfast & Blether group to link with emerging Thriving Places Locality Plan. Establish Thriving Places Steering Group to support implantation of draft connecting communities plan. -Milton & Lambhill- Identity and recruit Thriving Places Anchor organisation. Recruit TP Community Connector to link with Connecting Milton group and wider community to develop local community involvement plan - Ruchill & Possilpark - Continue to deliver on local action plan together with local people and partners under a joint TP development group. - In line with annual targets set out within AXIS contract

6. PROMOTING EQUALITY

North West Locality will contribute to delivering the actions and priorities set out within Glasgow City HSCP's Equality Plan 2016-18. Key actions and priorities for NW Locality in 2017/18 include:

- Maintaining accessibility audits of new buildings
- Participation in Equality Impact Assessments of cost savings, service redesigns, service developments and policies
- Hate crime awareness and reporting
- Routine enquiry money worries, gender based violence (GBV), employability and appropriate onward referral
- Extend number of GBV local delivery groups from 3 - 5 to deliver on Equally Safe strategy
- Participation in age discrimination audits as required
- Responding to findings of the Fairer NHS staff survey alongside staff training priorities (Asylum seekers & Refugees, Poverty e-learning module, Key care groups: GBV)
- Meeting the requirements of the HSCP's participation and engagement strategy including equalities monitoring of community engagement
- Analysing performance monitoring and patient experience by protected characteristics as required
- Provision of a programme of equality and diversity training for NW HSCP staff and local organisations in North West

7. RESOURCES

7.1 Accommodation

New Health and Care Centres

The new Maryhill Health and Care Centre opened in September 2016 and provides the local community with purpose built, modern facilities. This £12m development replaced the existing health centre and incorporates 3 GP Practices, physiotherapy, podiatry, community dental services, speech and language therapy, district nursing, health visitors, community mental health services, a youth health service, along with health and social work teams.

Site work has commenced on the development of a new £20m Woodside Health and Care Centre. As with Maryhill, it will accommodate a similar range of health and social care services as well as specialist children's services, community alcohol and drug services and an older people's day care unit. The new health and care centre is planned for completion in October 2018.

Sandyford Sexual Health Services

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

Reviewing Accommodation Requirements and Promoting Co-location

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

7.2 Human Resources

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

7.3 Finance

North West Locality has a total net recurring budget for service provision of approximately £230m and directly manages a staffing compliment of approximately 1800 people. An indicative budget for North West in 2017/18 is set out below. This will be confirmed in the weeks ahead.

GCHSCP - North West	**2017/18**
	£
Children and Families	11,334,700
Prisons Healthcare and Criminal Justice	2,402,400
Older People	27,093,700
Addictions	28,228,400
Carers	585,700
Elderly Mental Health	6,323,700
Learning Disability	14,484,000
Physical Disability	5,176,300
Mental Health	18,928,900
Homelessness	976,200
Prescribing	40,244,300
Family Health Services	55,547,500
Hosted Services	9,890,400
Other Services	4,872,100
Total	**226,088,300**