GLASGOW CITY HEALTH & SOCIAL CARE PARTNERSHIP
Shadow Integration Board

2.00pm on Tuesday, 6th October 2015 in the
Sir Peter Heatly Boardroom, Commonwealth House,
32 Albion Street, Glasgow G1 1LH

AGENDA

		Enclosure
1.	**Membership** To note that Simon Carr has been appointed to the Shadow Board by the Health Board effective from 1st September 2015 to replace Ken Winter who has retired as a member of the Health Board. Mr Carr is unable to attend the October meeting due to holiday commitments. To note that Annie Craig has been appointed as the Carers representative on the Shadow Board, with John McVicar as her substitute.	
2.	**Apologies for Absence** Simon Carr and Councillor Archie Graham	
3.	**Minutes** To approve as an accurate record the Minutes of the meeting of the Shadow Board held on 11th August 2015.	Minutes
4.	**Matters Arising** (not otherwise on the Agenda)	
5.	**Chief Social Worker's Annual Report** Susanne Millar, Chief Officer Planning, Strategy & Commissioning/CSWO	Report
6.	**Integration Scheme** David Williams, Chief Officer Designate	Oral
7	**Strategic Plan Update** David Williams, Chief Officer Designate	Report
8.	**Joint Inspection of Older People's Services** David Williams, Chief Officer Designate	Report
9.	**Integrated Care Fund – Update** Stephen Fitzpatrick, Head of Older People's Services	Report

10.	**Finance Report to July 2015**	
	Sharon Wearing, Chief Officer Finance & Resources	Report
11.	**Unscheduled Care Winter Planning**	
	David Williams, Chief Officer Designate	Report
12.	**Participation & Engagement Strategy**	
	Allison Eccles, Head of Business Development	Report
13.	**Health Board Clinical Services Strategy**	
	Jennifer Armstrong, Medical Director and Catriona Renfrew, Director of Corporate Planning & Performance, NHS GG&C	Presentation
	Background paper approved by the Health Board on 20th January 2015	Report
14.	**Next Meeting**	
	The next meeting is scheduled for 2.00 pm on **Monday, 2nd November 2015** at Commonwealth House, 32 Albion Street, Glasgow, G1 1LH.	

NOT YET APPROVED AS A CORRECT RECORD

Item No 3

6th October 2015

GLASGOW CITY SHADOW HEALTH & SOCIAL CARE INTEGRATION BOARD

Minutes of meeting held in the Sir Peter Heatly Boardroom, Glasgow City HSCP, Commonwealth House, 32 Albion Street, Glasgow, G1 LH at 2pm on Tuesday, 11th August 2015

PRESENT:	Cllr James Adams	Councillor, Glasgow City Council
	Cllr Malcolm Cunning	Councillor, Glasgow City Council
	Cllr Marie Garrity	Councillor, Glasgow City Council
	Cllr Archie Graham	Councillor Glasgow City Council (Chair) (Joint Chair)
	Trisha McAuley	NHSGG&C Board Member
	Robin Reid	NHSGG&C Board Member
	Andrew O Robertson	Chairman of NHSGGC (Joint Chair)
	Rev. Norman Shanks	NHSGG&C Board Member
	Donald Sime	NHSGG&C Board Member
	Mari Brannigan	Nurse Director
	Richard Groden	Clinical Director
	Ian Leech	Glasgow City Staff Side
	Alex MacKenzie	Chief Officer Operations
	Dorothy McErlean	NHSGG&C Staff Representative
	John McVicar	Carers Representative
	Susanne Millar	Chief Officer Planning, Strategy & Commissioning/CSWO
	Peter Millar	Independent Sector Housing Provider Representative
	Anne Scott	Social Care Users Representative
	Ann Souter	PPF Representative
	Sharon Wearing	Chief Officer Finance and Resources
	David Williams	Chief Officer Designate
IN ATTENDANCE:	Colin Birchenall	Programme Manager, Open Glasgow
	Sybil Canavan	Head of HR (NHS)
	Kay Carmichael	Administration Manager
	John Dearden	Head of Business Administration
	Allison Eccles	Head of Business Development
	Sandra McDermott	Head of Financial Inclusion and Improving Cancer Journey
	Fiona Moss	Head of Health Improvement and Inequalities
	Janice Preston	Janice Preston the General Manager for Macmillan Cancer Support in Scotland
APOLOGIES:	John Brown	NHSGG&C Board Member
	Baillie Aileen Colleran	Councillor, Glasgow City Council
	Cllr Russell Robertson	Councillor, Glasgow City Council
	Dr Michael Smith	Lead Associate Medical Director, Mental Health & Addictions

1. MINUTES

The minutes of the meeting held on 22nd June 2015 were approved as a correct record.

2. IMPROVING THE CANCER JOURNEY

David Williams introduced Sandra McDermott, Head of Financial Inclusion and Improving Cancer Journey; Janice Preston, General Manager for Macmillan Cancer Support in Scotland and Colin Birchenall, Programme Manager – Open Glasgow.

Janice and Sandra gave a presentation on the role and work of Improving the Cancer Journey (ICJ) which links to the Scottish Government's 20:20 Vision for the NHS and the Integrated Health and Social Care 9 National Health and Wellbeing Outcomes. Sandra highlighted that the work of ICJ already demonstrates the benefits from integrated working.

Colin Birchenall then presented the data analytics to the group highlighting how the data captured can be used as dashboards to show health, housing, age profiles of those using the service within the City.

Members questioned the cost/benefit analysis of the work and what else could be done to get more people engaged. It was confirmed the University of West Scotland were undertaking research in relation to the social economic benefits and that work is underway with GPs to try and encourage take up of the service.

The Board noted the presentation.

3. INTEGRATION SCHEME - UPDATE

David Williams advised that the revised draft Integration Scheme was not yet available as discussions continued around the future arrangements in relation to Specialist Children's Services.

The Scottish Government had written to the Chief Executives of both organisations seeking an update on the planned timescales for the submission of the revised Scheme.

Members queried whether there was a given date when the return had to be made before Ministers would impose a solution. David indicated that there is no date set.

Members questioned whether the delay in the Scheme being approved was impacting on staff, patients/users and stakeholders and whether other areas had yet to submit Schemes. David stated that there were a number of other areas whose Schemes were still outstanding and that outstanding issue was causing uncertainty for the staff group involved with Children's Services.

The Board noted the update.

4. STRATEGIC PLAN – UPDATE

David Williams spoke to the paper on the development of the Strategic Plan detailing the planned Communication Strategy and Consultation Process.

It was intended to publish the plan on Monday 14th September for 6 weeks to allow individuals, groups and organisations to review and discuss prior to approval to go out to consultation by the Integration Board once formed. It was hoped that the formal consultation process will begin in early November and end on 31st December.

Members made a number of comments on the content of the plan:

- Page 4 - A&E should not be described as a delegated function
- Page 12 - reference should be made to the NHSGG&C Clinical Services Strategy (CSS)
- There was currently no reference to the 3rd Sector and housing options.

The Joint Chair commented that it was useful for members of the IJB to comment on the plan prior to the formal consultation.

The Board

(a) noted the report and approved the proposed plan for Communication and Consultation; and

(b) suggested that the content of the Plan is amended to take account of the comments made by members.

Chief Officer (Designate)

5. WORKFORCE DEVELOPMENT & SUPPORT PLAN

Sybil Canavan presented report on the Workforce Development and Support Plan. The submitted paper included an initial draft workforce profile and detailed the planning around the workforce that will support Glasgow City HSCP. Sybil highlighted that some of the detail had still be fully populated, however, following discussion at the Senior Management Team meeting it was felt important that the Shadow IJB members had an opportunity to review the initial detail.

A Workforce Development Board for the H&SCP was in process of establishment to take these issues forward.

A query was raised over the figures in the table on page 13 and whether the leavers shown were connected to the Council's workforce plans. Susanne Millar replied that this related to projected leavers and was not related to the overall Glasgow City Council workforce plans.

In response to an enquiry about linking with staff governance in relation to workforce planning for the parent organisations, it was confirmed that this would continue and links would be maintained.

The Board noted the report.

6. NEXT MEETING

It was noted that the next meeting was scheduled for 2.00 pm on Tuesday, 6th October 2015 in the Sir Peter Heatly Boardroom, Glasgow City HSCP, Commonwealth House, 32 Albion Street, Glasgow, G1 1LH.

The meeting ended at 3.20pm

Item No 5

6th October 2015

Glasgow City Council / NHS Greater Glasgow and Clyde
Shadow Integration Joint Board

Report By:	Susanne Millar, Chief Officer Planning, Strategy & Commissioning and Chief Social Work Officer
Contact:	Susanne Millar
Tel:	0141 287 8847

Chief Social Workers' Annual Report 2014/15

Purpose of Report:	This is the Chief Social Work Officer's report to Glasgow City Council for the year 2014/15, prepared in line with Scottish Government guidance.

Recommendations:	The Board is asked to note the report.

Implications for IJB	
Financial:	See paragraph 6.1 of body of report.
Personnel:	See paragraph 11 of body of report
Legal:	The report is prepared in line with Scottish Government Guideline
Economic Impact:	None
Sustainability:	None
Sustainable Procurement and Article 19:	None
Equalities:	The report does not propose any new policy, plan, strategy or service
Implications for Glasgow City Council	Relates to the Council Strategic Plan: "A City Which looks After its Vulnerable People"
Implications for NHS Greater Glasgow & Clyde	As a partner agency.

1. Purpose

1.1 This is the Chief Social Work Officer's report to Glasgow City Council for the year 2014/15, prepared in line with Scottish Government guidance.

2. Background

2.1 The requirement for every local authority to appoint a professionally qualified Chief Social Work Officer (CSWO) is contained within Section 3 of the Social Work (Scotland) Act 1968. This is one of a number of statutory requirements in relation to posts, roles or duties with which local authorities must comply.

2.2 The overall objective of the CSWO post is to ensure the provision of effective, professional advice to local authorities in relation to the provision of Social Work Services. The Changing Lives report concluded there was a need to strengthen the governance and professional leadership roles of the CSWO to oversee Social Work Services and ensure the delivery of safe, effective and innovative practice.

2.3 The Scottish Government has put in place statutory guidance relating to the role of the CSWO that clarifies:

a) role and function
b) competencies, scope and responsibilities
c) accountability and reporting arrangements

2.4 The Scottish Government has also preserved the statutory role of the CSWO within the terms of the Public Bodies (Joint Working) (Scotland) Act 2014.

2.5 A report was taken to Executive Committee in 17 April 2009 which confirmed the above role and functions of the CSWO and directed the CSWO to bring forward reports to Committee on an annual basis, in line with this guidance.

2.6 The format for this current report has altered from previous reports in line with new guidance from the Office of the Chief Social Work Adviser to the Scottish Government.

3. Local Authority Overview

3.1 Glasgow is an urban local authority, within the Greater Glasgow metropolitan area in the west of Scotland. Glasgow is the largest local authority area in Scotland by population, with 593,245 residents at the 2011 census. This accounts for 11.2% of the total Scottish population. Although the population of Glasgow declined sharply through the latter part of the 20th Century, it has been increasing again since 2004. This trend is expected to continue over the next few years. Glasgow's service user population is expected to increase significantly over the next few years:

- The number of users of children and families increasing by around 3% to approximately 13,000 by 2017/18.
- The number of adult service users has increased at an average rate of 7% per year between 2011/12 and 2012/13. Continuing on this trajectory will see an increase in the number of adult service users of 23% by 2017/18
- The number of older people service users has increased at an average rate of 11.8% per year between 2011/12 and 2012/13. This trend is expected to continue through 2017/18, increasing the overall number of older people accessing Social Work Services by around 40%

3.2 It is estimated that 11.6% of Glasgow's population is of a BME background or non-British White background.

3.3 Glasgow contains three in 10 of the 15% most deprived data zones in Scotland. This is the highest proportion for any local authority. 116 of these data zones are in the North East of the city, while the North West and South have 83 and 89 of the most deprived data zones respectively.

3.4 Although increasing, life expectancy at birth in Glasgow is currently 72.6 years for males and 78.5 years for females, lower than the Scottish averages of 76.6 and 80.8 respectively.

4. Partnership Structures/Governance Arrangements

4.1 Social Work Services is engaged in a number of strategic partnerships to support development and delivery of effective services across Glasgow. Key partners include Education Services, NHS Greater Glasgow and Clyde, Glasgow Community Planning Partnership and the third and independent sectors.

4.2 Following enactment of the Public Bodies (Joint Working) (Scotland) Act 2014, all current strategic partnerships, not least that with the health board, will evolve as a number of the council's functions are delegated to the Integration Joint Board. It is a key priority for Social Work Services to ensure that relationships with key partners are strengthened through the integration of health and social care.

4.3 The Chief Social Work Officer is a member of Glasgow City Health and Social Care Partnership (HSCP) Senior Management Team and leads the Professional Governance Forum; will be a statutory member of the Integration Joint Board when established; and sits on a number of other partnership boards and committees. In this way, the Chief Social Work Officer has a significant degree of involvement in the governance and accountability structures of the service and key partnerships.

4.4 The Chief Social Work Officer, as a member of the HSCP Senior Management Team and the Council Management Group, with lead corporate

responsibilities on key service reform areas, has a significant involvement in budgetary decisions of the service, and of the council as a whole as they relate to social care functions.

4.5 The Chief Social Work Officer works closely with the Executive Member for Social Care, Health and Social Care Policy Development Committee, Children and Families Policy Development Committee and other Elected Members and Committees as necessary to ensure appropriate scrutiny of social care functions at a political level. The nature of future political engagement is likely to evolve in the coming years following enactment of the Public Bodies (Joint Working) (Scotland) Act 2014, establishment of the Integration Joint Board and delegation of council functions to the Integration Joint Board.

5. Social Services Delivery Landscape

5.1 Glasgow's social and economic position in relation to its most vulnerable citizens is well known and frequently reported elsewhere in a myriad of fora.

5.2 Demand for services has increased over the reporting period across all age groups. Some indicative figures reflecting this are:

- A significant increase in the number of children on the child protection register
- A national annual average increase of 3-5% in the adult learning disability population
- Increasing numbers of frail older people delayed in returning home from hospital care and pressures on social care budgets.

5.3 This increasing demand, particularly in the light of reducing budgets, highlights the need for structural re-balancing within the delivery model of health and social care services in Glasgow. We need to develop a 'reablement approach', where use of statutory services is seen as a short terms means to an end, rather than an end in itself and through purposeful interventions we must aim to enable and empower people to live independently, in their own homes and communities for as long as possible. This approach requires partnerships from Social Work Services that reach into communities and working with a range of partners allows us to avoid becoming risk averse, and more to enabling and empowering individuals, families and communities.

6. Finance

6.1 The gross expenditure budget for Glasgow City Council Social Work Services for 2014/15 was £568m. The main changes from the previous year's budget being a significant reduction in Direct Departmental Expenditure and corresponding increase in Central Charges in comparison to previous years, which relates to the transfer of a number of clerical and administrative staff

from Social Work Services to Customer and Business Services under the Tomorrow's Support Services programme.

6.2 Social Work Services had a budget pressure of £3.7m in 2014/15 arising primarily in overspends in homelessness; personalisation and older people's care. Although overspent, the year-end budget position for 2014/15 is significantly improved from that of previous years, reflecting the management action taken in this area.

6.3 Social Work Services, along with all other Council departments, have been engaged in a major service reform programme over the past 5/6 years in an effort to ensure that the council can continue to meet its statutory duties in the face of unprecedented reductions in public funding. This drive towards major service reform will clearly continue for several years to come particularly with the advent of Health and Social Care Partnerships; increasing demographic demands; increasing legislative duties from the Scottish Government; the impact of welfare benefit reform; and the continued Westminster austerity programme in respect of the public sector.

7. Service Quality and Performance

7.1 The vision for Social Work Services in Glasgow is simply expressed in terms of 'protecting vulnerable children and adults; promoting independence; and ensuring positive outcomes from our intervention'.

7.2 Areas of work that are mainstays of social work provision in Glasgow are incorporated within the 'Vulnerability' theme of the Council's Strategic Plan on which there is a six monthly report to the Operational Delivery Scrutiny Committee. A copy of the last report, dated November 2014 is at Appendix 1.

7.3 The Annual Service Plan and Improvement Report (ASPIR) for the period 2014/15 was presented to the Health and Social Care Policy Development Committee in August. Some key points within the report included:

- Child Protection services were provided to 1,046 children during the first three quarters of the year, a significant increase in the previous year
- A 35% increase in the number of people receiving a Reablement service each week
- A 60% success rate for benefit appeals supported by the Welfare Rights Team, with an average client gain per successful appeal of £6,110.23

8. Statutory Functions

8.1 Social Work's performance over the range of statutory functions is outlined in the department's Annual Service Plan and Improvement Report (ASPIR), which is available at appendix 2.

8.2 The Multi Agency Public Protection Arrangements (MAPPA) report for 2014/15 will be a separate item presented to Health and Social Care Policy Development Committee in the autumn of 2015. The report for 2013/14 noted that Glasgow's performance against the national performance framework is good and exceeding target in a number of areas.

8.3 The statutory biannual Adult Protection report prepared by the Independent Chair of the Adult Protection Committee and covering the two year period 2012/14 has been published on the Adult Protection Committee website and is available at http://www.glasgowadultprotection.org.uk/CHttpHandler.ashx?id=26481&p=0

8.4 The report notes a 33% increase in Adult Support and Protection referrals during the reporting period.

8.5 Risk management is a key focus of the Senior Management Team, with the Social Work risk register being reviewed and updated on a quarterly basis and all risks having a mitigation strategy in place.

8.6 The Child Protection Committee's annual report and business plan was considered by the Children and Families Policy Development Committee on 28 August 2014. The report noted the methods adopted to ensure continuous improvement in policy and practice, partnership working with other initiatives and children's services across the city, and provision of public information. The report also noted a number of areas which have been identified by the Care Inspectorate as examples of good practice.

9. Improvement Approaches

9.1 To maintain a focus on continuous improvement and quality assurance, Social Work Services has an ongoing programme of internal audit and self-evaluations; in addition there are external inspections carried out on parts of the service. Recent and planned audit, self-evaluation and inspection activity is outlined in the table below.

Audit/ Review/ Self Evaluation / External Inspection	Service Area	Completion Date
Self-Evaluation	Staff Supervision	Completed January 2015
Audit	South Residential care discharges	Completed sept 2014
Audit	Older people at home into advanced age	Completed Feb 2015
Audit	Permanence planning for children	Autumn 2014 Completed
Audit	Working with providers of Unpaid Work	April 2015 Completed

Audit	Social Work Practice in Unpaid Work	May 2015
Self-Evaluation	Families for Children (stage 1) Families for children (stage 2)	April 2015 Dec 2015
Joint Inspection by Care Inspectorate and Healthcare Improvement Scotland	Joint inspection of Social Work and Health Services for Older People	Completed May 2015
Peer Review	Child Protection chairs, Quality of case conferences	Completed Dec 2015
Multi agency Self Evaluation	Adult Support and Protection Self Evaluation (ASP Committee)	Ongoing
Multi agency Self Evaluation	Pre Birth Child Protection (CP committee)	Ongoing

9.2 Learning from all of these activities is communicated by the Chief Social Work Officer through the Management Team and Professional Governance Board, with action plans developed to meet any recommendations or identified areas for improvement. Audit reports have confirmed areas of positive practice as well as areas that require further development. Examples of positive findings included:

- Examples of excellent use of Community Payback Orders to structure credible community sentences.
- Evidence that homecare services are supporting significantly vulnerable people to live in their communities.
- Evidence of effective rehabilitative work intended to help people regain independence following ill health.
- The Kinship Audit identified pockets of excellent practice in terms of assessment and analysis and also in terms of case management with regular reviews and support offered to both carer and child. More generally, it was noted that there appeared to be good recording and analysis of risk and need with regard to the child's circumstances.
- Increasing use of the Early Information Sharing Protocol, and strong evidence of joint work between Health and Social Work
- The audit work on permanence planning showed that good child-centered decision making prevailed for children requiring permanent placement. There were excellent examples of workers persisting to achieve permanent placement outcomes for children in the sample.

9.3 The Integration Scheme for the new Health and Social Care Partnership sets out proposals for clinical and care governance which will include a joint clinical and care governance group, with existing single agency governance arrangements to remain as sub structures of the joint group.

9.4 In January 2015 Social Work Services introduced a revised Contract Management Framework, to improve the processes through which relationships with purchased care services are managed by the department. The revised framework includes improvements to:

- the recording of contract information;
- contract management documentation, particularly in relation to service reviews and action plans;
- the approach to service reviews, moving to being carried out in a proportionate, risk-based way;
- the gathering and reporting on Social Work's performance in relation to the Contract Management Framework;
- the processes through which Care Managers can report concerns relating to purchased services; and
- the analysis, reporting and use of financial information.

9.5 Social Work Services continues to make service improvements based on learning from complaints received via service users or their representatives. In the period April – September 2014, of 31 complaints which were fully upheld, all but two resulted in some further action and improvement in provision of service for the client.

9.6 The most recent Social Work complaints report to the Operational Delivery and Scrutiny Committee, covering the period April to September 2014 is available at Appendix 3. The next report, covering the period October 2014 to March 2015 will be presented to Committee later in 2015.

10. User and Carer Empowerment

10.1 Social Work Services are committed to engagement with the people who use our services. We recognise that services cannot be shaped around the needs of individuals if individuals do not have the opportunity to contribute their views on the services they receive.

10.2 The primary method of engagement with service users, patients, and carers is on an individual and personalised basis through for example co-produced assessment and care planning activity. Referrals are received from all quarters and all sources including self-referrals at the point of identified need.

10.3 Glasgow already has an extensive network of engagement forums, including - but by no means limited to - service user and carer representation on the Integration Joint Board and Strategic Planning Groups, and we will evolve these networks going forward, including in the development of a Participation and Engagement Strategy for the Glasgow City Integration Joint Board, which will be published during 2016.

10.4 We will also continue to build on our primary method of engagement with service users and carers on an individual and personalised basis through co-produced assessment and care planning activity.

11. Workforce Planning and Development

11.1 Social Work Services has a workforce of approximately 3,300 (full time equivalent), the majority of whom work directly with service users. Social Work Services remain committed to the professional development of staff, with the activity of the Learning & Development Team based at our Brook Street training centre focussed on the core needs of the service. The team continues to deliver a wide variety of training programmes to support the delivery of high quality social care services in Glasgow.

11.2 Throughout 2014/15 the Chief Social Work Officer and Executive Director of Social Care Services have hosted a number of staff engagement sessions to allow colleagues at all levels to share their views on and make suggestions as to the future direction of social care services in Glasgow. Social Work Services also organise sessions for staff with long service to thank them for the commitment and dedication over many years.

11.3 Mobile Working presents a significant opportunity to further enhance the delivery of social care services in Glasgow. During 2014/15 over 1800 mobile devices were rolled out to staff across the service, and work is on-going to realise the benefits of this new way of working.

11.4 The council carried a Staff Survey early in 2015, with the findings from this survey expected later in 2015. Social Work Services will develop an action plan in response to the findings of the survey at service level to ensure that staff feedback continues to be acted on.

11.5 The financial situation of the council and the corresponding effect on capacity to recruit to vacant posts is well known and widely reported. To ensure appropriate staffing levels remain in place, the service has undertaken a programme of workforce planning, including the training and redeployment of staff where appropriate. In this way, the service can make best use of existing resources.

11.6 The integration of health and social care has led to the establishment of a revised management structure within integrated health and social care services. The Chief Social Worker remains a member of the senior management team of the newly established health and social care partnership, with professional social work representation on the senior management team of each locality, which ensures a strong link between the CSWO and front line staff.

12. Other Issues

12.1 **Good Practice and Successes**

This report outlines a number of examples of good practice and outstanding achievement across Social Work Services in Glasgow, but there are so many such examples that it would be impractical to outline them all. All of our staff

do an exceptional job in often very difficult circumstances, and their commitment, dedication and drive to deliver positive outcomes for service users means that the Council can be assured that we are delivering high quality, effective services to the best of our ability.

12.2 The Leader's Awards for Young People in Care showcases some of the exceptional achievements of young people in our care and who have recently left our care. These awards are also a testament to our staff, who help young people in our care to build their futures through opportunities for further education, work or training. We will continue to help our young people fulfil their potential as individuals who have so much to contribute to the future of Glasgow.

12.3 In the past year, Social Work Services have won Flourish Awards for:

- Housing Options - which aims to help people sustain their tenancies, make informed choices about their housing options and prevent homelessness; and
- Choose Life Training Group – training people to help them identify people who may be at risk of suicide, enabling early intervention to talk to the most vulnerable children, families and homeless individuals and link them to support.

12.4 The service has also had a large number of nominations for Flourish and other awards, further demonstrating the high quality of our services and the high regard they are held in.

12.5 **Looking Forward**
Projections for the next few years indicate an increased level of demand for social care services in Glasgow, along with reductions in funding potentially greater than those experienced in recent years. In the face of significant resource pressures and service user demands, as a service department we must not shy away from asking the difficult questions, nor from making the right decisions, however difficult they may be.

12.6 There is scope within Social Work Services to deliver the transformational change required to ensure a service fit for the future in partnership with NHS Greater Glasgow and Clyde through the Integration Joint Board, and achievement of this objective will be the key focus for Social Work Services over the next number of years.

12.7 Although there are significant challenges ahead, there are also significant opportunities in this important time for Social Work both nationally and locally. We have a huge responsibility towards the people of Glasgow, particularly to the most vulnerable people who rely greatly on our support. As a professional Social Work service we need to reflect on the values which bring people in to our profession and live up to those values in everything that we do.

Item 3

6 November 2014

Glasgow City Council

Operational Delivery Scrutiny Committee

Report by Executive Director of Social Care Services

Contact: Allison Eccles Ext: 78744

VULNERABLE THEME PERFORMANCE UPDATE

Purpose of Report:

To provide members with an update from Social Work Services on the progress made by partners in delivering activities which support the Vulnerable priority within the Council's Strategic Plan.

Recommendations:

Committee is asked to:

a) Note this report

Ward No(s):			Citywide:	√	
Local member(s) advised:	Yes ☐	No ☐	Consulted: Yes	☐	No ☐

1. Introduction

1.1 The Council's Strategic Plan was approved in November 2012 and outlines the Council's priorities from 2012 to 2017. The five priority areas for the Council are:

- Economic Growth
- World Class City
- Sustainable City
- A city that looks after its vulnerable people
- Learning City

1.2 The Vulnerable Theme falls within the remit of Social Work Services (SWS). Members will be aware that a presentation was given to this committee in April 2014 by the Theme Lead (Executive Director of Social Work Services) on the activities progressed by SWS in supporting the Vulnerable Theme.

1.3 The Vulnerable Theme priority focuses on 3 key outcomes. These are:

- Improve outcomes and prospects for our looked after and accommodated children and young people
- Reduce health inequalities both between neighbourhoods and between Glasgow and the rest of Scotland
- Support more people to live independently at home, where they choose to do so

1.4 This report provides an update based on the areas above. Appendix 1 provides detail on the Social Work Service priorities divided into those which have been delivered and those which are ongoing.

1.5 Efforts have been made throughout this report to incorporate references to the equalities agenda, however it should be noted that the entire focus of the Vulnerable theme is of addressing societal inequalities. Where references are made to services provided by Social Work Services, access to these is governed by a nationally agreed set of Eligibility Criteria, which has been subject to a full Equalities Impact Assessment.

2. Progress

2.1 Improve outcomes and prospects for our looked after and accommodated children and young people

2.1.1 Kinship Care

Following the 20% increase in payments to kinship carers in 2012, we aimed to increase this by a further 5% by 2015/16. We achieved and exceeded this aim ahead of the target date by further increasing kinship carer payments by 7% during 2013/14. For the current year payments to carers have been maintained at £50 per week per child plus a single payment of £200 per child which is paid before Christmas.

2.1.2 We allocate £45,000 annually across 5 Kinship Care Support Groups in the city. This money is used to fund activities such as holidays and trips, and the costs associated with the running of the groups.

2.1.3 In addition, we pay £45,000 to the Notre Dame Centre for work with Kinship Carers. These monies are used to provide:

- Direct support to carers to allow them to understand the needs, emotions and behaviours of the children and young people for whom they now have responsibility and to provide them with strategies to manage these (one to one support).
- Bespoke training sessions, devised in conjunction with kinship carers, in attachment, grief and loss, therapeutic techniques and other areas as identified by the carers themselves.
- Direct therapeutic work with children in kinship care.

2.1.4 Child Protection

We provided child protection services for 1,089 children during 2013/14. This number was significantly higher than the 993 children who received child protection services in 2012/13. In line with this upward trend, 780 children have received a child protection service during the first five months of 2014/15. Children from the most deprived areas make up a large proportion of this number.

2.1.5 Care Leavers

Between July 2013 and April 2014 we met our target of 100% recording of the employment status of our care leavers. At Q1 this slipped slightly to 98%, however work is underway to improve this.

Half of our care leavers (51%) achieved a training, job opportunity or college place in 2011/12. At year end 2012/13 this had increased to 58% and as a result our target was increased from 56% to 75% from April 2013. At the end of June 2014 this proportion had increased to 63% of our 334 care leavers. This is broken as follows:

- 31% of our care leavers are in education,
- 19% are in employment and,
- 13% are in training.

Although the 75% target has not yet been met the increase to 63% represents considerable progress, particularly in the current challenging economic climate.

Historically care leavers have been disadvantaged in terms of accessing employment, further education or training, and our actions in this area help to address this inequality.

2.2 Reduce health inequalities both between neighbourhoods and between Glasgow and the rest of Scotland

2.2.1 The Heath Improvement and Inequalities Group (HIIG)

The Health Improvement and Inequalities Group (HIIG) is currently chaired by the Council's Spokesperson for Health Inequalities and a work programme for 2014 has been established.

2.2.2 Progress has been made in the development of the Glasgow Tobacco Strategy 2014-17 particularly in the following key areas:

- Funding has been obtained through NHS Smoke free Services to support a specific programme of work with Looked After and Accommodated Children (LAAC).
- A comprehensive training package is being developed for social work staff working with foster carers, adoptive parents, children living in residential units and young parents in relation to second hand smoke.
- Work will be undertaken with adult residential care homes regarding smoke free policies.
- Actions have also been developed with a range of partner organisations such as Jobs and Business Glasgow in relation to addressing smoking within the 16-24 age group.

2.2.3 In is anticipated that the final strategy will be launched late 2014.

2.3 Welfare Reform

The impact of Welfare Reform on the most vulnerable service users - such as older people, single parents or individuals with a disability - continues to require a planned response with our partners to address impacts on the city and quality of life for individuals and families. As the reforms are being phased in over a period of time, detailed information on their impact will only become available over time.

2.3.1 There has been significant slippage in the timetable for roll out of two key Welfare Reforms:

- Universal Credit was scheduled for national roll out in October 2013 but to date has only been introduced in one Scottish area (Inverness) and only for single jobseekers who have no children, no ill health and no housing costs. In September 2014 the Secretary of State, Ian Duncan Smith, announced that Universal Credit would be rolled out to all Jobcentres and local Authorities across the country from early 2015 for the above noted client group. As yet no indications have been received when any of the Jobcentres in Glasgow will go live.
- The planned reassessment of current DLA recipients who will be required to claim Personal Independence Payments (PIP) has been delayed; again introduced in some parts of Scotland but with no identified date for Glasgow.

2.3.2 Some of the ongoing areas of work being undertaken under the auspices of the corporate approach are:

- Inform affected individuals about the impact. Through community engagement events it is clear that there is a lack of information reaching residents. Through the Poverty Leadership Panel a postcard conveying key messages in relation to Welfare Reform and an appeals pack to alert citizens of their right of appeal and the process to do so has been produced and distributed. Through the Corporate Welfare Reform Group a sanctions survival pack has been developed by Social Work Services to advise jobseekers of their rights and to give advice on how to avoid a sanction.
- Provide financial advice and support to affected individuals. Through Glasgow's Advice and Information Network (GAIN) citizens are able to access advice on benefit entitlement and with debt matters. Local social work staff can draw on support from Welfare Rights officers in this regard. The appeals pack will extend the support of representation to many more individuals or households across Glasgow.
- Training and Support. The Welfare Rights training section in SWS has been providing free of charge training on Welfare Reform and on the specific benefit changes to both Social Work staff and to the broader advice sector across Glasgow to ensure that advisers are up to date with the raft of changes.
- Coordinate the work of advice agencies in the city to respond to the demand for services. The work of advice agencies continues to be coordinated via the GAIN contracts and by participation in the area implementation groups where advice agencies come together locally.
- Prepare for the implementation of ‘digital by default’ by skilling up staff in libraries to support service users to apply for welfare benefits. Glasgow Life has established a team to assist Glasgow citizens ready themselves for the introduction of Universal Credit and the need to conduct benefit claims online. Training has been provided to 235 library staff to ensure that they can provide support to individuals who look to use the library computers to make benefit claims. This support

extends to a 'Digital Offer' which is an offer of access to computer literacy training.

- Work with DWP on preparing for the implementation of welfare reforms by communicating effectively with citizens and stakeholders. A bi-monthly meeting between council officers and key individuals from DWP has been established to look specifically at the welfare reforms and what both parties can do to make the changes work a smoothly as possible for Glasgow citizens. At the meetings the DWP provide national information available as well as providing local details including implementation timescales.

2.3.2 Welfare Reform – Key Facts and Figures:

- **Scottish Welfare Fund** – Given current demand, it is anticipated that the £7.7 million fund will be fully spent at financial year end.
- **Bedroom Tax/Removal of the Spare Room Subsidy** - Currently 10,499 Housing Benefit claims have a one bedroom reduction of 14% applied and 1,561 have a two-or-more bedroom reduction of 25%. There are 2,406 claims where additional bedrooms have been awarded. The majority of these have been awarded to claimants who need an additional bedroom to accommodate an overnight carer or for a child who is unable to share a bedroom due to a disability.
- **Discretionary Housing Payment (DHP) -** DHP is intended to provide short term assistance to Housing Benefit claimants that have a shortfall between their Housing Benefit and rental charge and are having difficulty in meeting the rental charge.

  The Scottish Government has provided assurances that additional DHP funding for 2014/2015 is available to all applicants affected by the Bedroom Tax. UK legislation to support this is expected in the next few weeks.

  Registered Social Landlords have been working closely with the council to ensure that DHP applications are received from all affected Bedroom Tax tenants and good progress is being made regarding the payment of additional DHP awards. The council continues to carefully manage DHP expenditure for all other purposes – Benefit Cap, Local Housing Allowance and non-Welfare Reform related reasons.

- **Benefit cap -** there are 146 households where a cap on benefits has been applied. 46 of these households have DHP in payment

2.4 Financial Inclusion

The following sub-sections report on activities which fall under the category of addressing inequalities as noted in the Glasgow Council Strategic Plan. Some of this activity is coordinated in conjunction with our Financial Services colleagues, while other aspects are coordinated by our own Welfare Rights team.

2.4.1 Long Term Conditions Macmillan Project
From January 2009 to September 2014, the Long Term Conditions Macmillan Project has delivered more than £36 million for over 14,000 clients and prevented 800 people from losing their homes. In March 2014 the service was successfully extended to people affected by Huntington Disease, their families and carers.

2.4.2 In 2013/14 the Long Term Conditions MacMillan Project assisted 2,677 people with a total of financial gains of £4.5 million. The Target for Long Term Conditions (LTC) in 14/15 is £5 million in additional financial benefits with the continued commitment that no-one in Glasgow who has a long term health condition and is supported by LTC will lose their home.

2.4.3 From funding secured from the BIG Lottery we have developed and are delivering a LTC service for people with a long term health condition within the Southern General Hospital. Since the launch in March 2014 we have delivered the service to 473 people with long term health conditions and have secured £635,925 in financial benefits.

2.4.4 The LTC has supported 5 people with amputations secure new purpose built homes (Gorbals Housing Association). All 5 clients received keys to their new homes in August 2014.

2.5 Improving the Cancer Journey
Improving the Cancer Journey (ICJ) is a new service that the council, in partnership with Macmillan Cancer Support, launched on 5th February this year. This service provides direct assistance, advice and information to cancer patients in Glasgow, as well as their families and carers. Partners in this service include Macmillan Cancer Support, NHS Greater Glasgow and Clyde, Cordia and Glasgow Life.

2.5.1 The ICJ Service :

- Invites all with a cancer diagnosis in Glasgow to have a Holistic Needs Assessment (HNA) and develop an individual care plan. This includes carers and family members.
- Provide the support of a dedicated named link officer to everyone with a cancer diagnosis.
- Facilitate the delivery of effective Health and Social care support solutions, based on the HNA outcomes.
- Develop re-enablement and rehabilitation packages to ensure health and well-being beyond clinical treatment pathways.

2.5.2 The pilot initially dealt with people with 5 cancer types (lung, bowel, sarcoma, prostate and gynaecological cancers). From September 2014 the service was extended to cover all cancer types.

2.5.3 Since the February launch, the ICJ service has supported 266 clients seeking help or support with 2,193 identified concerns. The service has made onward referrals to 724 organisations to coordinate care and support in order to meet the needs identified.

2.5.4 A Customer Relationship Management (CRM) system has been developed on careFirst to record all customers demographic details, needs identified, agencies referred to, and outcomes delivered.

2.5.5 Patient feedback has advised that 93% of patients/clients have assessed the service provided as excellent. The full 5 year independent evaluation on the impact of the service is complete and is ready to go to tender.

2.5.6 Due to the number of complex housing issues highlighted, the Wheatley Group has agreed to become a partner in the service and provide housing expertise to support the needs of people affected by cancer.

2.5.7 Prostate Cancer UK has also become a partner in the service and is providing funding to help support the needs of people affected by prostate cancer.

2.6 Helping Heroes

Since the launch in June 2010, Glasgow's Helping Heroes (GHH) campaign has assisted 1,274 veterans with 3,920 issues. This has resulted in 613 veterans being housed, 605 being supported into employment and 345 being assisted to gain access to health care. Financial gains for veterans stand at just over £1m.

2.6.1 The Helping Heroes campaign helped develop and launch the Glasgow Veterans Employment Programme (GVEP), which helps even more veterans gain permanent employment at the Glasgow Living Wage (supported by the Commonwealth Jobs Fund). In addition, they:

- Work in partnership with the Advice Sector and Housing Sector in Glasgow to deal with the impact of welfare reform and in particular the bedroom tax. Almost 100 veterans we have secured housing for are now impacted by the bedroom tax.

- Build capacity within the team by securing additional funding to ensure we can support veterans affected by the current armed forces redundancies.

2.6.2 It has been agreed to progress the evaluation of the GHH campaign in partnership with the Forces in Mind Trust whose aim is to promote the successful transition of Armed Forces personnel, and their families, into civilian life. The final draft of the scope of requirements for this evaluation is ready to be issued to the GCC procurement team.

2.6.3 Following discussions with the Housing Options team a direct referral route to Glasgow Rent Deposit Scheme for veterans has now been agreed. Discretionary Housing Payments (DHP) to support veterans affected by the bedroom tax have been extended. City Property is currently sourcing property options to enable GHH to continue to develop and expand to meet demand for these services.

2.6.4 The funding source for training for employers who fall outwith the criteria laid down by the GVEP has now been approved by the Director of Finance thus ensuring that Glasgow makes best use of the offer of ring fenced posts. First Bus Glasgow and the Electoral Registration Office have ring-fenced 150 and 6 FTE posts respectively for citizens living within the council area. This has resulted in 12 veterans being recruited to the First Bus initiative, and 2 to the Electoral Registration Office.

2.6.5 42 veterans have secured GVEP funded posts since the programme's launch in August 2013. To support the on-going promotion of the scheme, in line with the employability agenda, and to ensure further employers come on board, a promotional article will be included in the winter edition of the Glasgow Magazine.

2.6.6 GHH has been shortlisted for 2 national Military and Civilian Health awards in 2014 under the categories: Care of Veterans and Mental Health Awards.

2.7 Welfare Rights Team

The Welfare Rights Appeals Team represented at an average of 2,267 hearings per year over the last five years. Between January and September 2014 the Appeals team represented at 752 appeals. This extrapolates to 1,002 appeals by 31st December. Welfare reform changes have lead to a substantial reduction in the number of appeal tribunals. This is a trend nationally resulting firstly, from the new mandatory reconsideration process, and secondly, as a consequence of fewer disability benefit decisions being made because of the backlog in Personal Independence Payments (PIP) assessments. HM Courts & Tribunals anticipate that the number of appeals will increase in 2015.

2.7.1 Our success rate for concluded appeals is 60%. The average financial gain per successful appeal this year to date is £6,110.23. This is an increase on last year's figure of £5,129.30 so that although the number of appeals is down, the average financial gain per successful award has risen significantly.

2.7.2 The Income Maximisation Team made 3,898 visits to service users between January and December last year. The average annual number of visits was 3,504 over the last 5 years. Between January and September 2014 we visited 2,943 service users (which extrapolates to 3,924 visits by year end). If achieved this is slightly greater than our 2014 annual target of 3,800.

2.7.3 The migration from DLA to Personal Independence Payment (PIP) has yet to be introduced to the Glasgow area and consequently the number of PIP claims is currently relatively small. It is anticipated that once PIP is introduced there may be more repeat visits because the claim process is in two stages.

2.7.4 With the introduction of charges for day care we have been using resources from other parts of the service to assist with the increased workload.

2.8 Education and Support for Vulnerable Young People

2.8.1 Support for Young People affected by Substance Abuse
We are working to improve support to children and young people affected at home by substance abuse. Parental assessments are carried out to assess whether a parent with an addiction has the necessary skills and awareness to look after their child. At the end of June 2014, approximately three-quarters (74%) of those adults identified as having a relationship to a child under 16 had had an assessment. The target for 2014/15 is 50%.

2.8.2 It is planned to develop the current parental assessment indicator further to provide information about the length of time taken to complete an assessment. It has been proposed that there should be a 30 day target for completion of an assessment.

2.8.3 The Community Addiction Teams (CATs) continue to maintain and support a number of children and young people. In 2013, a snapshot audit identified 93 children and young people supported by CATs. The transfer of reporting from careFirst 5 to careFirst 6 means that caseload numbers are not currently available however new reports are being developed to provide this information.

2.8.4 The Alcohol and Drug Partnership (ADP) provides strategic leadership across the city to reduce accessibility and the misuse of alcohol and drugs in communities. Initiatives which are currently in practice include:

- Community Safety Services Glasgow is working with communities to identify and respond to alcohol related problems at a neighbourhood level.
- The Best Bar None initiative is continuing to run and expand across the city. The initiative, which promotes minimum standards for safe environment within pubs and clubs, will shortly celebrate its 10th anniversary in November.
- Progression of recovery activity across the city. Three recovery co-ordinators have been appointed - one for each sector. There are between 600 and 750 people involved in 'recovery activity' at community level.
- The Play Safe Alcohol Awareness Campaign recently evolved into the Blended Social Marketing Alcohol Campaign. This aims to deliver an engaging alcohol campaign which includes social media, web and mobile technologies to engage young people and young adults.

2.8.5 Community Addiction Teams are routinely included as part of Special Needs In Pregnancy clinics.

2.8.6 The delivery of alcohol and drug addiction-specific training to Children's Panel members in Glasgow remains ongoing.

2.8.7 The Glasgow Council on Alcohol (GCA) delivers the Core Alcohol and Drugs Prevention and Education Service. As they provide services to all 3 sectors, this ensures a coordinated and consistent approach to alcohol and drug prevention, and education across the city. A new contract is due to commence in April 2015. The process has been endorsed by the ADP and NHSGGC are managing the public procurement process.

2.8.8 The ADP has recently delivered its 2013/14 annual report (including performance measures) to the Scottish Government, and following consultation with key partners, communities and elected members, finalised its strategy for 2014-2017.

2.9 Tobacco Strategy: Schools-Based Education

We are continuing our work to reduce smoking among young people. Teachers are being offered introductory and refresher training on the two tobacco education programmes to support improved uptake and use of the materials. Education Services continue to work with a wide range of partners, including the NHS, GCA and Greater Easterhouse Alcohol Project (GEAP) to promote and develop substance misuse education and, increasingly, to focus on the impact of risk taking behaviours.

2.9.1 Glasgow has been accepted into the national pilot of the ASSIST tobacco prevention programme, funded by Scottish Government. This school based, peer-led programme has been evaluated as a useful smoking prevention initiative in England and Wales. Health Improvement and Education staff in Glasgow are working closely together to plan the pilot, which will introduce the programme to 10 secondary schools in the city. The first stage of the programme -'Train the Trainers' - is planned for October 2014 with the first cycle of programme delivery in schools scheduled for January 2015.

2.9.2 Substance Misuse: Schools-Based Education

Our colleagues in Education Services have completed a 3 year plan which offered 150 places for training on substance misuse for Early Years Practitioners. This programme improved staff understanding of the impact of substance misuse on children's development and learning and developed skills in supporting children and parents affected by substance misuse. The workshops have now all taken place and participants gave very positive feedback. This year, as a result of requests from staff, training places were also offered to staff in primary schools. Teachers working with young children in primary schools valued the opportunity to access the training and benefited from the cross-sector discussions and sharing of practice.

2.9.3 Staff in four Additional Support Needs (ASN) Secondary schools are being supported by ENABLE Scotland to pilot a programme to assist the development of informed personal choices. The 'SMARTER' programme is designed to support substance misuse education for some of the city's most vulnerable young people. Staff training in the new resource is underway and initial response to the material is very positive. Each school is working with ENABLE Scotland to introduce the materials in a way that best meets the needs of the young people involved.

2.9.4 A web–based Substance Misuse Toolkit for staff working in secondary schools and in children's units is now live. This interagency/inter-authority resource supports staff working with older children and young people in schools and children's units. The Toolkit provides access to material, training and contacts for substance misuse education.

2.9.5 Work is underway to produce a similar Toolkit for staff in primary schools and early years' establishments. Health and education staff across Greater Glasgow and Clyde are working in partnership to develop new resources and guidance suitable for Early to Second level in the Curriculum for Excellence. An inter-authority launch of the new material is planned for Spring 2015.

2.9.6 Work continues to implement the roll out of YouTube access to "Choices for Life" resources for staff in educational establishments in Glasgow. Police Scotland funded DVDs containing clips from "Choices for Life" to support lessons in substance misuse education have been distributed to all primary and secondary schools. This national distribution of DVDs enables staff across Scotland to have more flexible access to relevant resources from the website.

2.10 Enforcement of Anti-Social Behaviour Orders

We are continuing to work to reduce anti-social behaviour. Anti-Social Behaviour Enforcement measures are recorded via Glasgow Community Safety Services. Comparison of the numbers of Orders issued during 2013/14 (281 issued) with the first 5 months of the current year (April to August 2014 – 92 issued) suggests that we may see a reduction in the annual number of Orders at year end 2014/15.

2.11 Mental Health

We are working to improve the employment outcomes for people with mental health (MH) difficulties. As a first stage we want to ensure that we have accurate recording of the employment status of MH service users. Current analysis of MH clients aged between 16 and 64 (n=2,146), indicates that only 50% have their employment status recorded on careFirst. Of these, 80% were recorded as inactive, 19% were in employment, education, or engaged in training or voluntary work, and 1% had retired.

2.11.1 Development & Regeneration Services (DRS) are leading on housing support for MH service users via the Glasgow Housing Strategy 2011/12 - 15/16. The draft Strategic Housing Investment Plan (SHIP) is currently being finalised for consultation. We have engaged with SWS on Social Care Housing Investment Priorities (SCHIP) to be included within the plan. It is anticipated that, after Council approval, the SHIP will be submitted to the Scottish Government at the end of November.

2.11.2 A Housing, Health and Social Care Group has been established so that mental health and housing issues can be discussed. This group will meet at the end of October to consider the SHIP.

2.12 Support more people to live independently at home, where they choose to do so

2.13 Personalisation

SWS staff are continuing to roll out personalised services to service users and on 1 April this year personalisation was rolled out to older people over 65.

2.13.1 The number of completed *My Support Plan* e-forms is used as a measure of the roll out of personalised services and at the end of June 2014 a total of 3,409 e-forms had been completed. Of these, 1,153 were completed during 2013/14 – almost double the annual target of 600. In the first quarter of 2014/15 a further 309 were completed.

2.13.2 An improved Personalisation Process with a new suite of careFirst 6 e-forms was implemented at the start of October in the Adults and Older People care groups. Fieldwork staff contributed to the redesign of the assessment and other e-forms. It is anticipated that the new assessment frameworks and business processes will have benefits for both service users and staff. This change represents a significant investment and the opportunity to continue to improve social work practice in the city.

2.13.3 Training for the new process was rolled out in September and October along with detailed guidance for workers to ensure successful transition.

2.14 Reablement

The Reablement Homecare service supports people to regain independence where possible. The default position of the current pathway is for all hospital and community referrals to complete a Reablement rather than a Mainstream Homecare service.

2.14.1 There were 3,521 referrals to the Reablement service during 2013/14 with 2,033 either completing or partially completing the service.

2.14.2 During Q1 the number of service users supported each week via Reablement increased by 35% from 464 to 625. Over the same period, of the people who received post-Reablement Homecare support, 38% required no further service because their independence has been optimised.

2.14.3 Plans are underway to complete a service user reablement satisfaction survey on an annual basis. The last survey, carried out at the end of Quarter 1 2013/14, indicated that 100% (n=68) of service users were either "satisfied" or "very satisfied" with their Reablement service. A new survey is planned to take place in October 2014.

2.14.4 A direct referral process has been agreed with Glasgow Life to support individuals post-reablement to attend activity classes in their local community in order to support their independence, health and well-being, as well as to reduce social isolation.

2.14.5 Currently service development options are being explored around rolling out reablement to the Homelessness Service and the Dementia Strategy.

2.15 <u>Assistive Technology</u>
We continue to work with housing associations to ensure there is a range of suitable housing and support systems; we are also extending the use of technology and associated support systems to allow people to remain in their homes for longer with support.

2.15.1 SWS continues to work within the One Glasgow Vulnerable Older People's workstream with the Glasgow Housing Association and others, on the phased development of a hub and cluster accommodation base which will use telecare and other technology to enhance residents' safety and support.

2.15.2 A multi-agency steering group was established and a Project Manager appointed to implement 2 workstreams:

- The Hub and Cluster which is a buildings based service at 415 Nitshill Road, and
- the 'First Through The Door' approach which will run parallel to this and which provides support to elderly citizens in the Greater Pollok area.

2.15.3 The vision of the Hub and Cluster is to create a demonstration model where a range of facilities and services – health, social care and housing – are provided in a hub and cluster form to enable services users to stay as independently as possible in their own home or their own community. Older people would be able to choose the services they need at the right time in their lives.

2.15.4 Currently the Hub and Cluster structural and service development work is ongoing at 415 Nitshill Road while the 'First Through The Door' approach implementation date is currently planned for the latter part of 2014.

2.15.5 The aim is to apply the model more widely in housing association stock in the city in due course, and to assess its value in reducing demand on emergency / acute services as well as maintaining the person appropriately in their own home for a longer period before provision of care home placement is required.

2.15.6 A joint working group, involving partner agencies, is to be established in the latter part of 2014. The group's remit will be to develop an accommodation based strategy to allow older people to remain in their own homes.

2.16 Carers

The Carers Reference Group (CRG) has 3 representatives on the Carers Planning & Implementation Group (PIG). SW Community Development staff currently support the CRG's involvement in the Evaluation of the Glasgow Carers Partnership, and this includes an evaluation of CRG engagement in the planning and delivery of carer services. CRG continues to be represented at the Personalisation Sub Group and will be represented on the Health and Social Care Partnership Boards.

2.16.1 All carers who provide care for a Glasgow resident are eligible to receive a Carers Privilege Card free of charge. This card continues to be promoted through the GCC Carers Card website, Carers Information Line and by the Carer Services and Centres across the city. 7,480 cards have been issued between the September 2013 launch and June 2014.

2.16.2 Additionally during the first quarter of 2014/15, 62 Carers accessed 7 training courses provided by Cordia.

2.17 Independent Living

We have co-produced an Independent Living Strategy (ILS) Framework with disabled people and key third sector organisations. It sets out the areas we will prioritise for reform and improvement over the next two years. These include improving lifelong learning access and outcomes, and improving youth employment prospects for disabled people. It is managed through the Glasgow Community Planning Partnership public sector reform initiative, One Glasgow.

2.17.1 An externally facilitated workshop on Youth Employment took place in April 2014 and another is planned for early November on Lifelong Learning to determine specific project plans. Proposals and costs for the ILS Reference Group and Project Manager have been submitted to Community Planning for funding. The group are currently awaiting approval to advertise post.

2.18 Affordable Warmth Strategy

The affordable warmth budget which is administered by Financial Services, has been set at £1,500,000 for 2014/15. For the fourth year running an Affordable Warmth Dividend of £100 is being offered this winter to all residents of Glasgow who are over the age of 80 (approximately 22,000 people).

2.18.1 Colleagues in Land and Environmental Services have administered a designated Wind Turbine at Cathkin Brae since April 2013. This will contribute towards the overall Affordable Warmth Budget once capital costs and contributions to the community benefit fund have been cleared. As significant income from the turbine towards this budget will not be available for many years, other energy projects are currently being considered and some of these could, in future, assist with the strategy.

3. Policy and Resource Implications

Resource Implications:

Financial:	None
Legal:	None
Personnel:	None
Procurement:	None

Council Strategic Plan: NA

Equality Impacts:

EQIA carried out:	EQIAs were carried out for each of the projects and programmes noted within this report
Outcome:	Appropriate action plans were put in place

Sustainability Impacts:

Environmental:	None
Social:	None
Economic:	None

4. Recommendations

4.1 Committee is asked to:

a) Note this report

APPENDIX 1: Organisational Priorities and RAG Rating

The Social Work Service priorities have been divided into those which have been delivered and those which are ongoing.

Priorities Delivered

Ref	Service Priority	RAG rating as of 30/09/2014
4.01	Increase Payments to Kinship Carers	**Green**
4.04	Identification of where we can make the greatest impact on Health Inequalities	**Green**
4.06	Launch of Improving the Cancer Journey (ICJ) Service in February 2014	**Green**
4.07	Provide support for children affected by parental substance abuse: Parental Assessment target achieved	**Green**
4.10	Development of a Joint Advocacy Tender for Adult Mental Health Services	**Green**
4.12	Implementation of Revised Reablement pathway and new performance framework	**Green**
4.12	A further 600 service users to have personalised services	**Green**
4.14	Appointment of a Carers Champion and Carers Reference Group	**Green**
4.15	Implementation of a Carers Privilege Card	**Green**

Ongoing Priorities

Ref	Service Priority	RAG rating as of 30/09/2014
4.02	Provide support for Kinship Carer Support groups	**Green**
4.02	Provide Child Protection Services	**Green**
4.03	Record employment status of Care Leavers	**Green**
4.03	Ensure our Care Leavers are supported into positive destinations. 2014/15 target is 75%. By June we had achieved 63%, and we hope to increase this proportion by year end.	**Amber**
4.04	Health Improvement and Inequalities Group (HIIG) to address health improvement priorities	**Green**
4.05	Co-ordinate response to Welfare Reform	**Non-RAG rated***
4.05	Provide financial advice and support to individuals affected by Welfare Reform	**Non-RAG rated***
4.06	Provide support to Glasgow residents at social security appeals	**Non-RAG rated***
4.06	Assist social work service users to maximise their income	**Green**
4.06	Provide Welfare Rights training to front line social workers	**Non-RAG rated***
4.06	Provide housing and employment support to veterans	**Non-RAG rated***
4.06	Provide support to those with cancer or other long term health conditions	**Non-RAG rated***
4.07	Support for young people with addiction problems	**Non-RAG rated***
4.07	Reduction of anti-social behaviour	**Non-RAG rated***
4.07	Provide education to young people around substance misuse (tobacco, alcohol and drugs)	**Green**
4.08	Tackle health problems related to over consumption of alcohol	**Non-RAG rated***
4.09	Continue working with schools to reduce smoking amongst young people	**Green**
4.10	Development of the Strategic Housing Investment Plan (SHIP)	**Green**
4.11	Ongoing development of an Independent Living Strategy with the Glasgow Disability Alliance (GDA)	**Non-RAG rated***
4.12	Use of assistive technology to increase independence	**Non-RAG rated***
4.13	Ongoing development of an Affordable Warmth Strategy to meet the challenge of fuel poverty	**Green**

* There are a number of actions where it is not appropriate to apply a RAG rating. In some instances this is because an outcomes framework is being developed either as a result of new activity or a revised process of reporting (careFirst 6 implementation), and in others the tracking of activity (Anti-Social Behaviour orders/ DWP Appeal Activity) does not lend itself to simple RAG measures where a level of qualitative explanation is required and this is provided in the body of the report.

SOCIAL WORK SERVICES

ANNUAL SERVICE PLAN and IMPROVEMENT REPORT (ASPIR)

2015-2016

April 2015

CONTENTS PAGE

Introduction

The Social Work Services Annual Service Plan and Improvement Report (ASPIR) 2015 - 2016 is the sixth report to be produced by the service, and the final ASPIR before planning and delivery of social care services in Glasgow becomes integrated with community health services following enactment of the Public Bodies (Joint Working) (Scotland) Act 2014. The ASPIR provides a progress report on the delivery of the Council Strategic Plan, Single Outcome Agreement (SOA) and major service priorities.

The aim of the ASPIR is to review targets set for the period 2014 - 2015 and provide contextual and statistical evidence about how well we have performed in meeting our objectives. The ASPIR also looks ahead to the period 2015 - 2016 and where necessary sets out our refreshed targets and milestones for the period. In addition, this report sets out the service's approved budget changes and savings requirements for 2015-2016.

This document provides relevant information on the service's performance to a range of interested parties, including service users; members of the public; staff within the service and other council services, partner agencies and Elected Members of the Council.

Social Work Services Values, Vision and Aims

The service values underpin our vision and aims as illustrated below**:**

Values:

- Protect the rights and promote the interests of service users and carers
- Promote the independence and self-determination of service users
- Respect the rights of service users while protecting them from harming themselves or other people
- Foster a culture of rights and responsibilities among service users, carers and communities.

Section 1: Strategic Plan Commitments

This ASPIR reports on Social Work Services progress in meeting the priorities set out in the Council's Strategic Plan 2012-2017. The Council Strategic Plan is based around 5 thematic themes, Social Work Services lead on the theme **"A city that looks after its vulnerable people"**. The details below provide information on the progress we have made over the last 12 months against the priorities set against this theme:

- Of 24 commitments, 21 (87.5%) are completed, or where the commitment relates to ongoing service provision the necessary infrastructure has been put in place to support this
- 3 (12.5%) commitments are not yet delivered, but plans are in place to ensure delivery within the life of the Strategic Plan

Strategic Council Plan Theme Four **A City that looks after its Vulnerable People**		***Strategic Council Plan Commitments***	
SCP Ref	**Commitments**	**Progress against highlighted elements**	**Delivery Measures and Targets**
4.01	We have increased our payments to kinship carers by 20% in 2012 and aim to increase this by a further 5% by 2015/16. We will continue to lobby for kinship carers rights at a Scottish and UK level. **(Social Work Services)**	Following a 20% increase in payments to kinship carers in 2012, our aim was to increase this by a further 5% by 2015/16. We achieved and exceeded this aim ahead of the target date by further increasing kinship carer payments by 7% during 2013/14. For the current year payments to carers have been maintained at £50 per week per child plus a single payment of £200 per child which is paid before Christmas.	▪ Number of children in kinship care placements ▪ Increase to kinship care payments
4.02	We provided child protection services for 977 children in Glasgow in 2011/12 and all of these children were assigned a care manager. We will continue to intervene early and robustly to protect children. **(Social Work Services)**	We provided child protection services for 1,096 children during 2013/14, compared to 993 the previous year. **In line with this, 1,046 children received a child protection service during the first three quarters of 2014/15.** This upward trend is the result of earlier intervention and improved multi-agency working. All children receiving a Child Protection service are allocated a Social Worker. The outcome-focussed Child Protection Plan is based on the national approach Getting it Right for Every Child (GIRFEC) set out by the Scottish Government.	▪ Child Protection – Number of children receiving a service ▪ Child Protection - % assigned to a care manager. ▪ Number of children on the Child Protection Register.

Strategic Council Plan Theme Four **A City that looks after its Vulnerable People**		***Strategic Council Plan Commitments***	
SCP Ref	**Commitments**	**Progress against highlighted elements**	**Delivery Measures and Targets**
4.03	We will guarantee all children leaving care a job or college place and, most importantly, find innovative ways to support them to sustain the place and to attend college or training. **(Social Work Services)**	We are working towards all young people leaving care having positive destinations into employment, training or education. Year on year the numbers of care leavers moving into positive destinations has improved in the period 2013-2014 this rose to 64%, that is a 6% increase on previous year. Improvement actions been put in place to drive performance towards the 75% target.	▪ Percentage of young people receiving a leaving care service that are known to be in employment, education or training. ▪ As from April 2014 our aim is to support 75% of young care leavers into employment, training or further education.
4.04	We will work in partnership with the Health Board to tackle health inequalities. The Director of Public Health will lead work to identify priority issues where we can make the most impact. This will include the areas we have been addressing in partnership including tobacco, alcohol, obesity, mental health and physical activity. **(Health Improvement Workstream)**	The Health Improvement and Inequalities Group (HIIG) is chaired by the Council's Spokesperson for Health Inequalities and a work programme for 2014 has been established.	Key actions this year include a renewed focus on implementing the new Glasgow Tobacco Strategy 2014 -17, linking with the Alcohol priority of the SOA citywide implementation plan and updating the work previously undertaken through the Healthy Weight Action Plan.
4.05	We are developing a planned response with our partners to the national welfare reforms taking a strategic view on how it impacts on the city and quality of life for individuals and families. We will reform our services to meet the requirements to deliver new benefits and plan for how they impact on the city. Early emerging issues are the impact on vulnerable people, jobs and the economy and housing and homelessness. (**Corporate Welfare Reform Group)**	The impact of Welfare Reform on the most vulnerable service users continues to require a planned response with our partners to address impacts on the city and quality of life for individuals and families. As the reforms are being phased in over a period of time, detailed information on their impact will only become available over time. There has been significant slippage in the Government timetable for roll out of two key Welfare Reforms: ▪ Universal Credit was initially scheduled for national roll out in October 2013, however we are unlikely to see Universal Credit	The Scottish Welfare Fund came into effect on 1 April 2013 and offers crisis and community care grants. This is an interim scheme for 2 years, until April 2015. ▪ Measure the number of awards received by Glasgow citizens.

Strategic Council Plan Theme Four **A City that looks after its Vulnerable People**		***Strategic Council Plan Commitments***	
SCP Ref	**Commitments**	**Progress against highlighted elements**	**Delivery Measures and Targets**
		being introduced in Glasgow until after 2015. ▪ The planned reassessment of current DLA recipients who will be required to claim Personal Independence Payments (PIP) has been delayed. It has been introduced in some parts of Scotland but with no identified date for Glasgow. Scottish Welfare Fund – given demand at the moment, it is anticipated that the allotted £7.7 million will be fully spent at financial year end. To date over 16,000 Glasgow citizens have received an award. Glasgow's Advice and Information Network (GAIN) continue to provide financial advice and support to individuals	
4.06	Our Financial Inclusion Strategy sets out how we will ensure that our most vulnerable citizens can access advice and information to prevent them being financially excluded and enable them to fully contribute and participate in the social and economic life of the city. Some specific approaches include: Social Work Services, Welfare Rights Team: ▪ The Appeals Team provide representation to Glasgow residents at social security appeal tribunals to ensure our citizens are supported to pursue their right to receive correct benefit entitlement. ▪ Income Maximisation teams provide a	The Appeals Team: ▪ Between January and September 2014 the Appeals team represented at 752 appeals. This extrapolates to 1,002 appeals by 31st December ▪ Our success rate for concluded appeals is 60%. The average financial gain per successful appeal this year to date is £6,110.23. This is an increase on last year's figure of £5,129.30 so that although the number of appeals is down, the average financial gain per successful award has risen significantly. The Income Maximisation team:. ▪ made 3,898 visits to service users between January and December last year.	Appeals Team: ▪ Current year team representation at hearings (average) ▪ Average financial gain per successful appeal Income Maximisation team: ▪ Number of home visits by team. ▪ The target for 2014-2015 is 3,500.

Strategic Council Plan Theme Four **A City that looks after its Vulnerable People**		***Strategic Council Plan Commitments***	
SCP Ref	**Commitments**	**Progress against highlighted elements**	**Delivery Measures and Targets**
	home visiting service to assist service users to make appropriate claims that ensure their benefit entitlement is maximised. The Helping Heroes campaign ensures veterans, their families and carers receive local access to a range of services including financial, employability, housing and health advice. Our MacMillan and Long Term Conditions project, which provides targeted early intervention and support to ensure that poverty and broader social exclusion are not the consequence of a diagnosis of cancer or other long term health condition. Over the life of the Plan, we will ensure that this service reaches even more people.	Our Welfare Rights training team also provides benefits training to front line Social Workers and to organisations providing Welfare Rights Advice to allow them to assist Glasgow residents to make appropriate claims for benefits. Helping Heroes Campaign ▪ Glasgow Advice and Housing services are working together to assist almost 118 veterans who have secured housing. ▪ Glasgow Veterans Employment Programme (GVEP) has secured 32 funded posts since the launch of the programme in August 2013. The MacMillan and Long Term Conditions Project ▪ Provided a service to 2,677 people in 2013 and achieved financial gains for clients totalling £4,591,492. ▪ In 2013/14 the Long Term Conditions support service was successfully extended to include Dementia, Alzheimer's, Heart Disease, Stroke, Chronic Pulmonary Disease and Cystic Fibrosis. Currently the service is being further extended to people affected by Huntington 's disease.	Helping Heroes Campaign ▪ Numbers of veterans who have secured housing ▪ Number of veterans who have secured employment The MacMillan and Long Term Conditions Project ▪ Number of people receiving a services from the project ▪ Target for additional benefits in 2013-2014 is £5millon.
4.07	We will continue to work with referred young people with alcohol problems. We will work with social landlords to reduce anti-social behaviour and where necessary take action against	The Greater Glasgow and Clyde Alcohol and Drug Prevention, Education Model and the Greater Glasgow and Clyde Alcohol and Drug Prevention and Education Evidence document	Work to reduce alcohol and anti-social behaviour by young people is being tackled across the city on a number of fronts. The key measures listed below are provided from a

Strategic Council Plan Theme Four **A City that looks after its Vulnerable People**		***Strategic Council Plan Commitments***	
SCP Ref	**Commitments**	**Progress against highlighted elements**	**Delivery Measures and Targets**

	underage drinkers and their families. We have a number of established initiatives in schools to work with young people early on alcohol. This work will continue from 2012 through to 2015-2016 **(Social Work Services)**	(2012-17) are now utilised across the city.
		
		The Glasgow Council on Alcohol provides a local service in each of the City's 3 sectors and delivers the Core Alcohol and Drugs Prevention and Education Service, which provides a coordinated and consistent approach to alcohol and drug prevention and education.
		
		The Community Addiction Teams continue to maintain and support a number of children and young people. The transfer of reporting from Carefirst 5 to Carefirst 6 means that reliable caseload numbers are not currently available, although a snapshot report from March 2015 suggested around 103 children and young people being supported by CATs. New reports are being developed to provide this information on an ongoing and reliable basis.
		
		Community Addiction Teams are routinely included as part of Special Needs In Pregnancy clinics.
		
		A co-ordinated approach continues in early years to raise resilience and protective factors through the 'Oh Lila' nursery programme.
		
		The delivery of alcohol and drug addiction-specific training to Children's Panel members in Glasgow remains ongoing.
		
		Education Services continue to work with a wide range of partners, including Greater Glasgow and Clyde NHS Board, Glasgow
			range of services in the city:
			
			▪ Joint Social Work and NHS Services Addiction Teams
			▪ Education Services: initiatives to inform children of the impact of drug and alcohol misuse and risk taking behaviour
			▪ Community Safety Services:
			  ▪ Early identification of young people misusing drugs or alcohol in communities.
			  ▪ Progress reports on the implementation of the Alcohol Brief Interventions (ABI).
			  ▪ Number of anti-social behaviour enforcement measures.

Strategic Council Plan Theme Four **A City that looks after its Vulnerable People**		***Strategic Council Plan Commitments***	
SCP Ref	**Commitments**	**Progress against highlighted elements**	**Delivery Measures and Targets**
		Council on Alcohol (GCA) and the Greater Easterhouse Alcohol Awareness Project (GEAP) to focus children on the impact of alcohol misuse and risk taking behaviour. Some Additional Support Needs (ASN) Secondary school staff are working with ENABLE Scotland to introduce a programme to assist the development of informed personal choices. This programme is designed around substance misuse education for some of the city's most vulnerable young people. We are continuing to work to reduce anti-social behaviour. Anti-Social Behaviour Enforcement measures are recorded via Glasgow Community Safety Services. Comparison of the numbers of Orders issued during 2013/14 (281 issued) with the first 5 months of the current year (April to August 2014 – 92 issued) suggests that we may see a reduction in the annual number of Orders at year end 2014/15.	
4.08	We will continue to tackle the health problems related to over consumption and provision of alcohol by working with community planning partners to change the culture in Glasgow around alcohol and excessive drinking. We will also work to reduce the availability and consumption of alcohol and drugs. Most of this work will take place during 2013 - 2014. **(Community Safety Services Glasgow)**	The Alcohol and Drug Partnership (ADP) provides strategic leadership across the city to reduce accessibility and the misuse of alcohol and drugs in communities. Current initiatives that are being put into practice include: ▪ Community Safety Services Glasgow is working with communities to identify and respond to alcohol related problems at a neighbourhood level. ▪ The "Your Community" website has been developed to enable people living in the City to easily report incidents including those related to alcohol misuse. This	▪ Progress reports on the ADP Action plan

Strategic Council Plan Theme Four **A City that looks after its Vulnerable People**		***Strategic Council Plan Commitments***	
SCP Ref	**Commitments**	**Progress against highlighted elements**	**Delivery Measures and Targets**
		project is currently being piloted in Ward 9. ▪ We are currently refining the Alcohol Brief Intervention (ABI) model with community based housing providers and their tenants. Initial focus is in three South Thriving Places.	
4.09	We will continue to work with schools to reduce smoking amongst young people. Lung cancer rates amongst women in Glasgow are particularly poor. Our primary and secondary schools deliver tobacco education programmes and we have reviewed our materials to ensure that these are in line with the Curriculum for Excellence. **(Education Services)**	Education Services continue to work in partnership with a wide range of partners such as the NHS, GCA and GEAP to promote and develop substance misuse education and, increasingly, to focus on the impact of risk taking behaviours. Staff in some ASN Secondary schools will be linking with ENABLE Scotland to introduce a programme to assist the development of informed personal choices. This programme is designed to support substance misuse education for some of the city's most vulnerable young people. The Substance Misuse Toolkit is an interagency/ inter-authority resource that supports staff working with older children and young people in schools and children's units. The Toolkit provides access to material, training and contacts for substance misuse education. The increasing, concerning, use of e-cigarettes will be a key focus.	This work is ongoing in Schools in the city.
4.10	We want to protect and nurture people's mental health and we will work with NHS Greater Glasgow and Clyde, the Scottish Association for Mental Health and the Glasgow Association for Mental Health to deliver this. Our priorities	NHS Greater Glasgow and Clyde, the Scottish Association for Mental Health and the Glasgow Association for Mental Health have: ▪ Produced a joint commissioning plan for	▪ Update reports for the Mental Health Social Care Group ▪ DRS report on progress on Housing Support.

Strategic Council Plan Theme Four **A City that looks after its Vulnerable People**		***Strategic Council Plan Commitments***	
SCP Ref	**Commitments**	**Progress against highlighted elements**	**Delivery Measures and Targets**
	over 2012-2014 are; ▪ to establish joint commissioning of services with NHSGGC ▪ to ensure rehabilitation and care, and that there are employment opportunities ▪ that mental health is taken account of in local housing policies.	Mental Health services including Joint Tender for Advocacy Services for Adult Mental Health, Older People and Learning Disability. ▪ Improved employment outcomes for people with mental health difficulties we are working with partners to develop a process of recording this activity. ▪ Secured Silver Status in the Healthy Working Lives Award as we recognise the need to ensure the good mental health of our own staff. Development and Regeneration Services (DRS) are leading on Housing Support for people with Mental Health through the Glasgow Housing Strategy.	
4.11	We will develop an Independent Living Strategy with the Glasgow Disability Alliance following on from the launch event on 20th September 2012. We will produce a statement of intent from the Glasgow Family Group to support this strategy. **(Corporate Chief Executive)**	The Independent Living Strategy Board has been established to develop the Independent Living Strategy. The Board membership includes Glasgow Disability Alliance (GDA) and Glasgow Centre for Independent Living (GCIL). The strategy will set out the priorities for reform and improvement over the next two years, which include: ▪ improved lifelong learning access and outcomes ▪ improved youth employment prospects for disabled people.	▪ Measures to be determined through Glasgow Community Planning Partnership public sector reform initiative, One Glasgow.
4.12	We want to ensure more people can live at home or in the community independently,	Reablement Results show that over 40% of the individuals	▪ Number of people receiving a reablement

Strategic Council Plan Theme Four **A City that looks after its Vulnerable People**		***Strategic Council Plan Commitments***	
SCP Ref	**Commitments**	**Progress against highlighted elements**	**Delivery Measures and Targets**
	when it is safe for them to do so. We have agreed priorities with NHS Greater Glasgow and Clyde to support this. This includes ensuring that no one should remain in hospital for more than 6 weeks after they have been assessed as suitable to go home. Over 2012 -2015 we will build on new ways of working to include: **(Social Work Services)** ▪ Reablement is a care service tailored to support people to re-learn daily tasks that enable them to live independently. ▪ personalisation of social care; specifically we will aim to ensure 2,500 people have support plans in place; ▪ working with housing associations to ensure there is a range of suitable housing; and ▪ extending the use of technology to allow people to remain in their homes for longer with support.	who have received a Reablement Homecare support service no longer require a service, as they can successfully live independently. 6,701 people received a reablement service in the period 2013/14. Between April and June 2014 the number of service users supported each week via Reablement increased by 35% from 464 to 625. Over the same period, of the people who received post-Reablement Homecare support, 38% required no further service because their independence has been optimised. Personalisation Social Work Services continue to successfully roll out personalised services. By June 2014 3,409 individuals had a personalisation support plan in place. Suitable Housing and Technology Working within the One Glasgow Vulnerable Older People's work stream Social Work Services with Glasgow Housing Association (GHA) and other partners are developing a hub and cluster accommodation base which will use telecare and other technology to enhance residents' safety and support. A multi-agency steering group has been established and a Project Manager appointed who will implement the project. Structural and service development work will progress at the identified site in Nitshill through 2014/15.	service. ▪ Number of people with a personalisation support plan in place.

Strategic Council Plan Theme Four **A City that looks after its Vulnerable People**		***Strategic Council Plan Commitments***	
SCP Ref	**Commitments**	**Progress against highlighted elements**	**Delivery Measures and Targets**
4.13	Fuel Poverty remains a significant challenge to Glasgow. We are developing an Affordable Warmth Strategy to meet the challenge of fuel poverty in Glasgow. As part of this, we will continue to provide an affordable warmth dividend of £100 to those aged over 80 who live in the city to tackle fuel poverty and ensure older people can meet rising fuel costs. **(Land & Environmental Services)**	The affordable warmth budget which is administered by Financial Services, has been set at £1,500,000 for 2014/15. For the fourth year running an Affordable Warmth Dividend of £100 is being offered this winter to all residents of Glasgow who are over the age of 80 (approximately 22,000 people).	▪ Number of Glasgow residents who have received the affordable warmth dividend.
4.14	We have appointed a Carers Champion and will appoint a carers board with representation from across the sector to advise and steer our work with carers, listen to their priorities and implement approaches to support them, involving them directly in the development of services. **(Social Work Services)**	The Carers Reference Group (CRG), previously chaired by the Carers Champion, has recently appointed carers as the chair and vice chair. The Carers Champion will continue to work with the CRG and support them to achieve their objectives. Carer representatives from the CRG attend the Personalisation Sub Group and work with the Carers Strategic Planning Group..	Carers continue to influence improvement and development of services.
4.15	We will introduce a Carers Card with discounts and entitlements to services for our carers. **(Social Work Services)**	All carers who provide care for a Glasgow resident are eligible to receive a Carers Privilege Card free of charge. This card which was launched in September 2013 continues to be promoted through the GCC Carers Card website, Carers Information Line and by the Carer Services and Centres across the city. Over 7,500 carers cards have been issued to date.	Key measure ▪ Number of carers who have received a Carer's Privilege Card

Section 2: Single Outcome Agreement (SOA)

Below is some of the work that Social Work Services take forward to contribute to achieving the priorities in Glasgow's SOA. The priorities are: Alcohol, Youth Employment and Vulnerable People.

As stated in Section 1 Social Work Services, with partners, has responsibility to manage the Council Strategic Plan theme "A City that looks after its Vulnerable People". The SOA priorities are underpinned in this plan under the Vulnerable People theme and therefore work being undertaken to reduce alcohol misuse, improve youth employment and protect vulnerable citizens is comprehensively described in Section 1 of this report.

SOA Priority Youth Employment
In addition to the information provided in Section 1, the service identifies opportunities for vulnerable people to gain access to education, training and employment. Some examples of this work are listed below, Social Work Services working with partners:

- Aim to support 75% of young care leavers into employment, training or further education.

- The Supported Employment Service* supports people with learning disabilities to access and sustain full time employment. The service has an annual target of 25 full time based jobs. The service is for all age groups, however, 50% of the referrals are within the 16 – 25 age group.

* Within the Supported Employment Service a job coach develops an in depth vocational assessment of skills; abilities and aspirations of the client in order to tailor job search activities towards jobs which would be appropriate matches. The job coach works intensively with employers before, during and after recruitment and coaches a client on the job until they are confident about carrying out all the tasks required of them by the employer. The service has an 82% sustainability rate at 6 months which compares favourably with mainstream provision.

Section 3: Service Priorities

Social Work Services are currently working on a number of service improvement initiatives, preparing for a significant organisational and structure change through the integration of health and social care services and managing increased demand on services at a time when resources and funding are restrained. In addition we are working to ensure Social Work functions prioritise early intervention and prevention, by providing support to Glasgow's vulnerable citizens that is proportionate to their needs and is planned with specific outcomes that result in an increase in individuals' independence and reduced need for social work intervention.

Integration of Health and Social Care

The Public Bodies (Joint Working) (Scotland) Act 2014 received Royal Assent on 1 April 2014; the Act requires local authorities and health boards to integrate community health and social care services. The legislation requires the integration of all adult community health and social care services as a minimum, and allows partnerships to include other services as they see fit. In February 2014, Glasgow City Council Executive Committee agreed that *all* Social Care services, including Children and Families and Criminal Justice, will be included within the Glasgow Health and Social Care Partnership. This is a major organisation and structural change to how social work services carries out its business. The Partnership's Integration Joint Board (IJB), which oversees development and implementation of the Strategic Plan for integrated health and social care services, is expected to be established in June 2015.

Social Care Direct

Social Care Direct (SCD) is a jointly managed service delivered by Social Work Services and Customer and Business Services (CBS), which is intended to be the first point of contact for all general enquiries and new referrals to Social Work. SCD adult services has been established since September 2012 with Children and Families services commencing February 2014. Further development of the SCD model is currently underway to ensure that SCD continues to support the strategic direction of Social Work Services.

Joint inspection of Social Work and Health Services for Older People in the Glasgow City

A joint inspection of the care of older people by the Care Inspectorate and Health Improvement Scotland commenced in August 2014. The inspection looked at how older people in Glasgow are supported by health and social care services to remain in their own homes or in a homely setting. The findings of this inspection and any recommendations made will shape future development of integrated health and social care services to older people in the city.

Social Impact Bond

A Social Impact Bond (SIB) is a financial contract between socially motivated investors and the public sector to pay for improved social outcomes. The Scottish Government and Glasgow City Council (GCC) are very interested in exploring this method of funding. Glasgow City Council made a decision to concentrate on improving services for young people leaving care as the most applicable for the SIB bid and this project will be used as GCC introduction to this approach. The funding will be used for a range of interventions to improve outcomes of approximately 50 to 100 of the most vulnerable care leavers with complex needs.

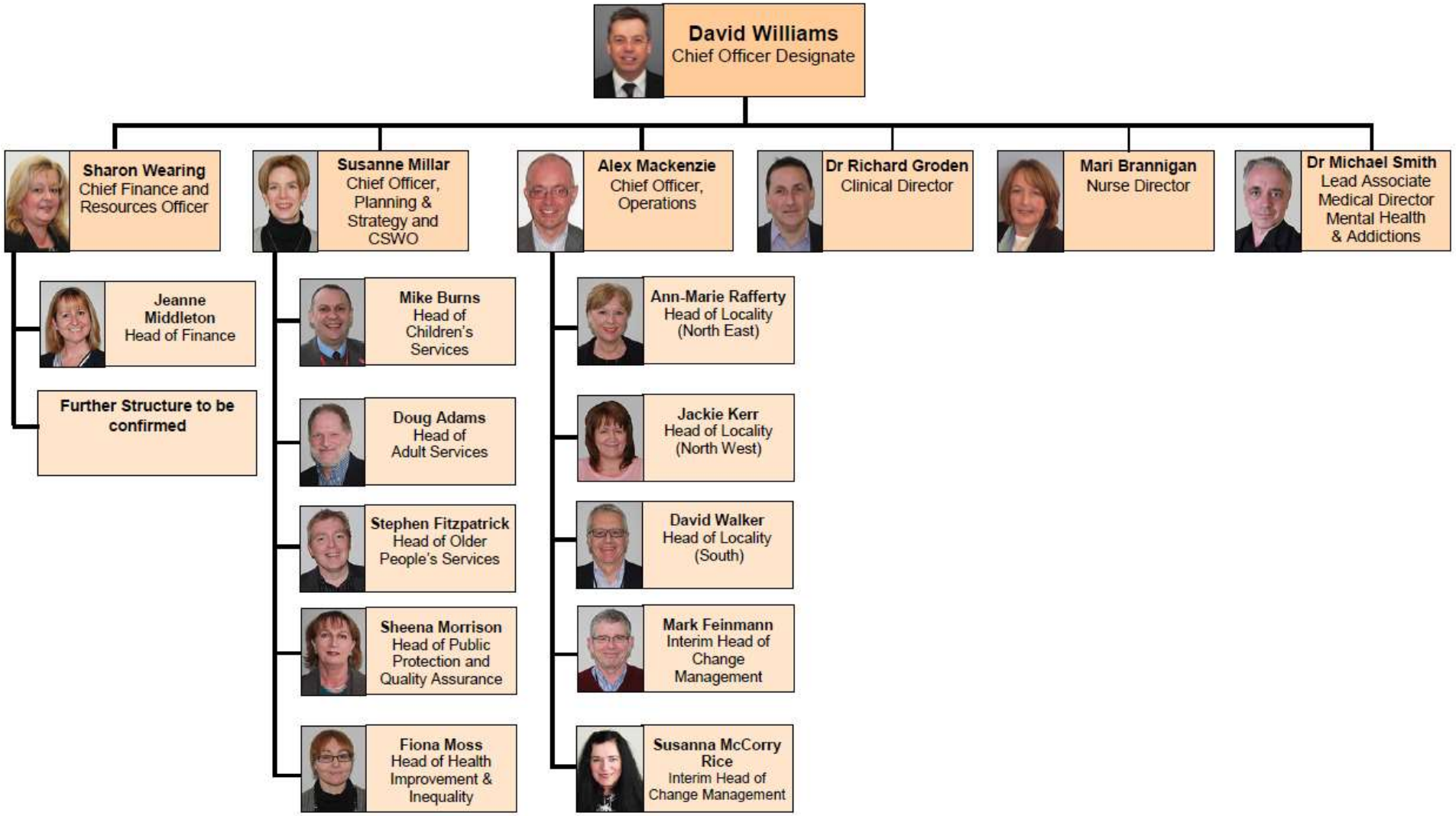
The bid has been linked to the activity that has previously been carried out by the Improving Leaving Care Services Working Group. This work provided us with intelligence on what works and identified service capacity gaps. This has enabled the development of a proposal for the SIB bid to build capacity and resources around service models that we know already work in the City.

The Improving Leaving Care Working Group membership includes statutory and third sector organisations. The purpose of the group is to promote collaborative working, make the most effective use of existing resources and collectively seek external funding. A trigger for this work is the financial constraints experienced by the statutory ad third sector organisations and the significant change to the range of duties and powers that affect those children and young people in care and care leavers through the implementation of the Children and Young People Scotland (Act) under Parts 9 – 14.

Section 4: Resources and Organisation

Service Structure: Senior Management
The senior management structure of Social Work Services is under review in light of integration with the former Glasgow Community Health Partnership and the move towards a joint management structure under the Chief Officer. The management structure with effect from May 2015 is as follows:

Glasgow Health and Social Care Partnership
Executive and Senior Management Structure
5 May 2015



Staff Resources

	The number and percentage of staff that are:											
Grade(s) (FTE)	**MALE**		**FEMALE**		**WHITE**		**ETHNIC MINORITY**		**DISABLED**		**TOTAL**	
	No	**%**	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**	**No**	**%**
1 to 4	**140.79**	**24.75%**	**428.15**	**75.25%**	**366.29**	**64.38%**	**29.19**	**5.13%**	**6.06**	**1.06%**	**568.94**	**16.35%**
5 to 7	**635.39**	**25.42%**	**1864.08**	**74.58%**	**1985.73**	**79.45%**	**56.53**	**2.26%**	**97.02**	**3.88%**	**2499.47**	**71.86%**
8	**97.74**	**33.98%**	**189.86**	**66.02%**	**251.19**	**87.34%**	**10.50**	**3.65%**	**6.0**	**2.09%**	**287.60**	**8.26%**
9 to 14	**20.00**	**27.56%**	**52.56**	**72.43%**	**64.56**	**88.97%**	**0**	**0%**	**1**	**1.38%**	**72.56**	**2.16%**
Non PGS*	**7**	**14.21%**	**42.26**	**85.89%**	**28.26**	**57.37%**	**2**	**4.06%**	**0**	**0%**	**49.26**	**1.4%**
Totals	**900.92**	**25.9%**	**2576.91**	**74.01%**	**2696.03**	**77.52%**	**98.22**	**2.82%**	**110.08**	**3.16%**	**3477.83**	**100%**
								Ethnicity Not Declared			**683.58**	**19.66%**

***Non Pay and Grading Structure**

Service Structure

At high level, Social Work Services is split into three local delivery areas, with a number of cross-cutting functions and a strategic centre. The overall structure of Social Work Services will evolve during 2015/16 as we move towards integration of health and social care; future developments in this area will be communicated later in the year.

Financial Resources - Budget

Social Work Services Objective Level

Expenditure	2014/15 Estimate	2015/16 Estimate
Community Care	374,678,900	371,033,400
Children and Families	128,634,700	129,994,400
Criminal Justice	17,839,000	16,614,500
Fieldwork	18,905,400	9,614,500
Other Services	12,985,200	10,954,200
Direct Departmental Expenditure*	553,043,200	538,211,000
Central Charges*	15,533,300	31,830,800
TOTAL EXPENDITURE	**568,576,500**	**570,041,800**
Income		
Community Care	118,370,700	121,017,800
Children and Families	1,045,900	1,047,800
Criminal Justice	18,710,400	18,583,800
Fieldwork	1,727,600	1,582,700
Other Services	230,400	264,300
TOTAL INCOME	**140,085,000**	**142,496,400**
NET EXPENDITURE	**428,491,500**	**427,545,400**

Social Work Services Subjective Level

Expenditure	2014/15 Estimate	2015/16 Estimate
Employee Costs	153,305,800	142,075,600
Premises Costs	22,119,600	23,346,700
Transport Costs	5,974,900	4,773,500
Supplies & Services	20,905,200	18,382,100
Third Party Payments	323,051,500	322,238,600
Transfer Payments	26,737,400	26,422,000
Financing Costs	948,800	972,500
Allocations	15,533,300	31,830,800
TOTAL EXPENDITURE	**568,576,500**	**570,041,800**

Social Work Services draft 2014- 2015 outturn

Draft unaudited service outturn £3.7m overspend at year end.

*The significant reduction in Direct Departmental Expenditure and corresponding increase in Central Charges between 2014/15 and 2015/16 relates to the transfer of staff from SWS to CBS under Tomorrow's Support Services.

Staff Development

Social Work Services remain committed to the development of staff, with the output of the Learning & Development Team focussed on the core needs of the service. The team continues to deliver a wide variety of training programmes to support the delivery of high quality social care services in Glasgow.

EDRMS and Information Management

The service continues to prepare for migration of all of its unstructured electronic documents (e.g. word, pdf, excel files) from our shared Windows drives to Livelink, a new web-based Electronic Document Records Management System (EDRMS). The Livelink project will assist the service and wider Council to meet its obligations in relation to the 2011 Public Records (Scotland) Act; reduce business risk; boost productivity; reduce costs; and improve information quality.

Livelink is already being used by staff working with files relating to; Communications & Marketing; Risk & Business Continuity; Learning & Development; Finance; HR; Rights and Enquiries and Research and Practice Audit. File planning is now underway to develop the area to be used by staff working with service users and providers, and Local Information Managers are being supported to assist staff in their areas to prepare for migration of the information they access. Planning work is ongoing to ensure migration of all information within agreed timescales.

Mobile Working

The council's IT refresh programme has rolled out across Social Work Services, with approximately 1800 fieldworkers and managers provided with hybrid tablet / laptop devices to support mobile working. Phase 1 of the rollout is now complete, and work is underway on phase 2 to realise the benefits of a mobile working approach.

Section 5: Performance and Future Targets

1. Full Year figures for Council Plan /SOA/ Service measures and indicators

Performance Report for 2014-15 and Targets for 2015-16

The following key sets out the thresholds for the Corporate System of RAG coding of performance information:

Green	Where performance is within 2.49% of the target
Amber	Where performance misses the target by between 2.5% and 4.99%
Red	Where performance misses the target by 5% or more

The following key reflects the 'Golden Thread', setting out where our ASPIR performance indicators feature in other local and national policy and performance frameworks:

CSI Corporate Scorecard Indicator	**SPC** Strategic Plan Commitment	**EOI** Equality Outcomes Indicator
SPI Statutory Performance Indicator	**HEAT Target** **H**ealth Improvement, **E**fficiency, **A**ccess to Services and **T**reatment. This is an internal NHS performance management system	

The tables below represent the performance of Social Work Services across Glasgow in relation to the service's key performance indicators. Please note that the figures given relate to the year end (Q4) figure unless otherwise indicated:

Staffing

Measures & Links	2011-12	2012-13	2013-14	2014-15 Target	2014-15 Actual	2015-16 Target	Rating	What this means
Sickness Absence Rate	5.25%	5.09%	4.7%	**<5% (2.3 average days lost)**	**5.95% (3.0 average days lost)**	**<5% (2.3 average days lost)**	**Red**	This is the absence rate for Periods 11-13 (20/12/14 – 31/03/15), which equates to Q4. Disappointingly we did not meet our target at year end this year despite robust absence management procedures being in place.

Customer Focus

Measures & Links	2011-12	2012-13	2013-14	2014-15 Target	2014-15 Actual	2015-16 Target	Rating	What this means
Complaints							**Green**	We exceeded all our targets for handling and responding to customer comments, complaints and enquiries in 2014-15.
Number of comments & enquiries received during 2014-15	228	246	208	**n/a**	**160**	**n/a**		
Number of complaints received during 2014-15	478	516	601	**n/a**	**604**	**n/a**		
Total	706	762	809	**-**	**764**	**-**		
% of the total handled within 15 working days	79%	84%	76%	**70%**	**75%**	**70%**		
% of complaints responded to within 15 working days	74%	80%	69%	**65%**	**70%**	**65%**	**Green**	
% of complaints responded to within 28 calendar days (statutory deadline)	90%	90%	87%	**85%**	**86%**	**85%**	**Green**	
Elected Member Enquiries							**Green**	This year there was a 7% increase in the number of enquiries received. Despite this increase, we exceeded our target providing responses to 93% of enquiries within 10 days of receipt.
Number of enquiries received during 2014/15	1,233	1,393	1,432	**n/a**	**1,531**	**n/a**		
Percentage handled within 10 days	93%	96%	95%	**80%**	**93%**	**80%**		

Measures & Links	2011-12	2012-13	2013-14	2014-15		2015-16 Target	Rating	What this means
				Target	Actual			
FOI Requests							Green	Despite a 13% increase in the number of Freedom of Information requests since 2013/14, we remained within the target range providing responses to 88% within the statutory timescale of 20 working days.
Number of requests received during 2014/15	194	190	192	**n/a**	**217**	**n/a**		
% responded to within 20 working days of receipt	95%	96%	95%	**90%**	**88%**	**90%**		
DP Subject Access Requests								We met our target for DP Subject Access Requests, providing responses to 90% within the statutory timescale of 40 calendar days.
Number of DP Subject Access Requests received during 2014/15	-	57	125	**n/a**	**112**	**n/a**	Green	
% responded to within 40 calendar days of receipt	-	91%	85%	**80%**	**90%**	**80%**	Green	

Employability – Care Leavers

Measures & Links	2011-12	2012-13	2013-14	2014-15		2015-16 Target	Rating	What this means
				Target	Actual			
Employment Status								
Percentage of young people receiving a leaving care service known to be in employment, education or training. **SPC EOI**	51%	58%	65%	**75%**	**66%**	**75%**	**Red**	There has been only a very slight improvement in performance over the past 12 months. This issue has been highlighted to SW Senior Management and improvement actions have been put in place.

Adult Services - Older People Reviews and Home Care

Measures & Links	2011-12	2012-13	2013-14	2014-15 Target	2014-15 Actual	2015-16 Target	Rating	What this means
Older People Reviews								
% of older people (65+) resident in a **Purchased** Care Home placement reviewed in the last 12 Months. **CSI**	-	41%	37%	**100%**	**34%**	**100%**	**Red**	In 2014/15 we did not meet the target set for reviews of older people in Purchased Care Home placements despite the introduction of a revised review process.
% of older people (65+) receiving **home care** services reviewed in the past 12 months. **CSI**	-	75%	85%	**85%**	**85%**	**85%**	**Green**	We have continued to meet the target set for reviews of older people receiving home care services each quarter over the last 18 months.

Adult Services – Care Homes and Delayed Discharges

Measures & Links	2011-12	2012-13	2013-14	2014-15 Target	2014-15 Actual	2015-16 Target	Rating	What this means
Care Homes								
Number of Older People 65+ in long stay care home placements (includes purchased, voluntary and directly provided placements). (snapshot figure)	3,877	3,907	3795	**< 4,000**	**3,574**	**< 4,000**	**Green**	We have not exceeded the upper limit set for the number of older people in residential care. Over the last 2 years the number of older people in care home placements (year-end snapshot) has fallen by over 8%.
Delayed Discharges								
Number of people remaining in acute hospitals 4 weeks or more after being assessed as ready for discharge	2	6	**15**	**0**	**35**	**0**	**Red**	There were 35 delayed discharges at the mid-March 2015 census date. A new approach to managing delayed discharges is currently being rolled out.

Adult Services – Carers, Reablement, Adult Support and Protection (ASP)

Measures & Links	2011-12	2012-13	2013-14	2014-15 Target	2014-15 Actual	2015-16 Target	Rating	What this means
Carers								
Number of Carer Assessments completed during 2014/15.	-	658	1,507	**1,000**	**1,601**	**TBC**	**Green**	In 2014/15 we exceeded our target in relation to carer assessments by 60%.
Percentage of carers who feel able to continue in their role as a carer	-	-	-	**65%**	**76%**	**65%**	**Green**	**New Indicator for 2014/15.** We exceeded our target in relation to this indicator.
Reablement								
Percentage of service users who completed a Reablement Service who were "satisfied" or "very satisfied" with the service (Annual Survey)	-	97%	100%	**90%**	**89%**	**90%**	**Green**	We met our target in relation to service user satisfaction.
Percentage of Service Users in scope (i.e. requiring care at home) referred for a Reablement Service.	-	-	57%	**100%**	**100%**	**100%**	**Green**	Excellent progress has been made in relation to screening for Reablement. All of our service users who require care at home are screened for suitability for a Reablement Service.
Number of service users fully/partially completing a Reablement programme between Jan – Dec 2014	-	-	1,731	**-**	**2,770**	**-**	**n/a**	In 2014 there was a 60% increase in the number of Service Users progressing Reablement in comparison with the previous year. **Additional Information:** 36.5% of Service Users who complete a Reablement programme require no further homecare service.

Measures & Links	2011-12	2012-13	2013-14	2014-15		2015-16 Target	Rating	What this means
				Target	Actual			
Percentage reduction in the number of ongoing home care hours provided where SUs have fully completed Reablement.	-	-	-	**30%**	**43%**	**30%**	**Green**	Reablement Service delivery has achieved and exceeded the 30% target. This percentage is based on Service Users who fully completed a Reablement programme between Jun and Aug 2014.
Adult Support and Protection								
Duty to Enquire completed within 5 working days from referral	-	53%	53%	**90%**	**43%**	**90%**	**Red**	We have not met the 5 and 8 day targets set for the completion of the Duty to Enquire and Completion of the ASP investigation respectively. Adult Support and Protection procedures and targets are currently being revised. From ASP referral to completion is likely to be changed to 20 days in line with Child Protection procedures.
Completed ASP Investigations within 8 working days from referral	-	35%	23%	**90%**	**23%**	**90%**	**Red**	
Management Information								
No. of ASP Referrals received during 2014/15	-	3,235	4,300	**n/a**	**5,182**	**n/a**	**n/a**	Over the last 12 months there has been a 21% increase in the number of ASP referrals received. In 2014/15 only 4% and 2% of ASP referrals moved to case conference, and review conference respectively.
No. of ASP Case Conferences held during 2014/15.	-	175	169	**n/a**	**183**	**n/a**	**n/a**	
No. of ASP Review Conferences held during 2014/15.	-	91	107	**n/a**	**117**	**n/a**	**n/a**	

Personalisation

Measures & Links	2011-12	2012-13	2013-14	2014-15 Target	2014-15 Actual	2015-16 Target	Rating	What this means
Personalised Budgets – Adults and Children/Young People								
Number of service users with:								
• an Individual Service Fund (ISF)	-	-	1,736	**No target set**	**2,093**	**No target set**	**n/a**	Over the past 12 months the total number of Personalised Budgets has increased by 26%. In that time the increase in the proportion of direct payments has been greater than the increase in the proportion of individual service funds.
• Direct Payment (DP)	-	-	214	**No target set**	**367**	**No target set**	**n/a**	
Total	-	-	1,950	**No target set**	**2,460**	**No target set**	**n/a**	
Percentage of service users with personalised services taking support in the form of a Direct Payment	-	11%	11%	**>15%**	**15%**	**>15%**	**Green**	The proportion of direct payments met the 15% target for the first time at year end.

Alcohol and Drugs Services

Measures & Links	2011-12	2012-13	2013-14	2014-15 Target	2014-15 Actual	2015-16 Target	Rating	What this means
Access to treatment								
Percentage of individuals receiving appropriate drug/alcohol treatment within 21 days that supports their recovery **HEAT Target**	-	91%	96%	**90%**	**91%**	**90%**	**Green**	This indicator is reported one quarter in arrears. At quarter 3 we ensured that 91% of service users received the appropriate treatment within 3 weeks.
Number of individuals entering **community rehabilitation** during 2014/15	-	959	907	**n/a**	**788***	**n/a**	**n/a**	**Provisional figures as at 14 Apr*. These figures indicate that the majority of alcohol and drugs service users receive treatment in a community, rather than a residential, setting. Complementary indicators, measuring the number of people successfully completing these services will be introduced in future. Reports are currently being developed.
Number of individuals entering **residential support** during 2014/15	-	151	182	**n/a**	**129***	**n/a**	**n/a**	
Number of individuals entering **specialist inpatient services** during 2014/15	-	457	474	**n/a**	**486***	**n/a**	**n/a**	
Total (2014/15)	-	1,567	1,563	**n/a**	**1,403***	**n/a**	**n/a**	
Support for Children of parents with a substance misuse problem								
% of Parental Assessments completed (where assessment has been identified as being required)	-	-	61%	**50%**	**86%**	**75%**	**Green**	We exceeded the target in relation to the completion of parental assessments in each quarter of 2014/15; the target has been increased to 75% This indicator will be replaced during 2015/16 following the implementation of a new Parental Assessment e-form.

Criminal Justice (CJ)

Measures & Links	2011-12	2012-13	2013-14	2014-15 Target	2014-15 Actual	2015-16 Target	Rating	What this means
Community Payback Orders							**Green**	Over the past 12 months performance increased significantly in relation to this indicator and at Q4 the 75% target was exceeded. The target has been increased to 80%
Number of new CPOs in the final quarter of 2014/15.	412	576	695	**n/a**	**704**	**n/a**		
% of work placements commenced within 7 days of sentence	80%	77%	67%	**75%**	**76%**	**80%**		
Case Management Plans							**Green**	We met and exceeded the target in relation to the proportion of clients with a case management plan within timescale. The target has been increased to 85%.
% of CPOs with a Case Management Plan within 20 days.	41%	59%	83%	**75%**	**82%**	**85%**		
Reviews							**Red**	Although we did not meet target in relation to client review timescales, performance increased slightly during 2014/15. This issue is discussed routinely at monthly performance meetings and closely monitored. It is anticipated that ongoing scrutiny will result in improved performance during 2015/16.
% of 3 month reviews held within timescale	-	61%	59%	**75%**	**63%**	**75%**		
Client Attendance Rate at review	69%	60%	48%	**65%**	**34%**	**65%**	**Red**	Performance in relation to client attendance slipped again during 2014/15. This appears to be due mainly to new recording procedures introduced as part of the migration to careJust. Immediately prior to migration, performance stood at 70% (Q3 2013/14). This issue continues to be addressed by management.

Children & Families

Measures & Links	2011-12	2012-13	2013-14	2014-15 Target	2014-15 Actual	2015-16 Target	Rating	What this means
Looked After Children								
Total number of looked after children (snapshot at year end)	3,742	3,634	3,588	**n/a**	**3,477**	**n/a**	**n/a**	At year end, **2,000** children were looked after at home (LAC), and **1,477** children were looked after away from home (LAAC).
• Proportion looked after at home with family/friends.	62%	60%	59%	**>60%**	**58%**	**>60%**	**Amber**	Although currently we remain within the target range for this indicator, the long term trend shows a slight decrease in the proportion of children looked after in the community in favour of being looked after away from home.
• Proportion looked after away from home.	38%	40%	41%	**<40%**	**42%**	**<40%**	**Amber**	
Primary Worker								
• Children looked after at home or with family/friends (LAC)	92%	89%	92%	**100%**	**89%**	**100%**	**Red**	Approximately 11% of looked after children (LAC) do not have a primary worker, however we continue to provide almost all looked after and accommodated children (LAAC) with a primary worker.
• Children looked after away from home (LAAC).	100%	99%	98%	**100%**	**99%**	**100%**	**Green**	
Care Plans								
Percentage of looked after and accommodated children with a Care Plan				**100%**	**TBC mid-year**	**100%**		The new Child's Plan is currently being implemented on careFirst. As staff training needs to be rolled out and a reporting process developed, it is anticipated that it will be mid-year before we are able to report on this indicator.

Measures & Links	2011-12	2012-13	2013-14	2014-15 Target	2014-15 Actual	2015-16 Target	Rating	What this means
Recruitment of foster carers and adoptive parents								
Number of foster carers approved during 2014/15 (including respite care and shared care)	50	57	68	**75**	**64**	**75**	**Red**	We did not meet our annual target of 75 new foster carer approvals during 2014/15. During the second half of 2014/15 there were a range of applicant issues which reduced the overall number approved by year end. The identification of these issues is a reflection of the high standard of quality assurance and the rigour of the assessment process.
Number of foster carers (includes multi-dimensional treatment, respite care and shared care)	490	513	612	**490**	**628**	**490**	**Green**	In 2014/15 we continued to meet the target in relation to the number of foster carers.
Number of adoptive families approved during 2014/15	54	43	45	**50**	**45**	**50**	**Red**	For 2014/15 the annual target for the number of adoptive families approved was increased from **35** to **50**. Unfortunately we failed to meet our ambitious new target as a result of delays due to personal applicant circumstances combined with the rigorousness of the assessment process.

Measures & Links	2011-12	2012-13	2013-14	2014-15 Target	2014-15 Actual	2015-16 Target	Rating	What this means
Permanence								
Number of Looked after and accommodated children aged under 5	266	229	206	**n/a**	**164**	**n/a**	**Red**	Although we missed our target, performance improved by 9 percentage points over the last 12 months and we narrowly missed an Amber rating by 0.5% at year end.
% who have had a Permanency Review **CSI**	56%	72%	76%	**90%**	**85%**	**90%**		

Children & Families – SCRA Reports

Measures & Links	2011-12	2012-13	2013-14	2014-15 Target	2014-15 Actual	2015-16 Target	Rating	What this means
SCRA Reports								
Number of New reports (offence & non-offence based) requested by the Reporter between April and December 2014.	2,276	1,575	608 (Q3 and Q4 only)	**n/a**	**502 (Qu 1 to 3)**	**n/a**	**Green**	Q4 figures are not yet available – figures relate to Q3 (Oct-Dec 14). We met or exceeded the 55% target during Q1 to Q3. It is anticipated that performance will improve further as SCRA reports remain an important focus for Social Work Services.
% of **New** SCRA reports submitted within 20 days/on time	26%	52%	55%	**55%**	**55% (Q3)**	**55%**		

Children & Families – Child Protection

Measures & Links	2011-12	2012-13	2013-14	2014-15 Target	2014-15 Actual	2015-16 Target	Rating	What this means
Child Protection Register								
Number of children on the Child Protection (CP) Register at year end **CSI**	-	403	500	**n/a**	**483**	**n/a**	**n/a**	This indicator monitors the number of children on the CP register at the end of each quarter. The number of children on the register rose sharply during 2013/14 and has remained at this level during 2014/15.
Percentage of children on the Child Protection Register with a primary worker.	-	-	98%	**100%**	**99%**	**100%**	**Green**	We have continued to ensure that almost all children on the Child Protection Register have a primary worker.

Homelessness

Measures & Links	2011-12	2012-13	2013-14	2014-15 Target	2014-15 Actual	2015-16 Target	Rating	What this means
Assessments								
Number of households assessed as homeless or potentially homeless during 2014/15	6,297	5,937	4,974	**< 4,500**	**4,988**	**< 4,500**	**Red**	The target for this indicator was revised from **<7,000 to <4,500** for 2014/15. This was as a reflection of the success of Housing Options advice and assistance which has reduced the number of cases requiring to be assessed. Although we failed to meet this ambitious target we were within 6% of the target range. It is anticipated that performance will improve with the continued roll out of Housing Options.

Measures & Links	2011-12	2012-13	2013-14	2014-15		2015-16 Target	Rating	What this means
				Target	Actual			
Number of households reassessed as homeless or potentially homeless within 12 months during 2014/15	250	153	329	**<300**	**633**	**<300**	**Red**	There was further slippage in performance during 2014/15 with the number of reassessed cases having quadrupled since 2012/13. Detailed work is being undertaken by the homelessness team to establish reasons for repeat cases and to identify and take action on any policy or practice issues which arise.
Completion of Duty								
Percentage of decision notifications issued within 28 days of initial presentation: **SPI CSI**								
• Permanent accommodation	91%	91%	89%	**95%**	**96%**	**95%**	**Green**	There has been a significant increase in performance over the last 12 months. This improvement has been achieved as a result of ongoing monitoring of individual cases and changes to casework practice.

Measures & Links	2011-12	2012-13	2013-14	2014-15 Target	2014-15 Actual	2015-16 Target	Rating	What this means
• Temporary accommodation	88%	80%	77%	**95%**	**86%**	**95%**	**Red**	Although we did not meet the 95% target, we increased our performance by 9 percentage points since year end 2013/14. The annual number of cases has fallen since 2010/11 and during the period Jan-March 2015 there were 44 cases recorded. Given the ongoing close scrutiny of individual cases by management, it is anticipated that performance will continue to improve.
Temporary accommodation:							**Green**	We have made excellent progress in relation to this indicator over the last 12 months, decreasing the average number of days spent in unsuitable accommodation by 60% at Q4.
Households with pregnant women or dependent children in B&B:								
• Average length of tenancies ended	14 days	16 days	15 days	**<10 days**	**6 days**	**<10 days**		
Temporary furnished accommodation:								Although we did not meet our target at year end, the average length of tenancy in temporary furnished accommodation decreased by 15% compared to year end 2013/14. The availability of permanent/supported accommodation for homeless people remains a major challenge.
• Average length of tenancies ended	215 days	211 days	242 days	**<140 days**	**205 days**	**<140 days**	**Red**	

Section 6 - Benchmarking

The Local Government Benchmarking Framework (LGBF) was approved by the Operational Delivery Scrutiny Committee on 22 May 2014. The LGBF is used by Audit Scotland to compare all 32 Scottish local authorities against a suit of statutory performance measures used by Audit Scotland to understand how the Council is performing in its duty to deliver Best Value.

Listed below are the indicators that relate to Social Work Services:

	Data	Indicator Description	National Position 2014
Children's Services	CHN8a	The cross costs of "Children looked After" in Residential Based Services per Child per week	The national average weekly cost per looked after child in a residential setting is £2928. Glasgow City Council is currently sitting around this cost.
	CHN8b	The cross costs of "Children looked After" in Community Setting per Child per week	National figures show there is a wide variation of costs. Therefore, until we can measure outcomes there is currently on method of linking spend to results.
	CHN9	Balance of Care for looked after children: % of children being looked after in the Community	Over the last 3 years, Glasgow City Council has sat at the national average which is approx 85% to 90% of children being looked after in the community over the past 3 years.
Adult Social Care	SW1	Older Persons (Over 65) Home Care Costs per Hour	Measuring costs against age structure does not provide enough information. Work still has to be done to consider the needs profile of the local population.
	SW2	Self Directed Support spend on adults 18+ as a % of total social work spend on adults 18+	The national spend on self directed support between 2010/11 and 2012/13 improved by 4.3%. Over the same period Glasgow City Council had a growth of 28.5%.
	SW3	% of people 65+ with intensive needs receiving care at home	Glasgow City Council is currently sitting above the national average of 34% in 2012/13, but this is related to effective practices to improve outcomes for older people.
	SW4	% of Adults satisfied with social care or social work services	Further work required on this measure.

Social Work Service is a member of the Health and Social Care Benchmarking Network (formerly known as the Scottish Community Care Benchmarking Network), and engages with quarterly meetings to review practice, policy and outcomes with colleagues from other authorities.

Audit and Inspection

Social Work Service has an ongoing programme of internal audit and self evaluations; in addition there are external inspections carried out on parts of the service.

Audit/ Review/ Self Evaluation / External Inspection	Service Area	Completion Date
Self Evaluation	Staff Supervision	Completed January 2015
Audit	South Residential care discharges	Completed sept 2014
Audit	Older people at home into advanced age	Completed Feb 2015
Audit	Permanence planning for children	Autumn 2014 Completed
Audit	Working with providers of Unpaid Work	April 2015 Completed
Audit	Social Work Practice in Unpaid Work	May 2015
Self Evaluation	Families for Children (stage 1) Families for children (stage 2)	April 2015 Dec 2015
Joint Inspection by Care Inspectorate and Healthcare Improvement Scotland	Joint inspection of Social Work and Health Services for Older People	Completed May 2015
Peer Review	Child Protection chairs, Quality of case conferences	Completed Dec 2015
Multi agency Self Evaluation	Adult Support and Protection Self Evaluation (ASP Committee)	Ongoing
Multi agency Self Evaluation	Pre Birth Child Protection (CP committee)	Ongoing

Equality Outcomes

The table below lists all Equality Impact Assessments (EQIA's) completed during 2014/15:

SWS Business Area	Completion Date
Review of Addictions Services	Dec 2014
Review of Homelessness Services	Dec 2014
Mobile Working	Dec 2014
Personalisation Framework	Dec 2014
Reduction in Spend on Purchased Residential Care	Dec 2014
Review of Mental Health Services	Dec 2014
Review of Transport	Dec 2014
Integration Scheme Between Glasgow City Council and NHS Greater Glasgow and Clyde	Jan 2015
Homelessness Strategy 2015-2020	March 2015

Section 7: Service Reform, Budget Change and Investment

7.1 Service Reform

Framework Tender Process for Personalisation
Development of an approach to commissioning and contract managing third party care and support services that are fit for the future of Social Care and tie in with the philosophy and aims of Personalisation. The overall intention is to provide a mechanism to allocate work/contracts amongst providers on the framework which is transparent, efficient, person centred and which meets procurement rules.

Strategic review and reform of Addiction Commissioned Services
The renewed Alcohol and Drug Partnership strategy, Community Addiction Team review, and integration agenda provides an effective catalyst to change the addiction service, and the pursuit of prevention, earlier intervention and recovery. Securing such outcomes will improve the effectiveness of the addiction service and assist local communities to promote recovery and break the cycle of deprivation.

Strategic review and reform of Homelessness Services
This will include a review of the supply, access to, and management of permanent and temporary accommodation for homeless households within the city, and identification of approaches which enables the Council to fully deliver on its statutory responsibilities. We will review and reform all directly provided homelessness services to deliver a modern, community based model with focus on prevention, throughput and purposeful interventions, and review all purchased services to ensure that this support complements the wider role of Social Work Services.

7.2 Service Budget Change Summary 2015 - 16: Service Reform

Budget Change Summary: Service Reform					
Ref	**Title of Proposed Service Change**	**Reason for Change (e.g. Savings Proposal/Service Reform/Income Generation etc)**	**Council Strategic Plan Priority/ SOA Theme Link**	**Financial Impact**	**Personnel Implications**
				2015/16	**2015/16**
15SW15	Framework Tender Process for Personalisation	Service Reform	A City That Looks After Its Vulnerable People	£1,000,000	none
15SW17	Strategic review and reform of Addiction Commissioned Services	Service Reform	A City That Looks After Its Vulnerable People	£800,000	none
15SW19	Strategic review and reform Homelessness Services	Service Reform	A City That Looks After Its Vulnerable People	£500,000	none
			Total	**£2,300,000**	**none**

Glasgow City Council Social Work Services

Complaints Report April – September 2014

Index:

Section 1 Executive Summary

1. Executive Summary

1.1 Volume has risen since 2013-14 with 326 formal complaints in the period 1st April – 30th September 2014, leading to a projected annualised total of 652 as against 601 in 2013-14. 10% of these are second stage reviews of complaints. It is estimated that this represents a complaint rate of 0.82% of the client base for the full year but if accounting for multiple instances of complaints by the same person, this falls to 0.69%

1.2 Performance against an internal 15 working day target for response has improved from the 66% achieved in 2013-14 to 74%, against a target of 65%. Performance against a statutory deadline of 28 calendar days is at 88% against a target of 85%, unchanged from 2013-14.

1.3 There are variations in volume and performance against timescale between areas. South and North East teams had a higher number of complaints than North West, though the volume for North East was skewed by multiple complaints about a single issue (the departure of an addictions worker from a project). Although North West upheld a higher proportion of complaints, their lower overall volume means that they upheld fewer in absolute terms than the other two areas. North West performed least well against timescales and the reason appears to lie with a specific client group (OPPD).

1.4 Homelessness have improved their meeting of timescales since 2013-14, as has South. Direct Services had a quite poor performance, though this is based on small numbers and there are additional requirements around responding to looked after and accommodated young people. However it was actually within older person's residential care that the poorest performance was found.

1.5 The proportions of complaints as analysed by issue, service area, client group and outcome were all skewed by a very high number of complaints received around the single issue of the introduction of a client contribution for older persons day care in May 2014. This led to 35 formal complaints (10.7% of total).

1.6 For the first time in a decade complaints generated by the children and families client group was not the highest proportion of complaints. It accounted for only 29% of all complaints as against 46% in 2013-14. Whilst it may be premature to speculate on only 6 months of figures, this may be a genuine fall in complaints for this client group as a result of investment and initiatives in those services.

1.7 Far fewer complaints were upheld or partially upheld than had previously been the case - only 23%. Though more likely to be the subject of complaint, complaints about the actions of staff are marginally less likely to be upheld than those about general issues of service quality.

1.8 Issues around Self-Directed Support continues to account for approximately 10% of all complaints. Complaints around Free Personal Care and Kinship Care have however fallen.

1.9 There were four stage 3 complaints review committees completing the process in the reporting period. Only one of these was upheld in any aspect and that was the minor matter of the failure to respond to a single letter amongst many from the complainant.

1.10 Of the 31 complaints that were upheld, all but two resulted in some service improvement. The types of service improvements implemented were at the level of individual interventions in the cases rather than service-wide changes to policy or procedure. The specific improvements are listed.

Section 2 Complaints process, report format and data quality issues

Social Work Services operates a separate complaints procedure from that used by other GCC Services. Those other services use a model Complaints Handling Procedure (CHP) established by the Scottish Public Services Ombudsman (SPSO) introduced in 2013. That process has three stages of early resolution (5 working days), formal investigation (20 working days) and review by SPSO. Social Work Services continues to use a statutory process set out in section 5B of the Social Work (Scotland) Act 1968 and statutory directions (1996). The status of this statutory process had been reviewed by a number of bodies over the past few years but cannot be amended locally in any essential element until such time as the statutory framework is repealed and replaced, for which there is currently no firm timescale.

The Social Work process consists of four stages. Stage 1 is investigation and response, usually carried out by the Head of Service or delegated by them within a statutory timescale of 28 calendar days. Stage 2 is internal review within the same timescales as for stage 1, usually carried out by the central social work complaints team. This stage is permitted but not mandatory within directions. Stage 3 is a review by independent complaints review committee. This must report findings and recommendations into a relevant council committee overseeing social work matters and presently reports to Operational Delivery Scrutiny Committee. It may comment on and make recommendations with regard to decisions and practice as well as matters of service quality. Stage 4 is a referral to the Scottish Public Services Ombudsman. This body is currently prohibited from making findings on matter of professional social work decisions and practice but may reach findings on matters to administration, process and quality of services.

In this report figures are given on performance against timescales for stages one and two. This includes reporting against a target of responding within 15 working days as well as the statutory 28 calendar day timescale. This is not a statutory requirement but was the standard response time for all Council complaints under the previous council-wide process. Social Work Services have retained this as an internal performance target throughout 2014-15, though this is currently under review following an audit conducted in late 2014.

An overview will also be given of stage 3 complaints – i.e those referred to Complaints Review Committee, although these are arranged and supported by Committee Services. SPSO referrals continue to be mainly dealt with by the office of the Chief Executive for all Council services and are reported though the complaints reporting of Chief Executive Department.

Social Work Services does not use the Lagan system used by al other services but continues to use the internally developed ‘C4’ (Council Compliments, Comments and Complaints) system, which has no appreciable reporting function. The data in this report is produced by manually coding or recoding complaints records within the C4 system which have been downloaded as raw data into an Excel Spreadsheet. There is therefore room for error in both the initial data entry and the coding exercise. As much care as possible has been taken to reduce error and inconsistency but some of the complexity of complaint has been lost in this process. Social Work complaints are often complex and a single complaint may concern different parts of the service and multiple issues. In producing these figures judgement has been exercised as to what the main service and issue of complaint has been within such multi-dimensional complaints.

Complaints figures are given by overall activity, timescales, client group, issue and outcome. Within each section the figures are given first for SWS as a whole and then by each sector of the service – Centre, Direct Services, Homelessness, North West, North East and South Areas.

It may appear questionable that total activity should subsume counts of complaints at the second or third stage as opposed to measuring only the number of unique complaints within an end-to-end process and this may be taken as ‘double counting’. There are however sound reasons for compiling statistics in this manner as follows:

1. Technical constraints: The C4 database is a flat structured database with a new record for each complaint stage. The system is not capable of storing multiple complaints against a single individual or multiple stages of a single complaint within the same record.
2. Data integrity: A complaint may arise in one reporting period and subsequent stages in a different period. If dealt with only as attributes of the original complaint then these further stages would either not be counted at all or the entire complaint would necessarily be counted twice, but not consistently, as it would depend on the reporting period in which it falls. In addition, in reporting trends one must count complaints on the same basis each and every year.
3. Accurate measurement of activity: One of the purposes of recording and reporting complaints is as a measure of activity and workload for the teams involved. Second and third stage complaints involve considerable work and it is important to capture this as an activity in its own right.
4. New issues: Unlike straightforward complaints in other council services about a single incident such as an incorrect bill or an unaddressed fault, social work complaints tend to relate to ongoing involvements with clients and our complaints process is longer. Consequently it is usual, rather than the exception, that as a complaint progresses to the second or third stage then the complainer adds new issues such that certain aspects of the complaint are indeed a new complaint.

The above gives an overview of the complexity of reporting in this area. Commentary concerning the figures themselves is within the body of the report. Any questions on format or content of this report can be directed to the officer responsible for the complaints process: Jim Charlton, Principal Officer Rights and Enquiries, Service Modernisation, City Chambers East, 40 John Street Glasgow G1 1HL. Telephone 0141 287 8714. Email jim.charlton@sw.glasgow.gov.uk.

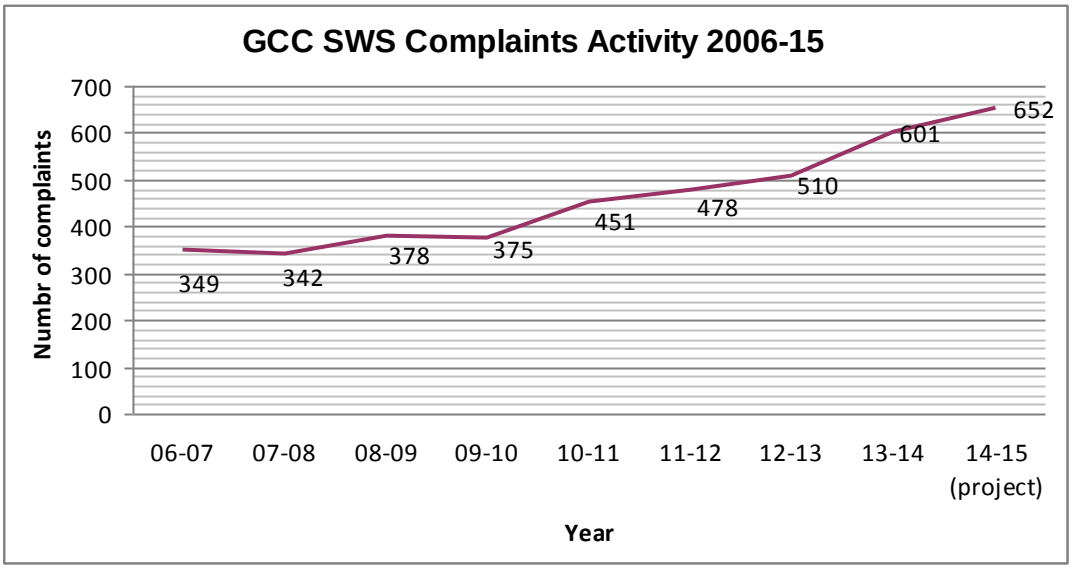
Section 3 Statistical Information and commentary

3.1 Activity and trends

There were a total of 326 formal complaints dealt with in the period 1st April to 30th September 2014: 288 at Stage 1, 33 Stage 2 reviews and 4 stage 3 committee hearings. There was also one complaint in respect of a vexatious complainer referred directly by SPSO to SWS.

When projected on a pro-rata basis for 2014-15 as a whole (should this trend continue) this represents an 8.5% increase on the previous year as part of a clear upward trend since the financial crisis of 2008-09 as chart 1 illustrates below.

Chart 1: Trend in complaints activity 2006 - 2015



Complaints as a proportion of client base

As of June 2014 (i.e. the midpoint of this reporting period) SWS had just over 50,000 active service users / open cases across different care groups. Over the whole of the year it is estimated that we will engage with 80,000 individuals (there had been 76,000 in 2013-14 and planning assumptions for 2014-15 predict a 5% rise).

Complaint numbers for this period were therefore around 0.65% of the client base (or 0.82% on a projected annualised basis for both complaints and clients). It should be borne in mind however that the reach of the service extends beyond clients to their relatives and other indirectly involved parties, many of whom are in fact the source of complaints. Though total numbers of such individuals cannot be accurately estimated, this clearly suggests that the above figures are the maximum figures for complaint expressed in terms of a proportion of those who have contact with our services and may complain.

It is also the case that some people submitted more than one complaint during this period. Through making multiple stage 1 complaints, or submitting both stage 1 and stage 2 complaints within the same reporting period. In all, 37 people submitted two complaints, 1 person three complaints, 3 persons four complaints and 1 person five separate complaints. That is to say 42 people generated 94 complaints. If one were to count unique complainers as opposed to complaints then the figure would be 274 as opposed to 326 or 0.55% for the period April-September (0.69% on a projected annualised basis).

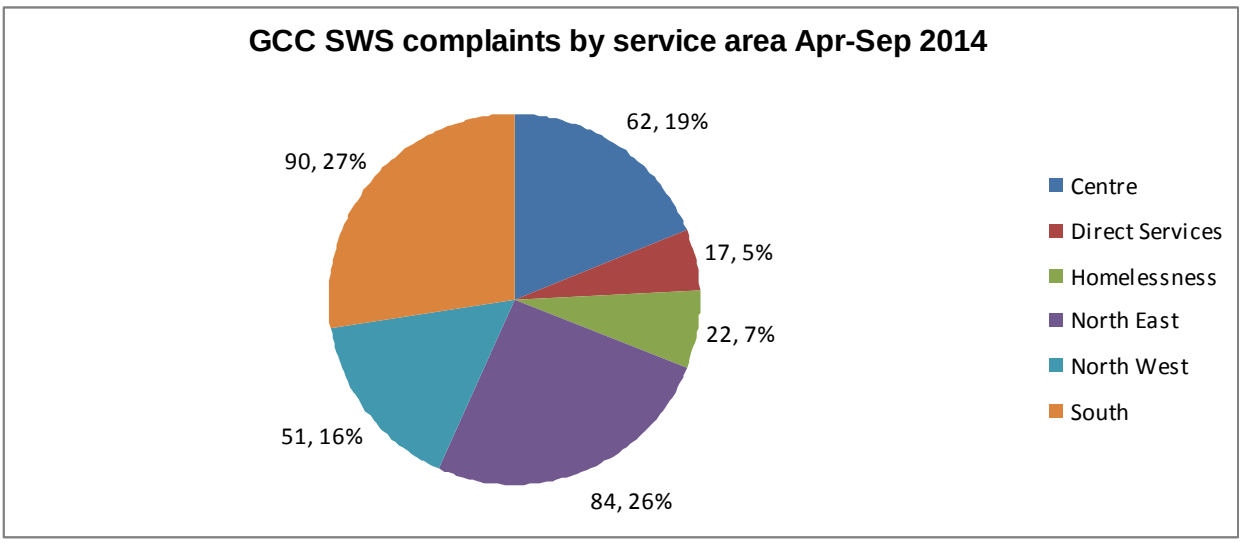
Complaints by service area

The proportion of all complaints that relate to each service area can be seen in table 1 and chart 2 below. Table one also gives a comparison with last year's figures.

Table 1: Complaints by service area April – September 2014 and comparison with 2013-14

	Complaints					
Area	Stage 1	Stage 2	Stage 3/4	Total	%	% 2013-14
Centre	53	8	1	62	19	4.7
Direct Services	17	0	0	17	5.2	5.5
Homelessness	21	1	0	22	6.7	8.3
North East	73	9	2	84	25.8	20.1
North West	46	4	1	51	15.6	25.5
South	78	11	1	90	27.6	35.9
Grand Total	288	33	5	326	99.9	100

Chart 2: Percentages of complaints by Sector April – September 2014



As can be seen there has been a significant upturn in complaints about functions located at centre. Complaints about services in the three main areas have shifted in that the proportions of complaints in South and North-West have fallen (this is partly a relative effect due to the proportionate rise in centre complaints) whilst those in North East have risen.

These phenomena are almost entirely explicable in terms of two complaints issues that each generated a large number of complaints:

1. Day Services Charges: There was a large influx of complaints about the introduction of a client contribution for older people attending day services. These complaints spanned Direct Services (because some of the services affected are council managed), adult services (because the strategic decision to introduce charges and reports to committee on the subject had been managed through that team) and Finance (as some complaints addressed specific billing issues and as this forms part of the general charging policy overseen by Finance). For purposes of statistical consistency and because this is essentially a financial issue, these complaints have all been coded against the finance team. Of the 326 complaints in this period, 35 (10.7% of total) related to this single issue.

2. The departure of a single worker: In North-East a specific worker left a project which provides support for person's with addictions. There were a large number of complaints which both praised the support this worker had offered and complained that because he was leaving the project and the clients felt they would not be so well supported in future. Of the 84 complaints submitted about North East services in this period, 10 (11.9% of North East complaints, 3.1% of total) were about the departure of this worker.

In addition to this, three of the five complainers who made in excess of two complaints were North-East Clients. That is to say three complainers were responsible for 11 of the North East complaints (13.1% of north East complaints, 3.4% of total). None of these complaints, nor the ones concerning the departure of the worker, were upheld.

Relative drops in complaints to other services are therefore largely explained by the relative rise in Centre and North East complaints due to these highly specific factors.

3.2 Timescales overall and by service area

Performance has recovered to a degree in terms of meeting timescales in the first two quarters of 2014-15 in terms of meeting the internal target of responding within 15 working days compared with 2013-14. The performance against the statutory deadline remains reasonably constant. Volumes of complaints continue to increase as highlighted above. The complaints team continued to experience staffing pressures. There is one grade 8 principal and two grade 7 senior officers within this team along with a grade 5 officer. One grade 7 left at the end of February and was not replaced until 1st September 2014. The other senior officer commenced maternity leave in November 2014 and is yet to be replaced. For much of 2014-15 therefore, including much of this reporting period, the team has been operating with only 75% of its full staffing complement. The internal performance targets of dealing with 65% of complaints within 15 working days and 85% within the statutory 28 day deadline have nevertheless been met during this six month period. Table 2 and chart 3 below illustrate this trend.

Table 2: Performance against 15 working day and 28 calendar day timescales 2006-15

Year	%15 WD	%28 Days
06-07	59	80
07-08	63	86
08-09	68	86
09-10	71	86
10-11	73	89
11-12	74	90
12-13	80	90
13-14	66	88
Apr-Sep 2014	74	88

Chart 3: Trend in complaints timescales 2006-14

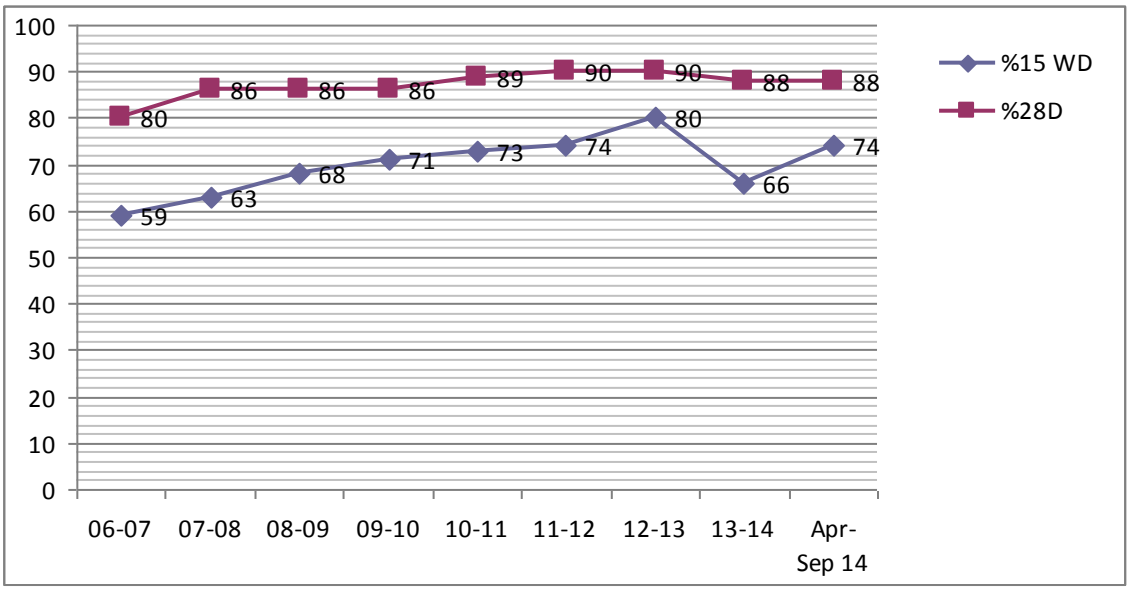


Table 3 shows the performance against these two timescales by sector for stage 1 and stage 2 complaints only. Poorest performance in relative terms can be seen in Direct Services (both targets) and in North West and South (15 day target).

Table 3: Performance against 15 working day and 28 day timescales by service area

	15 WD		28 days		
Area		%		%	Grand Total
Centre	49	80.3	54	88.5	61
Direct Services	5	29.4	6	35.3	17
Homelessness	18	81.8	21	95.5	22
North East	75	91.5	80	97.6	82
North West	34	68.0	41	82.0	50
South	57	64.0	80	89.9	89
Grand Total	238	74.1	282	87.9	321

As set out in the 2013-14 annual report, many complaints for Direct Services are from looked after and accommodated young people in residential or foster care. The procedure specifies that when looked after and accommodated children complain then there must be a meeting with the child at both the outset of complaint and after investigation is concluded. The logistics of arranging such a meeting can often put the response outwith timescales. However this service did respond to complaints within the statutory 28 day timescale in 73% of cases in 2013-14 so the fact that it did so in only 35% of cases in the first six months of the year is disappointing.

Of the 17 complaints for this service, 7 were in families for children (fostering and adoption) of which 5 were responded to within the statutory deadline, 6 were in children's residential care of which only one was responded to within the statutory deadline (perhaps reflecting considerations above) whilst 4 were within older people's residential services, of which none were responded to within timescale. This latter is an area that might be looked at as it does not have the same constraints around meeting clients.

South has actually improved its performance from 2013-14 (from 56% within 15 days to 64% and from 83% within statutory deadline to 89%).

Conversely North West has slipped marginally (72% down to 68% and 86% down to 82%) despite having markedly fewer complaints (50 in six months as opposed to 153 last year).

When analysing different client groups the issue appears to be with responding to complaints in a timely manner within the older persons and physical disability team. Whereas 2 of 3 addiction complaints were answered within time, 13 of 15 children and families, 4 of 5 learning disability, all 3 criminal justice and all 5 mental health complaints, only 15 of 20 OPPD complaints were within statutory deadline and only 12 of 20 within 15 working days. Of the five outwith statutory deadlines however three were delayed by less than a further 3 days and one by 10 days. This suggests an area requiring a little tightening up around deadlines rather than a major issue.

It was highlighted in the annual report that Homelessness had been operating on an incorrect basis due to a miscommunication such that they based their responses only on the 28 day target. This having been addressed, performance against the 15 day target has improved from 50% to 82% and performance against the statutory deadline has also increased.

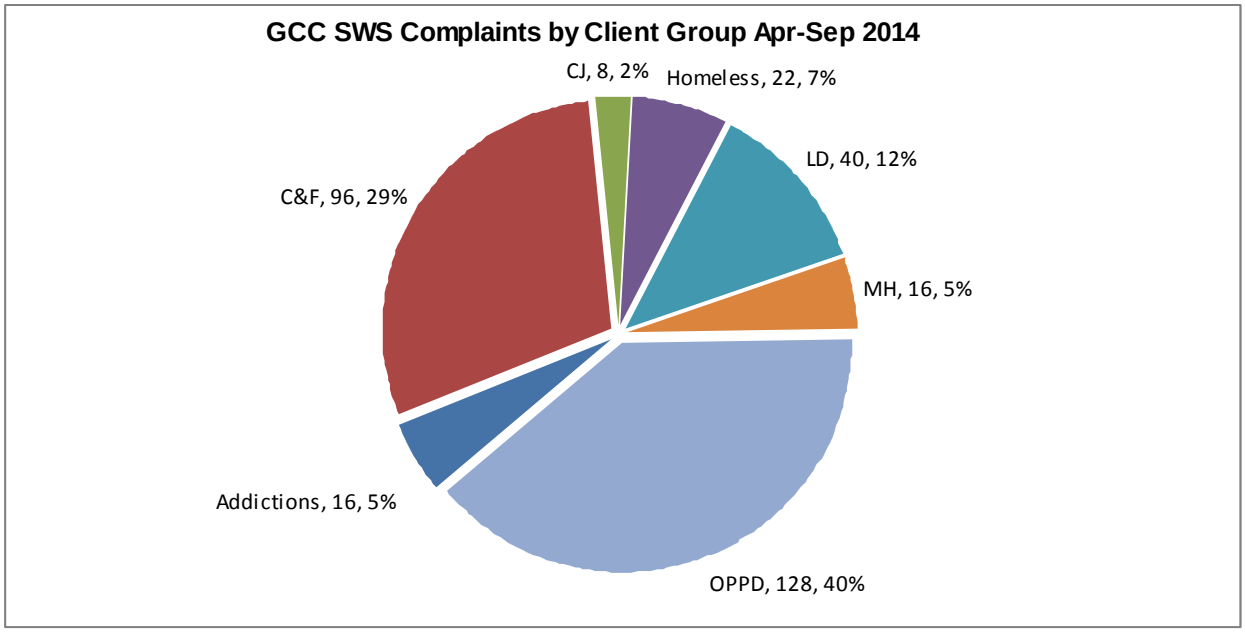
3.3 Complaints by client group overall and by service area

Chart 4 below illustrates a marked shift in the pattern from all other previous years. The largest proportion of complaints had always been generated by the children and families client group. This group has represented between 40 and 50% for complaints for at least the past 10 years . This group includes fieldwork in the three geographic areas and services delivered by Direct Services in terms of foster care, adoption and residential care.

This proportion of complaints in this group has fallen from 46% in 2013-14 to only 29% in the first two quarters of 2014-15. Whilst this is only for a 6 month period and has yet to be established as a real effect over the longer terms, the suggestion of such a marked drop in complaints is of interest. The individual records have been checked and this is a genuine effect, not a data quality or coding issue.

Conversely there has been a marked rise in complaints amongst the older persons and physical disability group from 26% to 40%. There have also been slight rises in mental health and learning disability.

Chart 4: Complaints by client group April – September 2014



There are two obvious reasons for the rise in complaint amongst the OPPD group - both financial in nature. All adult community care groups are now subject to Self-Directed Support. Complaints about the level of budget set through this process continues to be an issue of complaint, no longer restricted only to Learning Disability clients as was generally the case prior to 2012-13. This is however a relatively minor effect.

The main apparent reason for a rise in OPPD complaints is the same one that accounted for a marked rise in complaints at social work centre (finance). The introduction of client contributions towards cost of day services for older people, as of May 2014 has led to 35 (10.7% of total) complaints in this period. As this by definition is an issue only relating to the older person's client group then it has naturally skewed the figures one would normally expect to see.

It might therefore be thought that the proportionate drop in children's and family complaints is merely an artefact of the rise in OPPD complaints resulting from day service charges. In fact however the number of children and family complaints has dropped in absolute as well as proportionate terms.

For 2013-14 there were 274 complaints in this group. In the first six months of 2014-15 one might therefore expect something in the region of 130-140 complaint and this would be in line with previous years. The actual number of complaints however has only been 96. There are a number of possible explanations for this in terms of investment in children and families and initiatives to improve working practices such as the 'One Glasgow' approach, GIRFEC, the targeting of neglect within the child protection action plan or the focus on expediting permanency planning for children under 5 years of age.

Complaints within this group have tended to come from birth families rather than Looked After Children themselves. For example complaints about disrupted contact, contact expenses, the content of reports submitted to panel and review or the manner in which staff engage with birth families in a child protection context.

Any improvement in services which increases support to families, particularly at an early stage, or those that reduce the length of time in which the status of a child is unsettled and therefore the parents have more contact with and more opportunity to complain about social work staff, may be expected to reduce complaints.

However this is speculative and there is no clear explanation for the apparent drop in complaints from this client group.

Table 5 below illustrates the variation between the three Glasgow geographic areas, Centre and Direct Services in terms of proportional complaints by client group. Homelessness is omitted as clearly all homelessness work, and therefore all complaints, is amongst the client group 'homeless'.

Table 4: Comparison of complaints by client group and Service area Apr-Sep 2014

Service Area	Centre		Direct Services		North East		North West		South		Grand Total
Client group	N	%	N	%	N	%	N	%	N	%	
Addictions	0	0.0	0	0.0	12	14.3	3	5.9	1	1.1	16
C&F	2	3.2	13	76.5	30	35.7	15	29.4	36	40.0	96
CJ	1	1.6	0	0.0	0	0.0	3	5.9	4	4.4	8
LD	7	11.3	0	0.0	15	17.9	5	9.8	13	14.4	40
MH	2	3.2	0	0.0	4	4.8	5	9.8	5	5.6	16
OPPD	50	80.6	4	23.5	23	27.4	20	39.2	31	34.4	128
Grand Total	62	100.0	17	100.0	84	100.0	51	100.0	90	100.0	304

As can be seen the majority of complaint to centre were in the older persons and physical disability group, as a result of the high number of complaints to finance / adult services about the imposition of a client contribution for older person's day services in May 2014.

The 22 **homelessness** complaints largely comprised of complaints about community casework teams (15), with additional complaints about the Hamish Allan Centre / Emergency Accommodation (5) and the TADS team (Temporary Accommodation Development Service) (2). There were no complaints about the refugee and asylum team or prison casework throughcare teams in this 6 month period.

In terms of **centre** complaints, 46 of the 62 complaints were about Finance, again largely linked to day service client contributions. 1 was a criminal justice MAPPA matter, 1 concerned transport, 1 adult services on a policy matter, 4 were about Social Care Direct, and 9 about Service Modernisation which subsumes Welfare Rights, Supported Employment and the complaints team itself, all of which subject to complaint.

Direct Services complaints were few in number (17) but those that were received were largely around the children's residential (6) and fostering and adoption teams (7) rather than older person's residential services (4). The low numbers may be surprising but it should be borne in mind that these are formal complaints. For residential care clients and their relatives also have the option of making formal complaints to the Care Inspectorate rather than Social Work Services. It may be that issues are either being raised and resolved informally within units or taken through a different route altogether.

Within the **three geographic Glasgow areas**, there continues to be some marginal variation but this differs from the pattern in 2013-14. South now has a comparatively higher proportion of children and family complaints than the other two areas, having had the lowest in 2013-14. Conversely North West has the highest proportion of OPPD complaints, having previously had the lowest. This may illustrate nothing more than the danger of looking for patterns in small numbers and it may perhaps be better in terms of trends in client groups to look across the whole data as above, when dealing with only six month's worth of data.

3.4 Complaints by issue overall and by service area

The main presenting issues have been categorised under thirteen separate issue headings as set out below. Secondary issues are also recorded such that the number of issues exceeds the number of complaints. Complaints with more that two presenting issues are summarised only in terms of the main two issues.

The relevant headings are as follows:

P = A policy issue

F = A financial Issue

C = Staff personal performance issues subdivided as:
C1 – Attitude or conduct of staff
C2 – Lack of response to the customer
C3 – Poor information or communication / information errors
C4 – Breach of confidentiality / privacy
C5 – Discrimination or breach of human rights

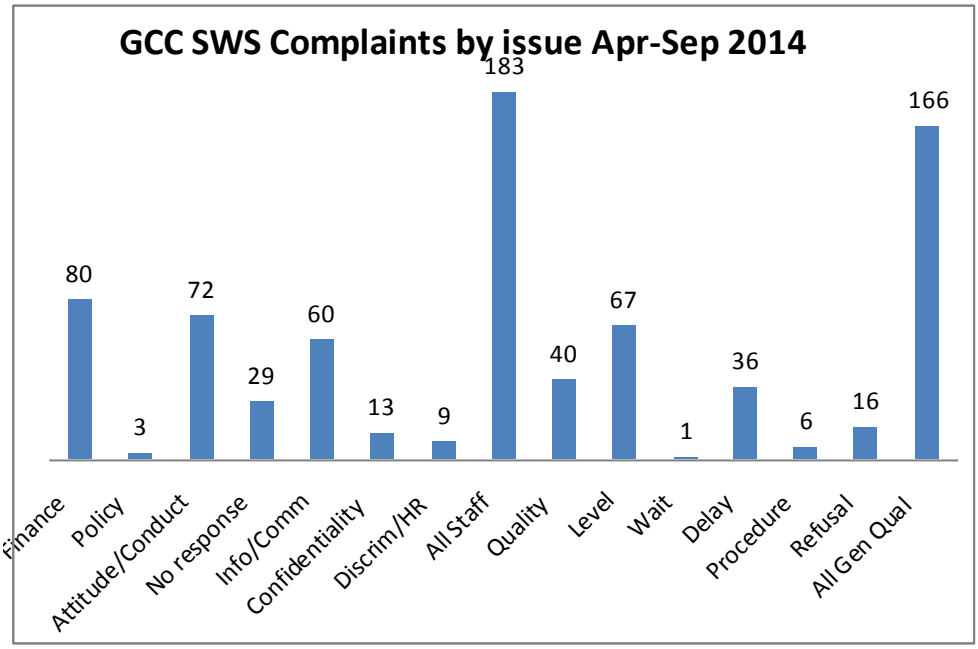
Q = General Service Quality issues subdivided as:
Q1 - Poor quality of service
Q2 – Poor level or quantity of service
Q3 – Short terms waiting issues e.g waiting to be seen at an office
Q4 – Long terms delays e.g waiting lists for assessment.
Q5 – Procedures not being correctly followed (by the whole team as opposed to a personal conduct issue).
Q6 – Refusal of service / not eligible for service / service withdrawn

Table 5 below shows the relative percentage of each of these issues as a percentage of all issues. Charts 5 and 6 show separately overall numbers of complaints about those issues and the proportions for ease of reference.

Table 5: Main issues complained of Apr-Sep 2014

Issue	N	%	% 2013-14
Finance	**80**	**18.5**	**8.8**
Policy	**3**	**0.7**	**2.2**
Attitude/Conduct	72	16.7	26.6
No response	29	6.7	7.9
Info/Comm	60	13.9	10.0
Confidentiality	13	3.0	1.9
Discrim/HR	9	2.1	0.6
All Staff	**183**	**42.4**	**47.0**
Quality	40	9.3	13.8
Level	67	15.5	11.0
Wait	1	0.2	0.4
Delay	36	8.3	8.2
Procedure	6	1.4	5.5
Refusal	16	3.7	3.1
All Gen Qual	**166**	**38.4**	**42.1**
Total of main issues	**432**	**100.0**	100.0

Chart 5: Numbers of complaints by issue complained of Apr-Sep 2014

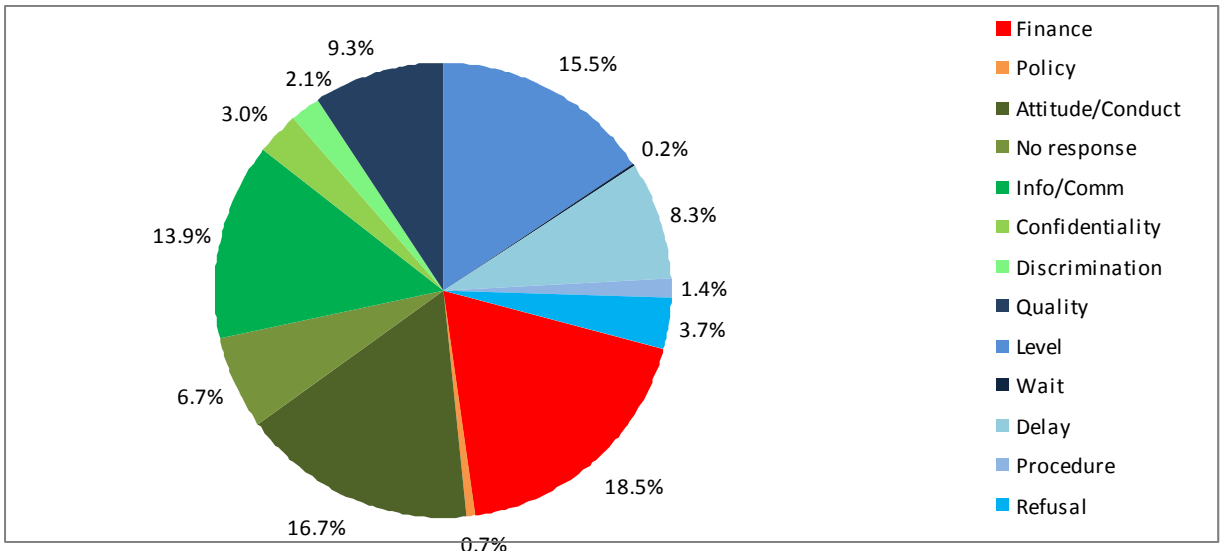


Complaints about issues attributable to the actions of individual staff (such as poor information, communication, not responding to service users or criticisms of their individual action or attitude) are slightly greater than complaints about general service quality (such as delays, poor quality or level of service or services being refused or withdrawn) . Both are however proportionately lower than in 2013-14, largely due to the sharp rise in complaints about finance issues, as highlighted above stemming from the issue of day service charges. Adjusting for this factor there is little difference in absolute terms between the pattern of issue complained about in this reporting period and those complained about in 2013-14, with two exceptions as highlighted below.

There is a noticeable drop in complaints about the personal conduct and attitude of staff. This is most likely attributable to the lower number of children and family complaints where, as highlighted in the 2013-14 annual report, families of children who have been taken into care tend to personalise their complaint issues.

There was a relative rise in complaints about discrimination or human rights being breached. Although these are still few in number this is clearly a sensitive and important area so all nine complaints have been individually analysed. None of these complaints were upheld. Three were from men complaining of being discriminated against by female workers (two of these from the same man). One was a foster carer claiming her human rights were being breached in being de-registered. One was a person objecting to the policy of not paying relatives to care for their family, claiming this breached her right to family life. Two were claims of discrimination on grounds of disability and two of racial discrimination.

Chart 6: proportions of complaints by issue complained of Apr – Sep 2014



Some specific issues complained of included the following:

- The high volume of complaints about day service charges (35 or 10.7%) and about the departure of a single worker from an addictions support project in North East Glasgow (10 or 3.1%). The latter will not recur. The former will continue to work through the second half of 2014-15 in terms of one or two additional complaints as well as stage 2 and stage 3 reviews of the complaints in the current period.

- 34 (10.4%) complaints about some aspect of Self-Directed Support, usually the level of budget awarded. This is slightly higher than for 2013-14. As highlighted above this is not unexpected considering that finances remain tight and Self-Directed Support continues to roll out to ever greater numbers of clients.

- 4 (1.2%) complaints about Free Personal Care for self-funding elderly persons in care homes and either delays in making this award or refusal to accept the person as ordinarily resident. This is slightly lower than in 2013-14

- 4 (1.2%) complaints from kinship carers regarding lack of contact, support or financial assistance. This is much lower than in 2013-14 suggesting the issues are being resolved.

- 15 (4.6%) of complaints from looked after and accommodated children or care leavers. The latter group most often complaining about lack of support, including financial support and the former about conditions in residential care. This included the actions of other

young people and the degree to which staff intervened to control disruptive behaviours. This is almost identical to the pattern in 2013-14

3.5 Complaints by outcome overall and by service area

Table 6 and Chart 7 below show the outcomes of complaints in terms of whether they were upheld. Only a minority of around 23% of complaints are upheld or partially upheld. 58% are not upheld and the remainder are either withdrawn, informally resolved, not accepted as having any valid locus or transferred to other processes such as claims, litigation, disciplinary fact finding, child or adult protection procedures or complaints procedures of other organisations.

This is the lowest proportion of complaints upheld or partially upheld that has ever been reported and is 7% lower than the equivalent figure for 2013-14. This is partly because none of the complaints about day service charges were upheld and nor were any of those about the worker leaving in North East. This in turn is because the application of a client contribution towards costs of older person's day charges forms part of the formal charging policy of the council, approved by the relevant Council committee, and most service users were simply complaining about being charged, rather than highlighting within their complaints any genuine issues about errors in the handling of their case or poor quality of service. The departure of the staff member was unfortunate but unavoidable and not a matter of fault on the Council's part.

Table 6: Complaints Outcomes Apr-Sep 2014

Outcome	N	%
Informally Resolved	6	1.8
Withdrawn	3	0.9
Transfer To Other Process	13	4.0
Not Accepted	40	12.3
Not Upheld	189	58.2
Partially Upheld	43	13.2
Upheld	31	9.5
Grand Total	325	100.0

Chart 7: Complaints Outcomes Apr – Sep 2014

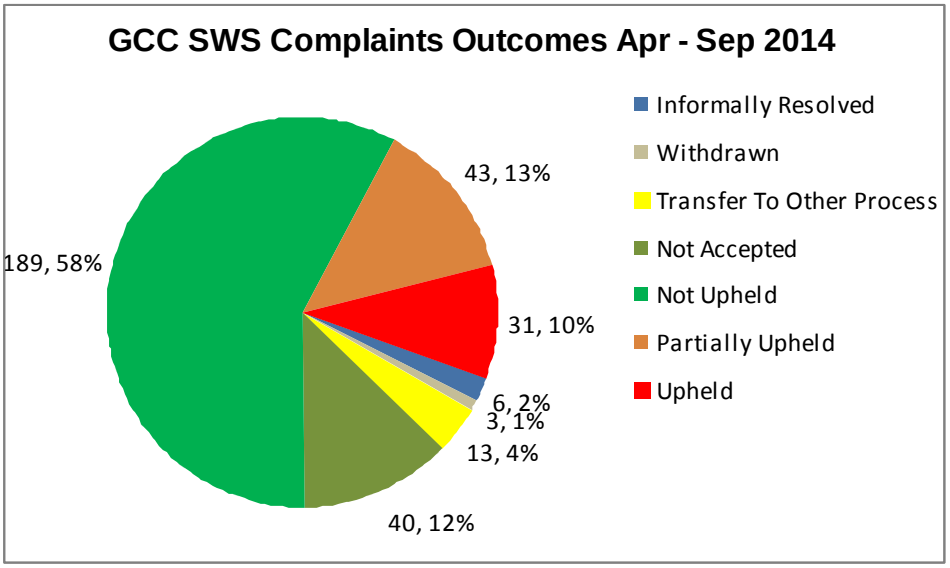


Table 7 shows complaint outcomes by area. Caution should be applied in interpreting what are relatively small numbers but it is reasonably clear that there is variation between service areas as to the proportion of complaints upheld or partially upheld and that this is broadly equivalent to the figures for the whole of 2013-14.

Direct services are more likely to be upheld or partially upheld than elsewhere, having the highest figure at 52.9% and previously having had the highest figure for 2013-14 at 36.4%. South and North East have the lowest proportion upheld or partially upheld at 17.8% and 19% respectively and again had the lowest proportion upheld by in 2013-14 at 28.8% and 28.9% respectively. The balance of upheld complaints in North West (24%) and Homelessness (36.4%) are broadly consistent with 2013-14 figures of respectively 30% and 32%. It is not worth considering Centre complaints due to the distorting effect of the high number of (not upheld) complaints about older persons day service charges in Centre Finance.

It is also worth pointing out that whilst North West has the highest proportion of complaints upheld, it has the lowest absolute number of complaints upheld as it has far fewer complaints to begin with than the other two Glasgow areas. This was not the case in 2013-14 when the lowest absolute number of upheld of partially upheld complaints was in North East, the greatest number in South and North West fell between the two.

Table 7: Complaints Outcomes by Service Area Apr-Sep 2014

Area	Centre		Direct Services		Homelessness		North East		North West		South		Total
Outcome	N	%	N	%	N	%	N	%	N	%	N	%	
Informally Resolved	0	0.0	2	11.8	0	0.0	2	2.4	1	2.0	1	1.1	6
Withdrawn	0	0.0	0	0.0	1	4.5	1	1.2	0	0.0	1	1.1	3
Transfer To Other Process	3	4.8	0	0.0	0	0.0	3	3.6	1	2.0	6	6.7	13
Not Accepted	3	4.8	2	11.8	2	9.1	12	14.3	11	22.0	10	11.1	40
Not Upheld	43	69.4	4	23.5	11	50.0	50	59.5	25	50.0	56	62.2	189
Partially Upheld	8	12.9	3	17.6	6	27.3	9	10.7	7	14.0	10	11.1	43
Upheld	5	8.1	6	35.3	2	9.1	7	8.3	5	10.0	6	6.7	31
Grand Total	62	100.0	17	100.0	22	100.0	84	100.0	50	100.0	90	100.0	325

Table 8 below shows complaint outcomes by client group. Again caution should be used in interpreting small numbers but the proportion of each client group complaints upheld or partially upheld are broadly in line with previous figures for 2013-14 only in the case of Children and Families and Homelessness complaints. By contrast those in criminal justice, addictions, learning disability and older persons / physical disability have all dropped markedly. CJ 0% from 28%, Addictions 6% from 24%, LD 23% from 41% and OPPD 22% from 32%. This may be in part due to the higher number of complaints about financial matters but the cause of this is otherwise not apparent.

Table 8: Complaints Outcomes by Client Group Apr-Sep 2014

Client group	Addictions		C&F		CJ		Homeless		LD		MH		OPPD		Grand Total	
Outcome	N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Informally Resolved	0	0.0	3	3.1	0	0.0	0	0.0	0	0.0	0	0.0	3	2.4	6	1.8
Withdrawn	0	0.0	1	1.0	0	0.0	1	4.5	0	0.0	0	0.0	1	0.8	3	0.9
Transfer To Other Process	1	6.3	6	6.3	1	12.5	0	0.0	1	2.5	0	0.0	4	3.1	13	4.0
Not Accepted	1	6.3	12	12.5	1	12.5	2	9.1	6	15.0	7	43.8	11	8.7	40	12.3
Not Upheld	13	81.3	51	53.1	6	75.0	11	50.0	24	60.0	4	25.0	80	63.0	189	58.2
Partially Upheld	0	0.0	13	13.5	0	0.0	6	27.3	8	20.0	4	25.0	12	9.4	43	13.2
Upheld	1	6.3	10	10.4	0	0.0	2	9.1	1	2.5	1	6.3	16	12.6	31	9.5
Grand Total	16	100.0	96	100.0	8	100.0	22	100.0	40	100.0	16	100.0	127	100.0	325	100.0

Table 9 below shows complaint outcomes by client issue. The totals will be different for previous tables as this is counting the outcomes of issues, not of complaints. The count of issues exceeds the count of complaints. The figures are consistent with figures for 2013-14 in that complaints about staff are marginally less likely to be upheld that complaints about general issues of service quality.

Table 9: Complaints Outcomes by issue Apr-Sep 2014

Issue	Financial		Policy		All Staff		All Gen Qual		Grand Total	
Outcome	N	%	N	%	N	%	N	%	N	%
Informally Resolved	3	3.8	0	0.0	3	1.6	1	0.6	7	1.6
Withdrawn	1	1.3	0	0.0	1	0.5	2	1.2	4	0.9
Transfer To Other Process	0	0.0	1	33.3	11	6.0	2	1.2	14	3.2
Not Accepted	2	2.5	0	0.0	28	15.3	20	12.0	50	11.6
Not Upheld	55	68.8	2	66.7	93	50.8	94	56.6	244	56.5
Partially Upheld	14	17.5	0	0.0	29	15.8	26	15.7	69	16.0
Upheld	5	6.3	0	0.0	18	9.8	21	12.7	44	10.2
Grand Total	80	100.0	3	100.0	183	100.0	166	100.0	432	100.0

3.6 Stage 3 Complaint Review Committees

There were four complaints that progressed through the stage 3 process of review by committee in the period April – September 2014. One in fact was heard in the last week of February 2014 but had not completed the process by the end of March 2014 as it had not yet been referred to Operational Delivery Scrutiny Committee and so was not captured within the previous reporting period. The others were heard in July, August and September 2014.The four complaints were as follows:

1. A complaint about the conduct and attitude of staff towards Mr M, a man whose children are in care. There were 8 separate focus of complaint including allegations that staff had falsified information and were discriminating against M on the basis of prejudice against him due to the age difference between M and the mother of the children. None of these complaints were upheld by committee.

2. A complaint concerning a child protection investigation focussed on Ms M and her child. Ms M submitted 5 separate focus of complaint including that reports contained inaccurate, out of date or deliberately falsified information concerning Ms M and that staff had not progressed the investigation in a reasonable timescale or following the proper process. None of these complaints were upheld by committee.

3. A complaint by Mr T the 'para legal' representative of a client concerning the finance team's pursuit of outstanding money which SWS maintained had been inappropriately spent by the client from her direct payment account without the required records having been submitted, The complaint asserted that SWS had been insufficiently clear as to what evidence it required, why this was required and in what way the client was in breach of contract. He also made complaints about the manner in which his complaint had been responded to and a failure by the finance team to answer his correspondence. None of these complaints were upheld with the exception of the complaint about unanswered correspondence, which was partially upheld on the basis that one of a large number of letters from T had not been responded to. The remaining letters had been responded to.

4. A complaint by Mr B that SWS were not taking sufficient steps to prevent his granddaughter from risk of harm in a shared supported living arrangement with another service user. There were five focus of complaint including that his concerns for his granddaughter's safety had not been properly investigated, that SWS had withheld information from him, had not told him of an incident in a timely manner and that they had failed to minute a meeting with the support provider. None of these complaints were upheld by committee.

3.7 Service Improvements

Of the 31 complaints that were fully upheld, all but two of them resulted in some further action and improvement in provision of service for the client. The types of service improvements implemented were at the level of individual interventions in the cases rather than service-wide changes to policy or procedure. This is likely to be the case for complaints that are often of a highly individual, complex and specific nature.

The kinds of improvements that took place at an individual level were:

- Financial: Seven service users had their financial information updated to prevent various billing errors and amounts credited to them or paid into their accounts.
- A disabled service user had £10,000 paid from GCC to the independent Living fund (ILF) to compensate for an error made by GCC, which then allowed GCC to negotiate with ILF and have the clients frozen ILF payments reinstated for the future.
- Five service users had workers allocated to their case to carry out assessments and take them off waiting lists
- One elderly client had mainstream homecare reinstated that had previously been withdrawn and another was given new bathroom aids. A third was offered a place in a local authority care home following an expedited assessment. A fourth was prioritised for allocation to a place in specialised day care.
- A father of a looked after child was found a more suitable venue for contact.
- Two homeless clients were immediately found temporary furnished accommodation and offered meetings with a senior manager to discuss their experiences.
- A number of looked after and accommodated children in residential units made complaints that led to allocation of new social workers in two cases, removal from the unit of other young people who were bullying the complainer in two instances and a special meeting set up to fully discuss a young person's needs in moving out of care in the final instance.
- Two young care leavers also complained. One was reimbursed for money they had spent on items that social work should have paid for and another had his special support services, which had been cancelled, extended for a further two months.

Only one wider improvement was instituted. Standard finance letters were amended to give better information as to how increases in charges would work in terms of service users paying by direct debit. In two other instances, within a children's residential unit and the sensory impairment team, complaints led to members of staff receiving further training around the issues complained of.

Item No 7

6th October 2015

Glasgow City Council / NHS Greater Glasgow and Clyde
Shadow Integration Joint Board

Report By: David Williams, Chief Officer Designate

Contact: Allison Eccles, Head of Business Development

Tel: 0141 287 8751

DRAFT STRATEGIC PLAN 2016-19

Purpose of Report:	To advise the Shadow Integration Joint Board of the publication of Glasgow's draft Strategic Plan for consultation

Recommendations:	The Shadow Integration Joint Board is asked to note this report

Implications for IJB	
Financial:	Budgets for delegated functions will transfer from the Council and Health Board to the Integration Joint Board upon the Strategic Plan taking effect
Personnel:	None
Legal:	The Integration Joint Board is required to have a Strategic Plan in place by 1 April 2016
Economic Impact:	None
Sustainability:	None
Sustainable Procurement and Article 19:	None
Equalities:	An Equalities Impact Assessment will be carried out on the final draft Strategic Plan before presentation to the Integration Joint Board
Implications for Glasgow City Council	Upon approval of the Strategic Plan, Council functions as outlined in the Integration Scheme are delegated to the IJB
Implications for NHS Greater Glasgow & Clyde	Upon approval of the Strategic Plan, Health Board functions as outlined in the Integration Scheme are delegated to the IJB

1. Purpose

1.1 To advise the Shadow Integration Joint Board of the publication of Glasgow's draft Strategic Plan for consultation.

2. Background

2.1 The Shadow Integration Joint Board were advised at its 11 August 2015 meeting of the intention to publish the draft Strategic Plan in September and invite comments ahead of the establishment of the Integration Joint Board and beginning of the formal consultation period.

2.2 It is now clear that the Integration Joint Board will not be formally constituted until December. There is therefore a significant risk that delaying consultation on the Strategic Plan until the Integration Joint Board is formally established will result in a significantly shortened period of consultation ahead of the statutory deadline of 1 April 2016 by which the Strategic Plan must be in place.

2.3 As the Integration Scheme is not yet agreed between Glasgow City Council and NHS Greater Glasgow and Clyde, in order to mitigate the risk outlined in 2.2 above it is necessary to begin the period of consultation on Glasgow's draft Strategic Plan ahead of establishment of the Integration Joint Board. This will allow the Integration Joint Board, when established, to consider a final draft Strategic Plan which has been subject to a substantial and wide ranging period of consultation in line with the principles of the Public Bodies (Joint Working) (Scotland) Act 2014.

3. Glasgow's Draft Strategic Plan

3.1 The draft Strategic Plan is appended to this report. The Plan has been revised following the last shadow IJB and the event held on 29 July 2015 attended by members of the Shadow Integration Joint Board, the Executive and Senior Management Teams, the six city-wide Strategic Planning Groups and other stakeholders.

3.2 The Plan has been drafted with due consideration given to clarity and accessibility. The final draft Plan will be submitted to the Plain English society ahead of submission to the Integration Joint Board, with a view to achieving a 'Crystal Mark' - the recognised seal of approval of the Plain English Society.

3.3 An Equalities Impact Assessment will be carried out on the Strategic Plan ahead of submission of the final draft to the Integration Joint Board, and appropriate action plans developed. Officers from the Council and Health Board have begun preparatory work on this.

4. Consultation

4.1 Consultation on the draft Strategic Plan will be wide ranging, encompassing all statutory consultees as defined in Regulations and other interested parties. Consultation will largely take the form of targeted email and briefings, stakeholder events and cascade through key partners.

4.2 The consultation period will run until the end of December 2015. This will allow sufficient time at the end of the consultation period to consider responses ahead of the final Strategic Plan being presented to the Integration Joint Board.

4.3 Feedback from the consultation will inform development of Action Plans for the Strategic Planning Groups, Localities and centre-based planning functions to support delivery of the vision of the Integration Joint Board and priorities identified by stakeholders.

5. Recommendations

5.1 The Shadow Integration Joint Board is asked to note this report.

Glasgow City HSCP
Health and Social Care Partnership

GLASGOW CITY INTEGRATION JOINT BOARD STRATEGIC PLAN 2016 - 2019

THE GLASGOW CITY INTEGRATION JOINT BOARD'S VISION

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

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

ABOUT THE STRATEGIC PLAN

This Strategic Plan for the delivery of health and social care services in Glasgow is prepared by the Glasgow City Integration Joint Board under the terms of the Public Bodies (Joint Working) (Scotland) Act 2014 ("the Act"). The Plan covers all topics which are required by the Act, along with a number of other relevant topics.

The Integration Joint Board is required by the Act to produce a Strategic Plan for how the functions delegated to it by Glasgow City Council and NHS Greater Glasgow and Clyde will be delivered. The Integration Joint Board is responsible for monitoring the delivery and performance of services by all partners including the Council and the Health Board, and may issue further directions if needed to ensure effective delivery in line with the Strategic Plan, making available whatever financial resources it deems appropriate from the budget within its control.

ABOUT THE INTEGRATION JOINT BOARD

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

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

The Glasgow City Integration Joint Board is a distinct legal entity created by the Scottish Ministers upon approval of the Integration Scheme[1].

[1] The Integration Scheme is the legal document which outlines at a high level the agreements that the Council and Health Board have made about how they will work together.

ABOUT THE INTEGRATION JOINT BOARD

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

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

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

ABOUT THE INTEGRATION JOINT BOARD

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

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

ABOUT THE INTEGRATION JOINT BOARD

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

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

ABOUT GLASGOW

Glasgow is a vibrant, cosmopolitan, award-winning city known throughout the world as a tourist destination and renowned location for international events. The city has been transformed in recent years, becoming one of Europe's top financial centres and developing remarkable business and tourism sectors, while the physical enhancement of our city has been dramatic. However, our challenges in addressing deprivation, ill health and inequality are significant and well documented. A lot of progress has been made in addressing these issues, but there is more to be done to ensure that there are opportunities for everyone in the city to live longer, healthier, more independent lives. We remain focussed on that ambition for the city.

Population

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

Estimates of Glasgow's population increase between 2012 and 2017 are:

- An overall population increase of 2.5%
- The number of children increasing by 2.4%
- The adult (aged 18-64) population increasing by 2.6%
- The population of older people aged 65+ rising by 1.8%

ABOUT GLASGOW

Deprivation

Glasgow City contains 3 in 10 of the 15% most deprived data zones[2] in Scotland. This is the highest proportion for a local authority. 116 of these data zones are in the North East of the city, while the North West has 83 and South has 89 of the most deprived data zones.

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

Health and Social Care Needs Profile

- Although increasing, life expectancy at birth in Glasgow is currently 72.6 years for males and 78.5 years for females (compared to the Scottish averages of 76.6 and 80.8).

- Around 8.7% of the Glasgow population live in 'bad' or 'very bad' health. With 31% of Glasgow's population, around 184,000 people, suffering with one or more long term health conditions.

- According to national estimates, around one in 25 people will be experiencing dementia by the age of 70, rising to almost one in five by the age of 80. Up to 4,500 people aged over 80 in Glasgow currently may be experiencing dementia.

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

ABOUT GLASGOW

- Just under a quarter (22.7%) of people in Glasgow believe that their day-to-day activities are limited in some way by a long term health problem or disability.
- Almost 2.7% of the population have some form of learning disability or learning difficulty.
- 7.8% of the population have a physical disability.
- Almost 6.9% of the population were recorded as having a hearing impairment and almost 2.5% of the population were recorded as having a visual impairment.
- It is estimated that up to 7,000 people in Glasgow have a form of autism.
- Around 9.3% of people in the City carry out unpaid caring duties.
- It is estimated that up to 75,000 people in Glasgow experience common mental health problems such as depression or anxiety, with around 6,000 people experiencing a more severe and enduring mental illness.

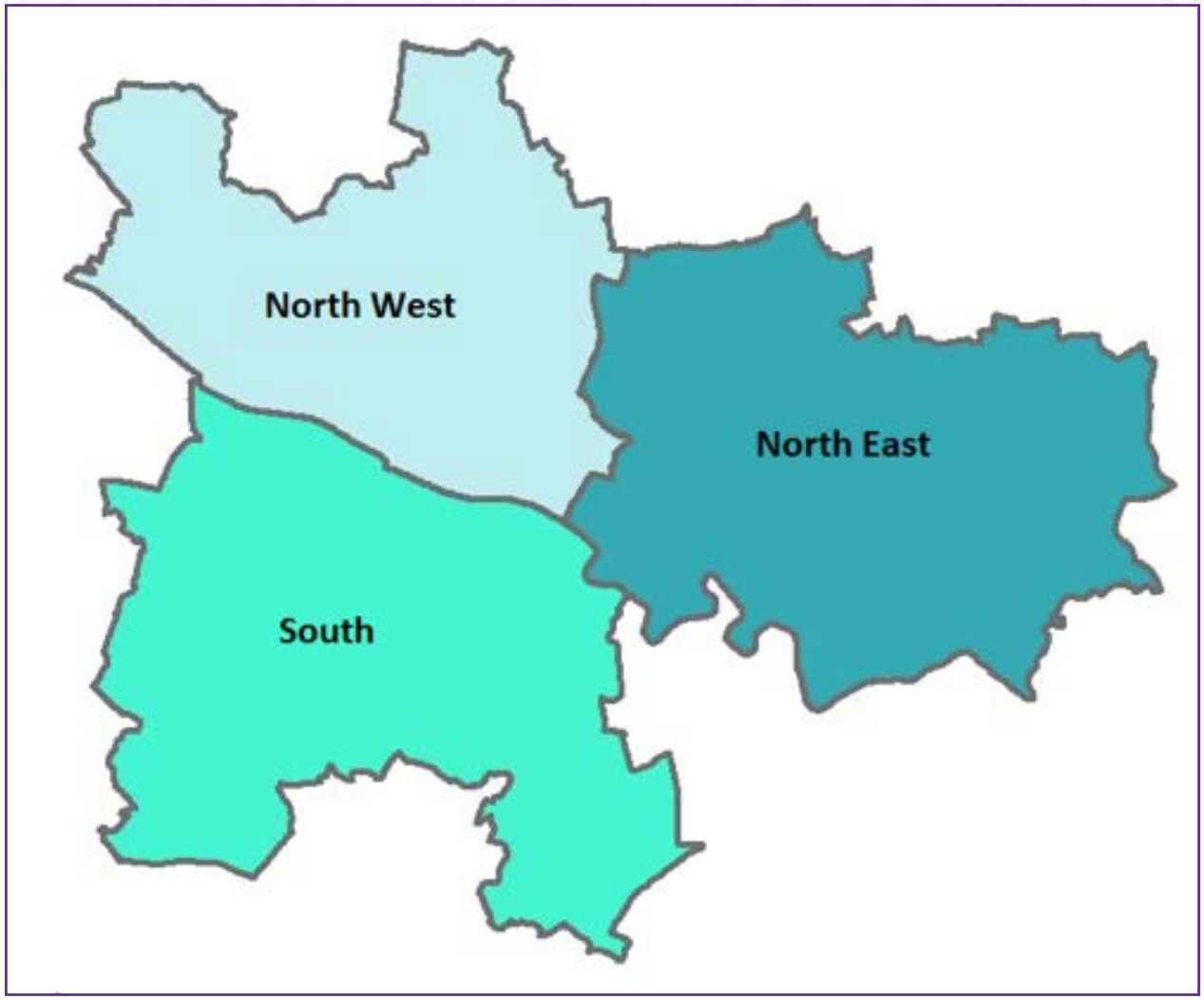
- Glasgow has over 69,000 residents estimated to be problem alcohol drinkers, and has the highest rate of alcohol related hospital admissions in Scotland.

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

The three-area model of service delivery

Glasgow is divided into three areas, known as localities, to support service delivery. To ensure consistency in local service delivery, the Glasgow City Health and Social Care Partnership has adopted the same strategic areas as the Glasgow Community Planning Partnership. Those localities - North West, North East and South are shown on the map below. More detail on the specific plans for each locality are outlined later in this Strategic Plan.

GLASGOW HEALTH AND SOCIAL CARE PARTNERSHIP LOCALITIES



ABOUT THE PARTNERSHIP

Key Opportunities

Integration of health and social care presents the Partnership with a number of opportunities, which we will work towards throughout the lifetime of this Plan. These include:

- Sustaining existing good quality services
- Removing artificial divisions between health and social care
- Minimising duplication and waste by improved coordination between health and social care services
- The ability for a range of non-health agencies to act in concert to prevent illness and promote better health
- A renewed focus on families and communities, as well as individuals
- Delivering transformational change in service provision, leading to positive health and well-being outcomes for Glasgow's citizens
- Improving connections between strategic and locality planning
- The opportunity to develop and embed a shared culture and identity across the Partnership, breaking down traditional organisational barriers
- Opportunities to engage with Primary Care and Acute Services to support effective service planning and delivery
- Joining up of Information and Communication Technology systems and processes to improve business and intelligence reporting

ABOUT THE PARTNERSHIP

The scale of the City of Glasgow and NHS Greater Glasgow and Clyde area is significant but this also creates the opportunity to work closely with the five other Health and Social Care Partnerships within the Health Board area to improve outcomes across all Partnerships

Equalities

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

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

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

ABOUT THE PARTNERSHIP

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

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

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

WORKING TOGETHER

Glasgow City Health and Social Care Partnership does not operate in isolation, and sets out that everyone has a shared responsibility at varying levels for the provision of support and services. We must work together to ensure that the services we provide are complimentary, easy to access, and that we have a shared understanding of how our services can integrate properly to better meet the needs of the citizens of Glasgow. The public, private, third sector and local communities share responsibility for providing services and support to meet public needs. The case study below is a fairly typical and shows how people often have complex needs requiring integrated solutions with involvement from a number of organisations.

Case Study

Mr and Mrs Smith are in their 60s. Mr Smith has a long-term health condition and visits his GP regularly. Mr Smith is also an unpaid carer for his wife who has dementia. Mr and Mrs Smith do not have any family members living nearby, and find it difficult to get time away from the house, or to see any friends.

As a result, they are both quite socially isolated, and Mr Smith began feeling increasingly depressed.

Mr Smith's GP had noticed a change in Mr Smith's demeanour and became concerned about his mental health. They discussed support available to Mr Smith, including the Primary Care Mental Health team. The GP also made a referral to the Dementia Post Diagnosis Support service, which could offer support to both Mr and Mrs Smith.

With support from the Primary Care Mental Health Team, Mr Smith contacted his local Carers Centre. The Centre was able to advise Mr Smith about a range of community-based supports and respite services. He also got information about the My Bus service, which could provide transport to appointments and clubs. Mr Smith was then able to leave his wife for short periods, allowing him to have time to access the local library.

As a result of the work of a range of agencies, Mr Smith felt supported to continue caring for his wife and both Mr and Mrs Smith were supported to live their lives independently at home and in their own community.

WORKING TOGETHER

We must collectively embrace change, more of the same won't meet the projected needs in Glasgow. Transformational change requires real commitment from all partners and service providers. We are ambitious in achieving more from integration and from the significant resources which are available to us. We will work collaboratively with all stakeholders in the city to achieve more.

As a Health and Social Care Partnership there are a number of key things we must do to enable effective integration.

- Across health and social care we have found ways to effectively share information, ensuring that it is safe, and we must continue to build on this. Sharing information will be key to providing effective joint services.
- A joint approach to service reform will create opportunities to ensure that transformational change can take place in a truly integrated way, taking account of impacts across health and social care services.
- We will use our property estate to encourage joint and flexible use of our accommodation.
- Information technology is crucially important in supporting our staff in their work and in sharing information. We want health and social care workers to be able to work from any building across the estate and we are developing a joint strategy to ensure that this can be achieved.

WORKING TOGETHER

Supporting Health and Social Care in Glasgow

The Health and Social Care Partnership directly employs around 9,000 staff. An estimated 20,000 people are employed by other organisations delivering health and social care services in the city. The number of unpaid carers in the city is estimated at 50,000. It is therefore clear that a significant proportion of the population is engaged in supporting the health and care needs of the people of Glasgow. This number will increase in the future. In addition, services which are not traditionally labelled as "health" or "social care" services provide significant levels of support, for example, social activity in libraries or community clubs and sports activities must increasingly play a significant role in combatting social isolation and improving mental health.

Primary Care

It is in primary care that most patient contact takes place. By "primary care" we mean all the community health services that work with General Practitioners (GPs), general dental practitioners, community pharmacists and optometrists to provide services to local populations. To deliver effective integrated health and social care services, it is essential that strong links with primary care services are developed and enhanced.

WORKING TOGETHER

In March 2015 we brought together representatives of all primary care professionals to consider the key issues and challenges for primary care in Glasgow, and the opportunities the Health and Social Care Partnership has to address these. The key themes to emerge from that session were how we respond to the pressures on primary care from:

- an ageing population;
- more people living with complex long term conditions;
- the impact of deprivation; and,
- workload and recruitment pressures.

We are committed to working with primary care practitioners to explore how best we can address these to maintain and develop the quality of services to patients. This includes working with primary care to implement the national primary care fund made available by the Scottish Government.

Within the Glasgow City Health and Social Care Partnership are 150 GP practices (437 GPs) providing the full range of general medical services to a registered patient population of 706,422 people, over 100,000 of whom live outside the city boundary.

WORKING TOGETHER

Within the Partnership are also 145 dental practices and five orthodontic practices, 163 community pharmacies and 113 optometry practices. In total in 2014/15 the NHS spent over £299m on primary care services of which £89.3m was on general medical services, £124m on prescribing, £48.3m on general dental services, £23.1m on general pharmaceutical services and £14.4m on general ophthalmic services.

Community health services supporting GPs and other primary care contractors include: district nursing, health visiting, community rehabilitation, primary care mental health teams, physiotherapy, podiatry, dietetics, school nursing, and continence services.

We acknowledge primary care's place at the heart of the NHS, as it is in primary care settings where most clinical encounters take place. The Partnership will support primary care in improving services to patients, including:

- taking forward agreed new health centres and improvements to GP surgery premises;
- supporting practices to improve GP access and screening targets;
- improving links with secondary care to build on developments such as electronic referrals, reduction of patient delays in hospital and implementation of the Clinical Services Strategy;
- improving discharge information;

- the introduction of step up / step down[3] beds as an alternative to hospital admission;
- the development of anticipatory care plans for patients who need them;
- supporting initiatives to improve the connection between GP practices and the wider community;
- promoting primary care approaches to tackling inequalities;
- implementing improvements in community nursing, through for example workforce development and improving access to community provision;
- further developing palliative care pathways; and
- building on the established locality groups and primary care forums to better support primary care clinicians to influence service delivery and service redesign in the new Partnership arrangements.

Acute Care

By 'Acute Care' we mean:

- Accident and Emergency services provided in a hospital
- Inpatient hospital services relating to the following branches of medicine:
- General Medicine
- Geriatric Medicine
- Rehabilitation Medicine
- Respiratory Medicine
- Palliative care services provided in a hospital

[3]Where current services are unable to support individuals in their own home due to a health crisis and they may require 24 hour care, but where a hospital stay is not medically required

WORKING TOGETHER

NHS Greater Glasgow & Clyde's Clinical Services Strategy for the period 2015-2020 informs the strategic context for the development of acute services over the next five years, and is a key component of the relationship between the Health Board and the Glasgow City Health and Social Care Partnership.

Key in delivering this strategy is the need to:

- improve the interface between the community and hospital to ensure care is provided at the right time in the right place, and is focused on patient and carers needs
- ensure that inpatient hospital care is focused on those with greatest need, ensuring equitable access to specialist care
- establish a consistent service model delivering within agreed clinical standards and good practice guidelines
- develop the rehabilitation model based on need not age
- working across the service within primary and secondary care and with partner organisations to provide rehabilitation at home or in local communities where possible and in the best interests of the individual

The key priority areas for the Glasgow City Health and Social Care Partnership in relation to Acute Services are:

- a reduction in bed days lost to delayed discharge
- a reduction in the number of Accident & Emergency presentations and emergency admissions - where alternatives to A&E and emergency admission exist, these services need to be maximised and plans developed to increase the scope and number of these services available in the community
- developing relationships between primary and secondary care clinicians - working to improve the interface and communication between primary and secondary care.

Children's Services

Our strategy for Children's Services aims to promote a plan to secure better outcomes for every child in Glasgow, with a targeted approach for those most in need. A great deal has been achieved in Glasgow in recent years, and the foundations are solid to sustain progress. The creation of the Health and Social Care Partnership provides a unique and critical opportunity to self-inspect, to review, to reform and to take stock. There is an ideal opportunity to strengthen collaboration, to develop a cohesive partnership and to ensure the most significant impacts to improve outcomes are secured.

WORKING TOGETHER

In establishing a guiding set of principles for Children's Services, it is essential that these operate across the single system of care. Critically, the single system of care for children involves our key partners such as: parents, carers, Education Services, the third sector and other key stakeholders.

Our principles include:

- Helping families to help themselves
- Prevention at every available opportunity
- Children and Families get the help they need when they need it
- Early engagement, early identification and earlier intervention
- Building resilience at every available opportunity
- Providing recovery from traumas within every part of the system
- Closing the attainment gap
- Health improvement across the system
- Addressing/minimising child poverty
- Acting as an integrated single system
- Achieving a step-change for the City of Glasgow

WORKING TOGETHER

The huge scale of children and young people with complex needs in the city highlights the need to take this opportunity to step back and review the whole system. This review will enable all our key partnerships to review the collective system, both city-wide and within localities.

This critical review will include the following key approaches and themes:

- GIRFEC and the new Children and Young People's Act
- Health Improvement co-ordinated contribution to prevention.
- Early Years and Earlier Intervention
- Data/Needs Analysis
- The Tiered Approach – analysis of each stage
- The Neglect Action Plan
- The Child Protection Action Plan
- Connections with Adult Services – particularly Mental Health, Homelessness and Addiction Services
- Connections with Acute and Primary Care
- Co-production with communities and the Community Planning Partnership
- System wide, corporate parenting.

Completing this work is a key priority for the Glasgow City Health and Social Care Partnership.

Sexual Health and Blood Borne Viruses Services

Sexual Health services are hosted by Glasgow City Health and Social Care Partnership on behalf of all six partnerships in the Greater Glasgow and Clyde area, and are based in Sandyford. New joint strategic and operational planning structures for sexual health will be established to reflect these new working arrangements across the health board area.

The Glasgow City Health and Social Care Partnership will work with the other partnerships, primary and secondary care, voluntary and community sector and other public sector partners to support the achievement of the outcomes set out in the Scottish Government's Sexual Health and Blood Borne Viruses Framework 2015 – 2010:

1) Fewer newly acquired blood borne virus and sexually transmitted infections; fewer unintended pregnancies.
2) A reduction in the health inequalities gap in sexual health and blood borne viruses.
3) People affected by blood borne viruses lead longer, healthier lives with a good quality of life.
4) Sexual Relationships are free from coercion and harm.
5) A society where the attitudes of individuals, the public, professionals and the media in Scotland towards sexual health and blood borne viruses are positive, non-stigmatising and supportive.

Our priorities are:

- Reducing conceptions in young people under 20 year olds
- Reducing unintended pregnancies for those over 20 years of age;
- Increasing uptake of long acting contraception (LARC) in all settings;
- Increasing access to early abortion services and reductions in rapid repeat abortions;
- Reducing transmission of sexually transmitted infections and HIV;
- Earlier detection of HIV in infected individuals;
- Improving gender reassignment services;
- Supporting improvements in sexual health and relationship education in schools and community settings;
- Improving support to young parents;
- Improving sexual health support to individuals with disabilities;
- Increasing access to Sandyford services in both a central location and in areas of high deprivation, and focusing on addressing sexual health inequalities.

This will involve targeted work with children and young people; men who have sex with men; people from countries with high HIV prevalence especially Sub Saharan Africa; women and men involved in prostitution; people with a diagnosis of HIV. Work will continue to improve access to services, in both primary care and specialist services with an increasing focus on self-management for patients with less urgent needs.

WORKING TOGETHER

Supporting Innovation

We are ambitious for the future of our health and care services, and making sure that we have integrated public services in the city. In order to achieve this we need to be receptive to ideas and suggestions and foster innovation.

Staff, patients and services users, carers and our key stakeholders in the third and independent sector across the Partnership know the challenges we face and will have ideas and suggestions about how we can do better. We are open to new ideas. Sometimes this may involve an element of risk in doing things differently and trying out new approaches. We will engage with all stakeholders about improvements and be open to a co-productive approach to service development and reform.

Engaging Stakeholders

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

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

WORKING TOGETHER

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

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

Links with Community Planning will also be essential as we strive to develop locally-influenced services which reflect the needs of communities. As a statutory member of the Community Planning Partnership the Integration Joint Board has a significant role to play in the Community Planning Process.

OUR ASPIRATIONS AND AMBITIONS

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

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

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

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

PARTNERSHIP KEY PRIORITIES

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

Early intervention, prevention and harm reduction

We are committed to working with a broad spectrum of city partners to improve the overall health and well-being of the population of Glasgow. We will continue our efforts to promote positive health and well-being, early intervention, prevention and harm reduction. This includes promoting physical activity, acting to reduce exposure to Adverse Childhood Experiences as part of our commitment to Getting it Right for Every Child, and improving the physical health of people who live with severe and enduring mental illness. We will seek to ensure that people get the right level of advice and support to maintain independence and minimise the occasions when people engage with services at a point of crisis in their life.

Providing greater self-determination and choice

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

PARTNERSHIP KEY PRIORITIES

Shifting the balance of care

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

Enabling independent living for longer

Priority work will take place across our all Care Groups to assist people to continue to live healthy, meaningful lives as active members of their community for as long as possible.

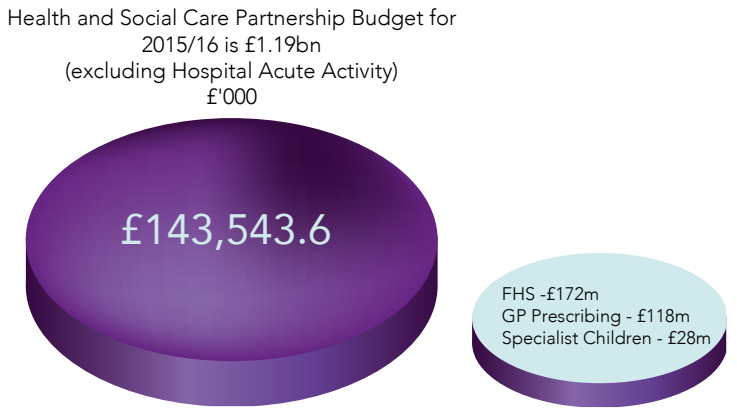
Public Protection

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

THE FINANCIAL CONTEXT

The total financial resources available to the partnership (excluding acute hospital activity) is £1.13billion. At a high level, this is allocated in the following ways:

Care Group	£'000
Children and Families	143,544
Prisons Healthcare and Criminal Justice	22,817
Older People	196,978
Addictions	46,292
Carers	1,720
Elderly Mental Health	25,735
Learning Disability/Physical Disability	98,318
Mental Health	134,995
Homelessness	76,368
Other Clinical/Hosted Services	333,553
Support Services	46,271
Total	1,126,591



Glasgow, in common with all public services in Scotland, has faced significant financial challenges in recent years, with further pressures anticipated in future years. The council will have to save an estimated 7% of its budget which is equal to a total of around £103 million over the two financial years 2016 to 2017 and 2017 to 2018. A similar level of savings is expected to be required of the Health Board. The overall picture will become clearer following the UK Government's Spending Review, subsequent implications for funding in Scotland through the Barnett Formula, and the Scottish Government's Budget for 2016/17.

THE FINANCIAL CONTEXT

The Chancellor of the Exchequer's Emergency Budget of July 2015 indicated that the UK Government intends to find approximately £37billion of savings within the 2015-2020 parliament. The impact of this savings requirement on the resources which will ultimately be available to the Integration Joint Board cannot be known at this point, given dependencies on a number of other decisions to be taken by a range of national and local bodies, however it is clear that the overall picture is one of reducing resources and increasing budget pressures. It is within this context that the Integration Joint Board must operate.

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

Financial pressures on health and social care services include:

- Reduced levels of funding from central government
- Increasing costs of medications and purchased care services
- An ageing population with a corresponding increase in multi-morbidities and individuals with complex needs
- Increasing rates of dementia

THE FINANCIAL CONTEXT

- Increases in hospital admissions, bed days and delayed discharges
- Increases in National Insurance contributions for employers
- The increasing minimum wage and move to a living wage, leading to increased employer costs and requests for uplifts from contractors
- Superannuation increases and the impacts of automatic pension enrolment

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

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

LOCALITY PLANNING

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

Each locality includes:

- a management team responsible for service delivery and co-ordination and ensuring implementation of the Partnership's policies and plans at a local level;
- management teams for adult services, children's services, older people's services and health improvement;
- a range of service user and carer networks and groups;
- primary care locality groups for GPs, a Primary Care Strategy Group and GP Forum;
- locality children's planning and implementation group; and,
- care group planning groups.

North East Locality

North East locality covers the following Local Area Partnerships:

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

The total population of North East Glasgow is 177,649 people. A breakdown of the population by age is shown in the table below:

Age Bands	No. of people	% of population	% of this age band in Scotland
0-15 years	29,538	16.6	17.6
16-64 years	122,092	68.7	65.7
65-74	13,810	7.8	9.0
75+	12,209	6.9	7.7

The percentage of the total population who are of working age is significantly higher than the Scottish average whilst the population aged 0 – 15 and over 65 is significantly lower.

LOCALITY PLANNING

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

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

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

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

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

Initial Priorities for North East Locality

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

North West Locality

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

- Drumchapel;
- Anniesland/Garscadden;
- Scotstounhill;
- Maryhill/Kelvin and Canal;
- Partick West;
- Hillhead; and,
- Anderston and City.

The total population of North West Glasgow is 190,332 people. A breakdown of the population by age is shown in the table below:

Age Bands	No. of people	% of population	% of this age band in Scotland
0-15 years	28,402	14.9	17.6
16-64 years	136,549	71.7	65.7
65-74	12,911	6.8	9.0
75+	12,470	6.6	7.7

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

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

A significant feature of North West locality is the very marked difference in the social and economic circumstances of people living in different areas in the locality, therefore an overview of statistics relating to the entire North West can mask stark inequalities within the locality.

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

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

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

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

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

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

Initial Priorities for North West

- Delivering the new Maryhill Health & Care Centre (completion due in summer 2016) and Woodside Health and Care Centre (completion due late summer 2017) to support integrated working and improve access to primary care, community health and social care services;
- Working with partners to reduce the health inequalities evident across North West, with a particular focus on the Thriving Places programme in Ruchill/Possilpark, Drumchapel and Milton/Lambhill;
- Improving access and reducing waiting times for psychological therapies and Primary Care Mental Health Team referral to treatment times;
- Implement findings of community addiction team review;
- Progress redesign of mental health and older people's inpatient services;
- Improve performance of Community Payback Order reviews and purchased care home reviews;
- Continue to embed housing options principles to prevent homelessness;
- Supporting redesign of criminal justice services, including better meeting the needs of female offenders and improving pathways to employability; and,
- Review provision of hub and satellite model for sexual health services.

South Locality

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

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

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

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

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

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

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

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

LOCALITY PLANNING

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

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

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

Initial Priorities for South Glasgow

- Delivering New Gorbals Health & Care Centre to support integrated working and improve access to primary care, community health and social care services;
- Responding with partner agencies to the specific needs in the Govanhill area including housing and the significant Roma population;
- Taking forward the Thriving Places agenda in Gorbals, Govan and Priesthill Househillwood;
- Supporting the development of new residential care and day care facilities in Toryglen and Castlemilk;
- Completion of the redesign of mental health services at Leverndale;
- Taking forward the Govan integrated care project with four GP practices testing new forms of integrated service delivery with community health, social care and third sector to support and prolong independent living in the community harnessing all available resources;
- Supporting implementation of the 415 Project with Glasgow Housing Association and other partners to test early warning system to enable earlier intervention to support frail older people and their carers before crisis happens;
- Developing Housing Options with four housing associations to prevent and avoid homelessness through a committed earlier cross agency response;
- Extension of Food for Thought through network of community gardens with housing associations and local communities;
- Incorporating the new asylum seeker/refugee reception facility in Kinning Park;
- Ongoing delivery of health improvement programmes for older people, encouraging older people to improve their health; and,
- Continue to deliver smoking cessation work with the local BME population.

DELIVERY OF THE PLAN WITHIN CARE GROUPS

The following Care Group level plans have been developed by Strategic Planning Groups and appropriate planning structures within Children's Services, Criminal Justice and Health Improvement. As well as the Strategy Maps in the following pages, the individual Strategic Planning Groups will develop their own Action Plans which will provide more details of the activities to be carried out over the lifetime of this plan. A Strategy Map outlines how each care group will deliver the National Outcomes in the medium and long term, and the main objectives of that care group.

The National Outcomes will be achieved through some of the key actions noted in the Strategy Maps. The Key Performance Indicators (KPIs) will demonstrate how effectively we are achieving our goals. Care groups have identified a number of KPIs in their respective Strategy Maps.

The Glasgow City Health and Social Care Partnership Vision	We believe that the City's people can flourish, with access to health and social care support when they need it. This will be done by transforming health and social care services for better lives. We believe that stronger communities make healthier lives. We will do this by: • Focussing on being responsive to Glasgow's population and where health is poorest • Supporting vulnerable people and promoting social well being • Working with others to improve health • Designing and delivering services around the needs of individuals carers and communities • Showing transparency, equity and fairness in the allocation of resources • Developing a competent, confident and valued workforce • Striving for innovation • Developing a strong identity • Focussing on continuous improvement

National Integration Outcomes	**Outcome 1** People are able to look after and improve their own health and wellbeing and live in good health for longer.	**Outcome 2** People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely community setting	**Outcome 3** People who use health and social care services have positive experiences and their dignity is respected.
	Outcome 4 Health and social care services are centred on helping to maintain	**Outcome 5** Health and social care services contribute to	**Outcome 6** People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role upon it.
	Outcome 7 People using health and social care services are safe from harm.	**Outcome 8** People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide	**Outcome 9** Resources are used effectively and efficiently in the provision of health and social care services.

Health Improvement Strategy Map

Long Term Outcomes	Improved healthy life expectancy for men and women	Less differences in healthy life expectancy between neighbourhoods	Improved life expectancy for men and women in Glasgow.	Less difference in life expectancy between neighbourhoods and group		A city with healthy public policy and infrastructure
Medium Term	Improved mental wellbeing and resilience	Improved health in neighbourhoods and groups	Reduced poverty and raised aspirations	Reduced exposure and use of tobacco smoke	Rebalanced relationship with alcohol and reduced drug use	More people being a healthy weight
Key Objectives	Implement GIRFEC with a focus on reducing impact of adverse events in early childhood implement child and youth mental well-being framework implement adult mental well-being framework Collectively these include emotional literacy, responding to distress, social connections,,, tackling stigma and suicide prevention	support area regeneration build community asset for changes build capacity of other organisations place based influence on HSCP support inclusive community approaches	address stigma to poverty contribute to mitigating child poverty poverty proof our business support access to financial advice and employability mitigate welfare reform support good work, healthy workplaces	protection programmes to reduce uptake of tobacco protection programmes to reduce exposure to tobacco smoke promote and support smoking cessation	prevention programmes (inclusive of multiple risk taking behaviours and public education) external harm reduction programmes including alcohol brief interventions contribute to programmes to protect the public in terms of alcohol availability contribute to community recovery	promote breastfeeding and healthy early years extend programmes to be more active more often promote healthy weight interventions promote healthy cooking skills promote healthy environments for food and activity
KPIS	Prevalence of high SDQ scores in young people	% People feeling isolated from friends and family	Proportion of children living in poverty	Smoking prevalence amongst adults (all 1 SIMD to 2)	Proportion adults reporting consume more than recommended weekly alcohol units	Trends in sales of high sugar snacks
		More resilient sustainable communities where people feel proud to live				Prevalence of obesity (BMI↑25) in children and adults
		More people reporting control over their lives	% Adults reporting difficulty meeting costs of fuel and food		Proportion young people reporting alcohol or drug use	Proportion young people and adults reporting meet recommended levels of physical activity weekly
	Mean WEMWBS scores for adults (measure of mental well-being)			Proportion reporting exposure to second hand smoke (children and adults)		% women breastfeeding at 6-8 weeks
		Proportion CPP partners informed on prevention and health improvement				Proportion of children and adults meeting recommended 5 portions fruit/veg daily

Older People Strategy Map

Long Term Outcomes	Quality of life optimised	Physical health and function optimised		Mental health and wellbeing optimised		Independence optimise		Quality of end of life optimised	
Medium Term Outcomes	Keeping healthy and active	Physical and social environments are more age-friendly		Keeping socially connected		Keeping financially and materially secure		Systems and services work better for older people	
Key Actions	Support older people to maintain healthy lifestyles Support the development of positive mental attitudes & resilience Provide older people with knowledge and confidence to improve their ability to self-manage their conditions Supporting carers to improve their health and the health of those they care for	Further enhance housing provision & support Extend the use of technology enabled care Develop the range of affordable and accessible local services, facilities & transport options Reduce stigma and discrimination about older people and the ageing process Promote a positive image of older people and the valuable contribution they can make to communities Encourage greater openness about dying and support older people and families to make future plans		Support capacity building amongst older people to enable them to effectively engage in community and family life e.g. through volunteering Support communities to build capacity to enable them to help and support older people in times of need Raise awareness amongst partners of the range of local community services and encourage them to promote these to older people and carers		Provide older people with better access to financial advice and assistance Support older people to maximise their incomes Encourage the provision of affordable services and commodities Promote opportunities for older people to continue working when they wish to do so.		Extend integrated services and working Ensure services become more personalised and responsive to individual needs Extend the use of outcomes focused care Adopt the principles of co-production in strategic planning and decision making Work in partnership with voluntary, independent and housing providers Reduce barriers to access to services and inequalities	
KPIS	% adults feeling services impacted positively on quality of life	% of adults supported at home who felt safe	% of adults supported who agree their health and care services are well co-ordinated	% of adults supported at home who agree they are supported to live as independently as possible	% of adults receiving any care or support who rate it as excellent or good	% of adults supported agree they had a say in their care provision	% of adults able to look after their health	% of people with positive experience of their GP practice	
	% care services rated above 3 in Care Inspectorate Inspections	Falls rate per 1,000 population in over 65s	Proportion of last 6 months of life spent at home or in the community	% of adults with intensive needs receiving care at home	% discharged within 72 hours	% discharged to care home who were admitted from home	Hospital re-admissions within 28 days	Delayed discharges and bed days lost	Emergency admissions rate
	Lengths of hospital stay	Unplanned acute bed days	Telecare provision	% of step-down users moving home	% of service users referred to reablement	Nos. accessing physical activity programmes	Nos. accessing capacity building programmes		Nos. in programmes to reduce isolation

Mental Health Strategy Map

Long Term Outcomes Carers	More people will have good Mental Health & Well Being and with good physical health	More people will have a positive experience of care and support	Health Inequalities are reduced	More people with mental health problems recover	A rebalanced system of care
Medium Term Outcomes	A stronger focus on Self-Management, Prevention & Early Intervention	Service users have a greater involvement and choice in decisions around their care	Needs of vulnerable and at risk groups are addressed in service planning & delivery	Outcome & Recovery Focused Services are in place	More people supported to live at home as independently as possible
Key Actions	Multi-agency response to the Healthy Minds Framework responding to population needs across the life-course Implement choose life self-harm and suicide prevention plans Ensure people with mental health needs have appropriate access to wider care services, including physical health services	Implement personalisation and self-directed care Open up the social care marketplace to new entrants and encourage innovation and greater choice Ensure service user and carer input and feedback is integral to care planning and review Better meet the needs of people with co /multi-morbidities, improving pathways and reducing duplication	Remove barriers to accessing services (including age-related) Progress social inclusion, employability and anti-poverty programmes Reducing stigma and discrimination Progress the Thriving Communities work to help build capacity in disadvantaged communities	Develop outcome/recovery based commissioning plans, service specifications, KPIs and assessment tools Meet waiting time and access targets Ensure effective care & treatment and reduce service variations	Carers are better supported: implement 'triangle of care' and mental health carer development work Supporting tenancy sustainment Agree process for identifying and meeting needs of people who are socially isolated

KPIS	Health & Wellbeing Indicators	Service user feedback	Delayed Discharges	CMHT & PCMHT waits	Care Plan Audits	Suicide & Self Harm rates	Clinical & Care Standards
	MH Hospital Admissions & Readmissions	% adults receiving care at home	% adults who agree they have a say in how their care or support is provided	Hospital Bed Days & Lengths of Stay	Psychological Therapy Waiting Times	% of Carers with Assessments	% adults supported at home who agree their health & care service are well coordinated
	% of carers who feel supported in their caring role		% adults supported at home who feel supported to live independently			% adults able to look after their own health well	

Disability Strategy Map

Long Term Outcomes Carers	Flexible systems of support in place provided in a personalised and holistic way	Positive relationships between individuals and professionals	Ability to access straightforward integrated and seamless support systems	Availability of peer support, advocacy/self- advocacy and capacity building as part of support	Disabled people will have access to the supports they need to have choice and control over their lives, define their own outcomes, and realise their full potential
Medium Term Outcomes	Complete implementation of personalisation for disabled people	Complete day service reform for disabled people	Develop transitional arrangements for young people during transition	Develop employability opportunities for disabled people	Contribute to the Corporate Independent living Strategy
Key Actions	Support people with disability to maintain healthy lifestyles Ensure easy access pathway to reablement services as appropriate –also ongoing development of this service Work in partnership with a full range of housing agencies to share knowledge and understanding of need	Adopt the co-production model where disabled people are fully involved in decisions about services that affect their lives and wider strategic planning Ensure the further development of an empowered professional workforce being seen as an expert resource by disabled people Acknowledgement of power imbalance in relationship and steps taken to mitigate and empower the individual	Work in partnership with key agencies to improve the outcomes for young people in transition	Develop clear pathways between services and opportunities e.g. employability, learning, volunteering and other services including disability led-organisations	Ensure implementation of "A Right to Speak Strategy" to enable full access to Augmentative and Alternative Communication (AAC) Work towards achievement of the 15 Rights for Independent Living
KPIS	Telecare Provision	Measure take up of day opportunities against take up of directly provided services	% of adults with disability supported at home who agree that their services and support had an impact in improving or maintaining their quality of life	% engaging with employment support services	Numbers of referrals to employment support services	% of adults with disability supported at home who agree that they are supported as independently as possible

Homelessness Strategy Map

Long Term Outcomes Carers	Increased focus on homeless prevention	People can access appropriate housing and support that enables them to live within their communities	Adequate supply of settled and emergency accommodation to meet the needs of people affected by homelessness		A sustainable and holistic, person centred and needs led response to homelessness in place
Medium Term Outcomes	Integrated community homeless service in place across Glasgow	Improved access to settled accommodation	Ensure effective Service Pathways in place	Keep service users financially secure	Access to employment, health and education for all service users
Key Actions	Continue service reform agenda e.g. redesign community casework services to create an integrated community homeless service across Glasgow Contribute to and support the development of Housing Options across Glasgow Review existing purchased service models to ensure strategic fit Develop two new emergency accommodation units e.g.	Work with registered social landlords, third and independent sector to ensure adequate supply of settled and emergency accommodation Establish a Housing Access Team to improve access to settled accommodation for homeless households Work with key stakeholders to continue to strengthen our focus on homelessness prevention so that we can support people to keep their accommodation when it is safe to do so	Develop a sustainable, holistic response to homelessness by ensuring collaboration across housing, health, social work, third and independent sectors Capitilise on the integration of health and social care services to ensure coherent service pathways	Strengthen the network of specialist and community based money, debt and legal advice provision Support services users to access support to mitigate the effects of welfare reform Develop two new emergency accommodation units e.g. Council's new build	Establish pilot City Centre Partnership with those voluntary sector providers who deliver city centre based services and focus on the needs of Multiple Excluded Homeless population Increase the use of the private rented sector and apply outputs from current DRS research
KPIS	Reduction in average length of stay within temporary accommodation	Increase in the number of homeless households resettled into settled accommodation	Reduction in repeat presentations	Increase in the number of homeless applicants accessing Money & Debt Advice	Increase in the number of homeless applicants accessing employability advice

Addictions Strategy Map

Long Term Outcomes Carers	Fewer people suffer avoidable harm	More people will have positive health behaviours	More people will have good physical health	More people with alcohol or drug issues will recover	More people will have a positive experience of care and support	Fewer people will experience stigma and discrimination

Medium Term Outcomes	Evidence shift towards prevention and earlier interventions	Further develop shared care theme within services	Develop recovery hubs and recovery communities	Ascertain service user and carer experiences to influence service design changes	Continue to promote equality agenda and to challenge negative societal perceptions of alcohol and drug issues

Key Actions	Place prevention as a core aim of services and continue to promote across the city Continued delivery on 'Alcohol Brief Interventions' HEAT standards Reduce the need for hospitalisation through anticipatory care and harm reduction Reduce the number of new BBV infections acquired as a result of injecting drug use Improve Naloxone distribution across the city Raise awareness of findings of the last SALSUS study to inform prevention and education practice across the city	Revise acute hospital guidelines on the management of drug misusers Continued development of 'specialist performance and image enhancing drugs' clinic Review assessment process with new Glasgow City Alcohol and Drug Recovery Service	Revise membership and structure of the ADP to reflect the new HSCP delivery environment Ensure services are best aligned to evolving recovery communities and recovery hubs Implement Scottish Government quality standards throughout new Glasgow City Alcohol and Drug Recovery Services	Actively engage with user and carer stakeholders to help communicate planned service changes Maintain high accessibility of services through Waiting Times delivery Complete independent evaluation of assertive outreach programme in the city centre Support research and data gathering on New Psychoactive Substances Identify and address barriers to engagement with services by people with Blood Borne Viruses	Establish a 'Women's Recovery Network' across Glasgow City Ensure equality impact assessments are embedded in service re-design agendas Extend Best Bar None award scheme across the city

Addictions Strategy Map (Cont.)

<table>
<tr><td rowspan="3">KPIS</td><td colspan="2">Rate of drug/alcohol related hospital discharges</td><td>Rate of drug/ alcohol-related mortality</td><td>Proportion of adults drinking above daily and/ or weekly recommended limits</td><td>Number of people receiving Opioid Replacement Therapies</td><td>Prevalence of Hepatitis C among injection drug users</td><td>The number of Naloxone Kits distributed</td><td colspan="2">Rate of Maternities recording alcohol/drug use</td></tr>
<tr><td colspan="2">The number of alcohol brief interventions delivered</td><td colspan="2">Estimated prevalence of injecting drug use among15-64 year olds</td><td>Percentage of 15 year olds who usually take illicit drugs in the last year</td><td>Number of people in recovery communities</td><td>Proportion of adults drinking above daily and/ or weekly recommended limits</td><td>Percentage of people who are identified in the Scottish Health Survey as ‘Problem Drinkers’</td><td>Percentage of 15 year old who report drinking on a weekly basis</td></tr>
<tr><td colspan="3">Percentage reduction in daily drugs spend during treatment</td><td>Reduction in percentage of clients injecting in the last month during treatment</td><td>Proportion of clients who abstain from illicit drugs between initial assessment and 12 week follow up</td><td colspan="2">Proportion of clients receiving drug treatment experiencing improvements in employment/ education profile during treatment</td><td colspan="2">Number of people referred to community/ residential/ in-patient rehabilitation</td></tr>
</table>

Carers Strategy Map

Long Term Outcomes Carers	Carers are recognised and valued as key partners in care	Carers are supported and empowered to manage their caring role	Carers are free from disadvantage and discrimination related to their caring role	Carers are enabled to have a life outside of caring	Carers are fully engaged in the planning of services
Medium Term Outcomes	More carers identified at point of diagnosis	Carers feeling supported on their caring role	Carer can better manage caring role	Carers are financially secure	Carers can influence service provision
Key Actions	Continue to promote single point of access to carer services Continue to develop carer pathways through a whole systems approach Continue to promote the carer pathway within primary and acute care services Continue to focus on early intervention and prevention	Embed carer issues with all care group plans and planning processes to support strategic objectives of each Ensure all staff routinely identify carers and signpost of services Continue to support 3000 new carers per annum Continue to support develop carer pathways for older people, mental health, disability and addictions Implement recommendations of Glasgow Carers Partnership evaluation Secure permanent funding for services currently short term funded	Continue to offer health review to all carers Continue to provide a range of training and learning opportunities for carers Continue to provide emotional support to carers through one to one support and access to peer support groups Continue to support carers to assist self-management of cared for	All carers are offered or signposted to income maximisation and money advice services Carers are encouraged to access community based services as required Carers are encouraged and supported to access education training and employment opportunities	Continue to support carer forums, groups and Carers Reference Group Ensure carer representation in strategic planning Regularly analyse information gathered in assessments and support plans and utilise for planning purposes

KPIS	Number of Carer Assessments	Number of Carer Health Reviews	% carers feeling supported in their caring role	No. of Carers attending moving and handling training	No. of Emergency Plans in place	Increase in referrals from primary and acute care	Nos. of carers accessing Mental Health Pathway	Numbers of staff attending carer awareness training	
	No of carers accessing Dementia Education	No of calls to Carers Information Line	Increase no of carers identified at point of diagnosis	Nos of carers accessing short breaks	Hours of short breaks provided	% carers feeling more secure having an Emergency Plan	No of carers referred for telecare services	Numbers of carers referred to income maximisation services	Nos. of parent carers accessing PC Pathway
	No of complaints		POA Guardianship referrals		% reviews completed for case closure	Nos of parent carers accessing Disability Pathway		Increase in carer assessments by SW Assessment and care management	

Children's Services Strategy Map

Getting it Right for Every Child Outcomes	SAFE: Protected from abuse and neglect and harm by others at home, at school and in the community	HEALTHY: Physically and emotionally healthy and support to choose safe and healthy lifestyle choices	ACTIVE: Physically active and encouraged to choose rewarding play and leisure, including sport	NURTURED: Live within a supportive family setting or caring setting, ensuring a positive and rewarding childhood experience
	ACHIEVING: Access to positive learning and opportunities to develop their skills, confidence and self-esteem, to reach their potential	RESPECTED: Involved in decisions that affect them, have their voices heard and play	RESPONSIBLE: An active role in their communities	INCLUDED: Assisted to overcome the social, educational, physical, environmental and economic barriers that create inequality
Key Actions	Promoting wellbeing and keeping children safe from harm and abuse Improve the early identification of children and families in need and provide the appropriate intervention to meet this need	Take action to reduce the neglect of children Promote the approaches "Towards a Nurturing City" and "Child Friendly City" Demonstrating a shift in resources from services responding to crises to early intervention and prevention	Focus on outcomes – being aspirational Continue to build capacity within existing evidence based interventions Encourage and help parents to be the best they can be	Contribution to reducing child poverty Improve the lives and life chances of looked after children and care leavers Improve engagement with children and young people

KPIS	% reduction in teenage pregnancy rates	No. of young people referred to SCRA on offence grounds	% reduction in the rate of still births and infant mortality rates	No. of mums participating in the family nurse partnership	% of mums breastfeeding	Waiting times for CAMHS	% Parental Assessments for drug and alcohol misuse completed	Childhood immunization rates
	% of children who reach their expected developmental milestones at 30 months and at entry to primary school	% of children looked after away from home aged under 5 (who have been looked after for 6 months or more) who have had a permanency review	No. of parents/carers completing parenting support and education programmes	No. of young people admitted to secure care (via Children's Hearing System)	No. of parents/ carers referred to financial inclusion services	No. of routine sensitive enquiries (domestic abuse)	No. of new approval for foster care	Rates of dental decay in children in P1 and P7
	Educational attainment levels for looked after and accommodated children	No. of places on schools vocational training programmes for young people who are school age and looked after by the authority	No. and % of looked after children who are cared for away from home	No. of young people leaving care receiving a service from SWS Leaving Care	Improvements in mental health for children who attended school counseling services	% of young people receiving a leaving care service who are in Education, Training or Employment	No. of children placed for fostering and adoption	No. of new Viewpoint questionnaires completed

Criminal Justice Services Strategy Map

Long Term Outcomes	Offenders are rehabilitated	People live their lives free from crime, disorder and danger	Criminal behaviour is tackled, and the risk of reoffending is reduced	Justice is delivered for victims	Sex offenders are better managed
Medium Term Outcomes	Offenders are supported	Offenders are re-integrated into communities	RRP2 projects are implemented	Improved MAPPA	Implementation of new Community Justice model
Key Actions	Using resources where they are most effective. Identify current and potential resources Improve information sharing Publicise benefits of community sentences Develop self-evaluation	Recognise where a different approach is needed. Use learning from change fund PSPs Test approach to rolling up charges Ensure robust alternatives to remand Develop new health improvement approaches Address mental health issues for CJ service users Improve communication with victims of crime	Identify and build protective factors; employability, relationships, health and wellbeing, learning, and accommodation. Support the work of Tomorrow's Women Glasgow Develop pathways for prison leavers into employment Increase access pathways to learning opportunities	Acting on the service user voice. Develop a service user engagement strategy	Delivering structural change without compromising quality or progress. Develop a local transition plan Support CPP to prioritise reducing re-offending
KPIS	Reduce one year conviction rate for Glasgow offenders	Reduce one year conviction rate for Glasgow women offenders	Reduce one year conviction rates for Glasgow under 21 offenders	Increase number of young people under 21 diverted from prosecution	Increase number of women diverted from prosecution	Reduce number of women serving custodial sentences
	Reduce number of women on remand	Reduce crime victimisation rates	Increase number of new CPOs per quarter	Increase percentage of unpaid work placements commenced within 7 days of sentence	Increase percentage of CPOs with a case management plan within 20 days of sentence	Increase percentage of 3 month reviews held within timescale	Increase client attendance at their review

** For further detail please refer to CJA Area Partnership Plan 2014- 2017.

PERFORMANCE MANAGEMENT

The Partnership has developed an integrated Performance Management structure to evidence achievement of the statutory National Health and Wellbeing Outcomes.

High level indicators related to the National Outcomes published by the Scottish Government, have been used as a basis for Glasgow's performance management framework, allowing links to be made between operational delivery in localities, performance across care groups and across the partnership as a whole following a 'logic' model.

The logic model links the National Health and Wellbeing Outcomes to the high level indicators published by the Scottish Government, and then in turn links these to indicators adopted by Social Work Services and NHS Greater Glasgow and Clyde to measure delivery at locality and care group levels. In this way we can ensure that all performance management activity is focussed on the National Outcomes, delivery of which is a statutory requirement for partnerships.

In addition to receiving care and service level summary performance reports the Integration Joint Board will receive a range of operational performance scrutiny reports from both internal and external scrutiny bodies such as Glasgow City Council's Internal Audit Team, Audit Scotland, Healthcare Improvement Scotland, and the Care Inspectorate. These reports will provide detail of services inspected, themes arising and trends in relation to grades awarded, alongside action plans for service development.

PERFORMANCE MANAGEMENT

The Public Bodies (Joint Working) (Scotland) Act 2014 requires partnerships to produce an annual performance report within four months of the end of each reporting year. Glasgow's first annual performance report, and subsequent reports, will be published in a number of locations, including the Health and Social Care Partnership's own website.

Item No 8

6th October 2015

Glasgow City Council / NHS Greater Glasgow and Clyde
Shadow Integration Joint Board

Report By: David Williams, Chief Officer Designate

Contact: Stephen Fitzpatrick

Tel: 0141 276 5596

JOINT INSPECTION OF GLASGOW OLDER PEOPLE'S SERVICES BY THE CARE INSPECTORATE AND HEALTHCARE IMPROVEMENT SCOTLAND

Purpose of Report: To advise the Shadow Integration Joint Board of the:

- outcome of the Joint Inspection of Older People's Services by the Care Inspectorate(CI) and Healthcare Improvement Scotland (HIS)
- the initial draft Improvement Plan against the 10 recommendations from the inspection and the 15 Glasgow defined recommendations as submitted within the position statement to the CI in 2014.
- mechanisms for monitoring progress of the Improvement Plan within Glasgow HSCP, Glasgow City Council, NHS GGC and reporting requirements to Care Inspectorate and Healthcare Improvement Scotland

Recommendations: The Shadow Integration Joint Board is asked to:

- Note the contents of the report, the grades awarded across the quality indicators and the recommended areas for improvement; and
- Note the draft Older People Services Improvement Plan which is based on the 10 Areas of Improvement recommended in the report and the 15 areas of Improvement defined locally by health and social care senior management

Implications for IJB	
Financial:	None
Personnel:	None
Legal:	None
Economic Impact:	None
Sustainability:	None
Sustainable Procurement and Article 19:	None
Equalities:	None
Implications for Glasgow City Council	Preparation and implementation of improvement plan
Implications for NHS Greater Glasgow & Clyde	Preparation and implementation of improvement plan

1 Background

1.1 Between October and December 2014, the Care Inspectorate and Healthcare Improvement Scotland carried out a joint inspection of health and social work services for older people in Glasgow.

1.2 The purpose of the joint inspection was to find out how well the services of Glasgow City Council and NHS Greater Glasgow and Clyde delivered good personal outcomes for older people and their carers.

1.3 The Joint Inspection Report uses the term 'Partnership' to describe the health and social care partnership arrangements for the governance, planning and delivery of health and social care services within the context of the emerging Health and Social Care Partnership in Glasgow.

1.4 The report "Services for older people in Glasgow - Report of a joint inspection of health and social work services for older people" is attached at Appendix 1 and was formally published by the Care Inspectorate and Healthcare Improvement Scotland on 14th August 2015.

1.5 This is the first ever inspection of older people's services in Glasgow.

2 Evaluation and Gradings

2.1 The Joint Inspection assessed the Glasgow Partnership against nine quality indicators and based on the findings the partnership were assigned the following grades.

Quality indicator	Evaluation	Evaluation criteria
Key performance outcomes	**Adequate**	**Excellent** – outstanding, sector leading **Very good** – major
Getting help at the right time	**Adequate**	

Impact on staff	**Adequate**	strengths **Good** – important strengths with some areas for improvement **Adequate** – strengths just outweigh weaknesses **Weak** – important weaknesses **Unsatisfactory** – major weaknesses
Impact on the community	**Good**	
Delivery of key processes	**Adequate**	
Policy development and plans to support improvement in service	**Good**	
Management and support of staff	**Adequate**	
Partnership working	**Good**	
Leadership and direction	**Good**	

3 Joint Inspection – Improvement Plan

3.1 The Glasgow HSCP is required to develop an Improvement Plan based on the nine recommendations for Improvement outlined in the report. The first draft of this is attached at Appendix 2.

3.2 The Improvement Plan will be agreed and monitored through the Older People's Strategic Planning Group and this in turn will report to the Integration Joint Board.

4 Glasgow Defined - Improvement Plan

4.1 The Inspection process included the submission of a Joint Position Statement against the ten indicators set out by the Care Inspectorate and Healthcare Improvement Scotland.

4.2 In preparing this statement, the Social Work Services and the then Community Health Partnership (CHP) defined a range of improvement measures. These are attached at Appendix 3.

5 Governance and Monitoring of Improvement Plan

5.1 The Improvement Plan will require to be agreed with the Care Inspectorate and Healthcare Improvement Scotland. A process and timescales for reporting progress against the areas of improvement will also be agreed.

6 Communications

6.1 A Partnership briefing has been prepared and was communicated to all stakeholders on the date of the report's publication 14th August 2015. This is attached at Appendix 4.

care inspectorate

Healthcare Improvement Scotland

Services for older people in Glasgow

August 2015

Report of a joint inspection of adult health and social care services

Services for older people in Glasgow
August 2015
Report of a joint inspection

The Care Inspectorate is the official body responsible for inspecting standards of care in Scotland. That means we regulate and inspect care services to make sure they meet the right standards. We also carry out joint inspections with other bodies to check how well different organisations in local areas are working to support adults and children. We help ensure social work, including criminal justice social work, meets high standards.

Healthcare Improvement Scotland works with healthcare providers across Scotland to drive improvement and help them deliver high quality, evidence-based, safe, effective and person-centred care. It also inspects services to provide public assurance about the quality and safety of that care.

We can also provide this report:

- by email
- in large print
- on audio tape or CD
- in Braille (English only)
- in languages spoken by minority ethnic groups.

Contents

Summary of our joint inspection findings

Background

Between October and December 2014, the Care Inspectorate and Healthcare Improvement Scotland carried out a joint inspection of health and social work services[1] for older people in Glasgow. The purpose of the joint inspection was to find out how well the services of Glasgow City Council and NHS Greater Glasgow and Clyde (referred to in this report as the Glasgow Partnership or the Partnership) delivered good personal outcomes for older people and their carers. We use Partnership to describe the health and social care partnership arrangements for the governance, planning and delivery of health and social care services within the context of the emerging Health and Social Care Partnership in Glasgow. In doing so, we recognised the stage of development the partner agencies shared at the time of the inspection. We wanted to find out if health and social work services worked together effectively to deliver high quality services to older people. This would enable them to be independent, safe, as healthy as possible and have a good sense of wellbeing. We also wanted to find out if health and social work services were well prepared for legislative changes designed to get health and social care services to work closer together. We were also mindful of the significant change and development agenda that was underway in Glasgow at the time of our inspection. In particular, we noted the evolving work to introduce new and improved arrangements for hospital discharge through the introduction of intermediate care. We were also informed about the Glasgow Partnership approach to mainstreaming initiatives funded from the change fund. At the time of our inspection the evaluation of this work was underway. We recognised the scale of the program underway and have attempted to reflect this in our narrative and assessment.

Our joint inspection involved meeting over 130 older people and unpaid carers who cared for older people, and over 380 staff from health and social work services. We read some older people's health records and social work services records. We also read policy, strategic and operational information about the health and social work services partnership and services for older people and their carers in Glasgow.

In Glasgow City, social work services and most community health services were delivered by Glasgow City Council and NHS Greater Glasgow and Clyde.

[1] S48 of the Public Services Reform (Scotland) Act 2010 defines social work services as — (a) services which are provided by a Council in the exercise of any of its social work services functions, or (b) services which are provided by another person pursuant to arrangements made by a council in the exercise of its social work services functions; "social work services functions" means functions under the enactments specified in schedule 13.

Outcomes for older people and their carers

Our joint inspection found that the Partnership provided a range of services to older people and unpaid carers who cared for older people. Health and social work services staff worked well together to deliver these services, In many instances, this transformed older people's lives, enabled them to remain in their own homes, kept them safe, as well as possible and maintained their wellbeing.

The Partnership had made some progress reducing the numbers of older people, whose discharge from hospital was delayed. The Partnership was also making progress reducing the numbers of older people permanently admitted to care homes. The Partnership needed to work together to reduce the numbers of older people who had an emergency admission to hospital.

What did older people and their unpaid carers think?

Many older people told us they were happy with the support they received from the Partnership. Carers told us they were generally happy with the services provided to them. They told us they felt that the services they received improved their health and wellbeing.

An extensive range of services had been developed across the Partnership to support older people to maintain their independence and feel supported in their own home.

We talked to a significant number of people who used services who told us a variety of opinions about how service was delivered by the Partnership. Some of these comments were:

"Have to work your way through the system".
"Top marks Wonderful People".
"Processing people not engaging with them".
"NHS community engagement officers do great work".
"It is not our fault that we are living longer!"
"Steady stream of different staff".
"Getting access to support could be a 'maze'.

Involving the local community

We found that the Partnership was committed to developing community capacity for supporting older people across the city. There was a good range of community supports already in place to enable older people to have healthy and fulfilling lifestyles at home or in a homely setting in their local community.

We saw a variety of pilot projects funded by the change fund and transformation monies. The Partnership had consulted with local communities about meeting the health and social care needs of older people across the city. Glasgow Council for Voluntary Services facilitated a series of engagement events for older people, carers and providers to inform and develop future service improvement plans and priorities.

Elected members and senior managers from health and social work acknowledged that they needed to do more to develop a cohesive approach to locality planning and community capacity building.

Getting a service and keeping safe

There was a good range of information available to older people referred for services, about how to access support. Waiting times for assessment and the availability of some services meant they sometimes had to wait to get the services they needed.

Financial pressures meant that sometimes older people had to wait until funding was available to access the support they needed.

There were effective processes in place to support adults at risk of harm and management of risk was improving. However, managers and staff were concerned about some delays in progressing adult protection referrals.

Plans and policies

The Partnership had a good set of joint plans, policies and procedures for older people's services. Older people themselves and carers who cared for older people had been widely involved in the preparation of plans for the services that they, the older people and their carers, depended upon.

We found that plans, such as the change fund plan[2], had been implemented by the Partnership, to improve services for older people and to improve outcomes for older people. An example of this, was the development of the reablement service, which helped older people who had had some form of crisis, such as a fall and a hospital admission, to regain their confidence, independence and ability to manage comfortably and safely at home. Implementation of service development plans was often initiated through pilot developments in different areas around Glasgow.

[2] The change fund is a Scottish Government grant to health and social work services partnerships, which aims to help the partnership develop services for older people and carers who care for older people.

Working together

Staff from health and social work services in Glasgow City had a history of good working relationships and effective joint working. The creation of the shadow integration joint board had helped to strengthen the existing good relationships and good joint working. The Partnership was well prepared for legislative changes designed to get health and social care to work closer together. One area for improvement was that communication between senior managers in the Partnership and frontline health staff and social work services staff needed to improve, to bridge the disconnect between strategic planning and staff delivering frontline services.

Leadership

Members of the health and social care partnership executive group and the shadow integration joint board gave strong leadership for the work of the health and social care partnership. The Partnership vision for integrated health and social care services was well developed and published within the commissioning strategy. The actions from the vision and aims reflected the national and local priorities. The Partnership vision for joint working was owned by Partnership senior and middle managers. However, the vision needed to be communicated effectively to frontline staff. Radical redesign of services has left some staff uncertain about the future. However, leaders were confident that they were working hard to resolve this.

Capacity for improvement

Overall, our joint inspection considered that the Partnership had good capacity for improvement. It delivered good outcomes for many older people and their carers. However, the leaders in the organisation were aware that there was much to be done, and there was further work required to improve performance, which would be challenging due to the competing pressures of strategic change and financial constraint.

Evaluations and recommendations

We assessed the Glasgow Partnership against nine quality indicators. Based on the findings of this joint inspection, we evaluated the Partnership at the following grades.

Quality indicators		
1	Key performance outcomes	Adequate
2	Getting help at the right time	Adequate
3	Impact on staff	Adequate
4	Impact on the community	Good
5	Delivery of key processes	Adequate
6	Policy development and plans to support improvement in service	Good
7	Management and support of staff	Adequate
8	Partnership working	Good
9	Leadership and direction	Good

Evaluation criteria

Excellent	outstanding, sector leading
Very good	major strengths
Good	important strengths with some areas for improvement
Adequate	strengths just outweigh weaknesses
Weak	important weaknesses
Unsatisfactory	major weaknesses

Recommendations for improvement	
1	The emerging Glasgow Health and Social Care Partnership should increase its efforts to reduce the number of older people admitted to hospital as an emergency or as a repeat emergency.
2	The Glasgow Partnership should ensure that all carers are offered a carers' assessment in line with legislation and that these are regularly reviewed, and ensure that carers linked to a carers' centre can seek a review should their needs change.
3	The Glasgow Partnership should continue to develop anticipatory care planning for older people, ensuring a more streamlined, standardised and multi-agency approach, with anticipatory care plans that are accessible across the partnership.
4	The Glasgow Partnership should make sure that older people have timely access to occupational therapist assessments to enable them to get the support they need to remain within the community.
5	The Glasgow Partnership should take immediate action to improve the engagement with frontline practitioners and their managers. They need to improve quality, consistency and frequency of communication and engagement with staff across all sectors. Thereafter the partnership should put systems in place to measure if the desired improvements are realised.
6	The new Glasgow Health and Social Care Partnership should routinely gather and report on comprehensive data on the numbers (and eligibility criteria categories) of older people waiting for an assessment or review, the length of time they have to wait, and the length of time for service deployment following completion of their assessment.
7	The Glasgow Partnership should make sure that proper chronologies are prepared and placed in the individuals' electronic or paper record.
8	The Glasgow Partnership should develop a joint workforce development strategy during the first year of integration which sets out clear joint priorities. This should identify possible staffing shortfalls and outline measures to address these as the integration of health and social care agenda progresses.
9	The Glasgow Partnership should reinforce and communicate their organisations' information sharing protocol so that there is a shared understanding among all staff about the confidential information they are permitted to share via secure email systems.
10	The Glasgow Partnership should ensure that development of a comprehensive risk register is aligned with the shadow integration joint board's function in overseeing the integrated arrangements and onward service delivery. This should be maintained when the integration joint board is established.

Background

Scottish Ministers have requested the Care Inspectorate and Healthcare Improvement Scotland carry out joint inspections of health and social work services for older people.

The Scottish Government expects NHS boards and local authorities to integrate health and social work services from April 2015. This policy aims to ensure the provision of seamless, consistent, efficient and high-quality services, which deliver very good outcomes[3] for individuals and unpaid carers. Local partnerships have to produce a joint commissioning strategy. They are currently establishing shadow arrangements, and each partnership is producing a joint integration plan, including arrangements for older people's services. We will scrutinise partnerships' preparedness for health and social care integration.

It is planned that the scope of these joint inspections will be expanded to include health and social work services for other adults.

How we inspect

The Care Inspectorate and Healthcare Improvement Scotland worked together to develop an inspection methodology, including a set of quality indicators to inspect against, shown in Appendix 1. Our findings on the Glasgow Partnership's performance against the quality indicators are contained in separate sections of this report. The sub-headings in these sections cover the main areas we scrutinised. We used this methodology to determine how effectively health and social work services worked in partnership to deliver good outcomes for service users and their carers. The inspections also looked at the role of the independent sector and the third sector to deliver positive outcomes for service users and their carers. The inspection teams were made up of inspectors and associate inspectors from both the Care Inspectorate and Healthcare Improvement Scotland and clinical advisers seconded from NHS boards. We also had volunteer inspectors who were carers on each of our inspections. To find out more go to: **www.careinspectorate.com** or **www.healthcareimprovementscotland.org**

[3] The Scottish Government's overarching outcomes framework for health and care integration is centred on, improving health and wellbeing, independent living, positive experiences, improved quality of life and outcomes for individuals, unpaid carers are supported, people are safe, health inequalities are reduced and the health and care workforce are motivated and engaged and resources are used effectively.

Our inspection process

Phase 1 - Planning and information gathering

The inspection team collates and analyses information requested from the Partnership and any other information sourced by the inspcetion team before the inspection period starts.

Phase 2 -Scoping and scrutiny

The inspection team looks at a random sample of health and social work records for 100 people to assess how well the partnership delivers positive outcomes for older people. This includes case tracking (following up with individuals). Scrutiny sessions are held which consist of focus groups and interviews with individuals, managers and staff to talk about partnership working. A staff survey is also carried out.

Phase 3 - Reporting

The Care Inspectorate and Healthcare Improvement Scotland jointly publish a local inspection report. This includes evaluation gradings against the quality indicators, any examples of good practice and any recommendations for improvement.

To find out more go to **www.careinspectorate.com**
or
www.healthcareimprovementscotland.org

Joint inspection of health and social work services for older people in Glasgow

The joint inspection of services for older people in the Glasgow Partnership took place between October and December 2014. During our inspection, we scrutinised social work services and health records for 103 older people using services in Glasgow. We analysed nationally published and local statistical data about the Partnership's provision of health and social work services for older people. We reviewed the Partnership's policy, strategic and operational documents. We spoke with people who received health and social work services and their carers. We spoke with health and social work services staff with leadership and management responsibilities. We talked to staff who work directly with older people and their families and observed some meetings. We are very grateful to all of the people who talked with us as part of this inspection.

Glasgow City context

Glasgow City is the largest city in Scotland and is situated on the banks of the river Clyde in the Western part of the Scottish central belt. Glasgow has a population of 595,080, which is the largest population of the 32 Scottish local authorities, with a population density of 3,407 people per square kilometre.

The Council area is bordered by six local authorities: East Dunbartonshire, West Dunbartonshire, North Lanarkshire, South Lanarkshire, East Renfrewhsire and Renfrewshire Councils.

Glasgow is divided into three sectors: North West, North East and South and these sectors are made up of the member wards of Glasgow City Council.

People aged 65 years or over made up 16% of the population compared with 21% average for Scotland.

The age group that was projected by the Scottish census projections 2011 to increase the most in size, in Glasgow by 2037, was people aged 75 years and over. This was the same as for Scotland as a whole. Glasgow's population of people of pensionable age was due to increase by 4.56% by 2020, and increase by 31.64% by 2030 respectively. The equivalent Scotland figures were 11.46% and 37.74%. More specifically, Glasgow's 75+ years population was due to reduce by 0.42% by 2020 and increase by 18.07% by 2030 respectively. The equivalent Scotland figures were 13.99% and 51.51%.

According to the Scottish Index of Multiple Deprivation, 233,714 (39%) of the population of Glasgow were living in one of the 15% most deprived areas in Scotland. In 2009, this

figure was 42% of the population. The number living within one of the 5% most deprived areas in Scotland was 117,307 (20%) of the population of Glasgow.

The ageing population profile in Glasgow brings with it significant opportunities with health and social care a growing employment sector throughout the area. The rise in population within the city comprises a high number of working age adults. The opportunity exists to further grow the care sector. The most significant increase for Glasgow is in the 85+ age group, with a 16.99% increase predicted in the period 2014 - 2020 and an even higher increase predicted between 2014 - 2030, with an increase of 33.46%. (Looking ahead to the year 2037 the data reflects a 51.67% increase in over 85s.) There are challenges too with significant areas of deprivation within the area remaining.

Quality indicator 1 – Key performance outcomes

Summary

Evaluation – Adequate

The Glasgow Partnership faced considerable challenges delivering positive outcomes for the high numbers of older people who needed health and social work services. These 'Glasgow' challenges included large scale of service delivery, high levels of deprivation,and associated higher morbidity levels for older people than the rest of the Scotland population.

Overall, we found that the Partnership delivered good outcomes for many older people. Some older people experienced poor outcomes, such as those who had their discharge from hospital delayed or who had an avoidable admission to an acute hospital bed.

The Partnership was trying to make sure that older people who were medically fit for discharge from hospital were discharged promptly. The Partnership had made progress reducing the number of older people who experienced an unnecessarily protracted stay in an acute hospital bed. It needed to sustain its efforts to meet the Scottish Government's delayed discharge target, and more importantly reduce the negative impact on the older people whose discharge from hospital was delayed. The Partnership had recently made good progress implementing the Scottish Government's discharge within 72 hours initiative.

The Partnership had below average performance on emergency admissions of older people to hospital. It needed to continue its efforts to reduce the number of older people who experienced an unnecessary unscheduled admission to hospital.

The Partnership provided proportionally more home care and intensive home care to older people than the Scotland average. In March 2014, over 5,000 Glasgow older people received a home care service. In general, home care services were provided promptly and delivered positive outcomes for large numbers of older people.

The Partnership delivered significantly less respite for older people and their carers than it had in previous years. Carers we met said that this had a negative impact on them.

The Partnership's extensive reablement initiative delivered very good outcomes for older people. The service users we met were highly satisfied with the reablement

service they received and their associated outcomes, whereby they were supported to live independently at home. The Partnership's performance data on reablement highlighted the scale and success of this joint service reform program.

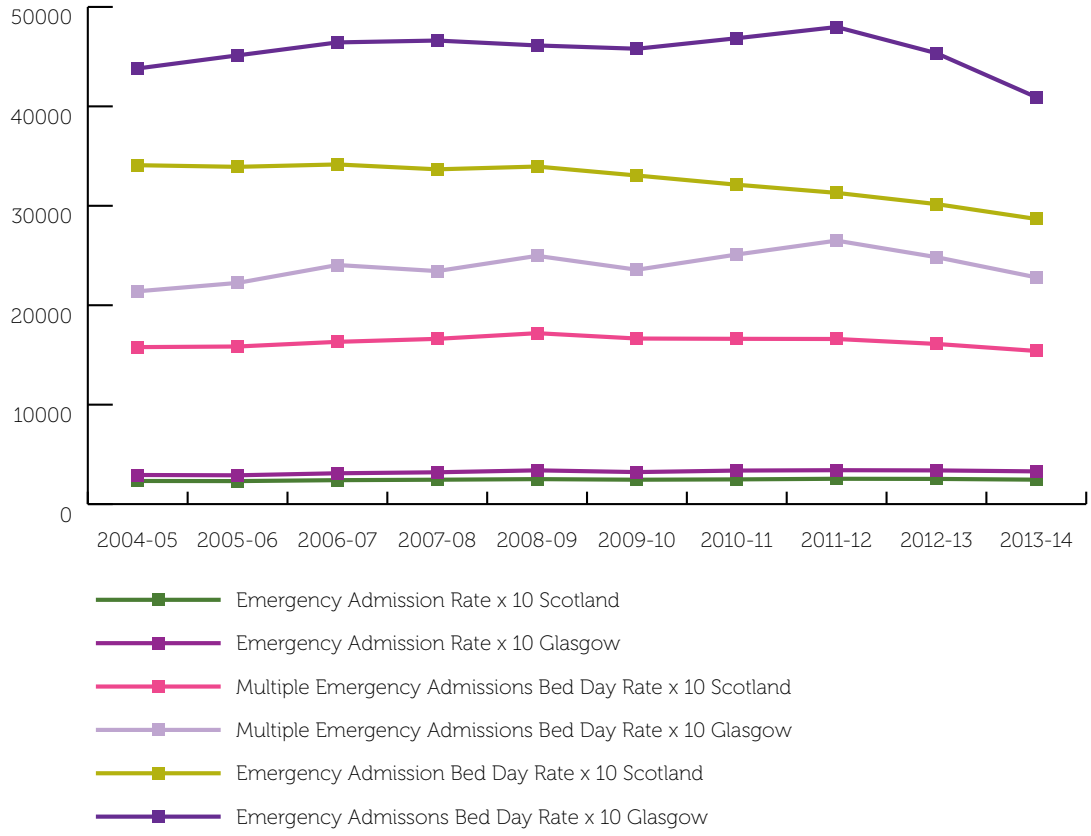
The Partnership had made modest progress providing direct payments to older people.

1.1 Improvements in partnership performance in both health and social care

Emergency admission to hospital

An emergency admission is 'when admission is unpredictable and at short notice because of clinical need'.

Chart 1: Glasgow, emergency admissions and multiple emergency admissions of older people, rates per 100k population



Source: Information Services Division

Chart 1 shows the Partnership's performance on emergency and multiple emergency admissions of older people to hospital. The Partnership's performance was significantly

below the Scotland average. The chart shows a small, three-year downward trend in both of these indicators. This may be the result of the Partnership's efforts to drive improvement in this area. One such effort was the recent initiative at Glasgow Royal infirmary to carry out investigations, diagnosis and treatment of older people at a specialist receiving frail elderly assessment unit, without the need for older people to be admitted to a ward.

One of the reasons for the Partnership's below average performance on emergency admissions is that there are five large general hospitals in Glasgow which have accident and emergency facilities. This increases the likelihood of older people being admitted to an acute ward. Another factor identified by the Partnership staff we spoke with, was that frail older people referred to accident and emergency departments tended to be admitted to hospital for investigations. Glasgow's high deprivation levels and health inequalities were other reasons for high numbers of emergency admissions of older people to hospital.

Health and social work services staff we spoke with said that the work of the falls service on falls prevention and falls management helped to prevent older people having an emergency admission to hospital. The care home falls prevention change fund project had delivered 90 falls awareness sessions to over 500 staff. Other services which had an impact on reducing the number of emergency admissions of older people to hospital included the following.

- The pharmacy service reviewing patients with multiple medications and carrying out medicines reconciliation for patients. There is evidence that a significant proportion of emergency admissions of older people to hospital are related to medicines.

- Step-up beds, used to reduce hospital admissions of older people by treating them within a care home. The Partnership strives to minimise patient stay in the step up service to a maximum of 7 days. Across Glasgow, six step-up beds are located in a single care home.

The closure of part of the Victoria Infirmary, Glasgow, and the opening of the new South Glasgow University Hospital in June 2015 will reduce the number of available acute hospital beds in Glasgow by 300 beds. Planning by the Partnership shows a significant shift to preventative and anticipatory care in the future. It is likely that this will reduce the number of emergency and multiple emergency admissions of older people to hospital as more people will be supported to remain in the community.

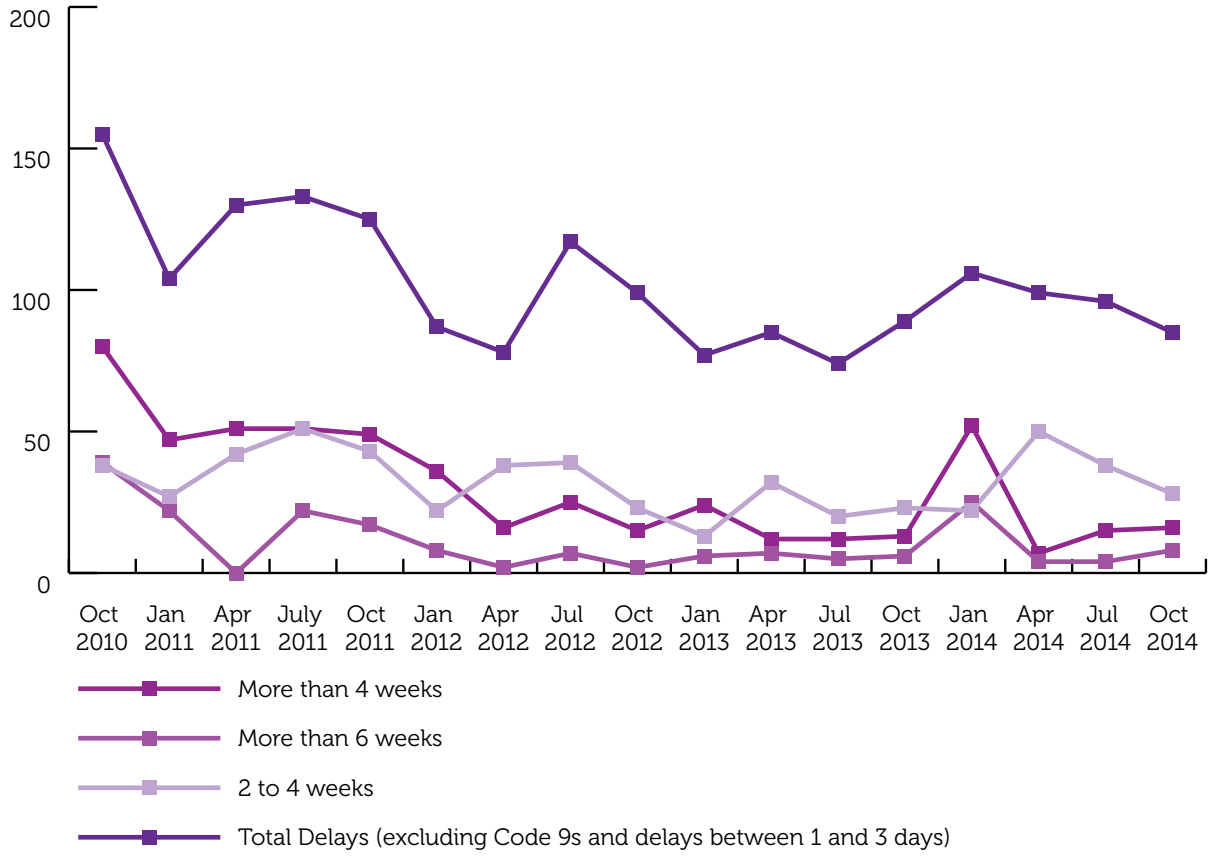
Recommendation for improvement 1

The emerging Glasgow Health and Social Care Partnership should increase its efforts to reduce the number of older people admitted to hospital as an emergency or as a repeat emergency.

Delayed discharge from hospital

Delayed discharge happens when a hospital patient is medically fit for discharge, but they are unable to be discharged for social care or other reasons. The Scottish Government's target is that there should be no delayed discharges over four weeks' duration, From April 2015, the target will reduce to two weeks.

Chart 2: Glasgow, delayed discharges by length of delay



Source: Information Services Division

Chart 2 shows comprehensive data for standard delayed discharges in Glasgow City, including a number of relatively positive factors.

- There is a broad downward trend in overall delayed discharges of older people from hospital.

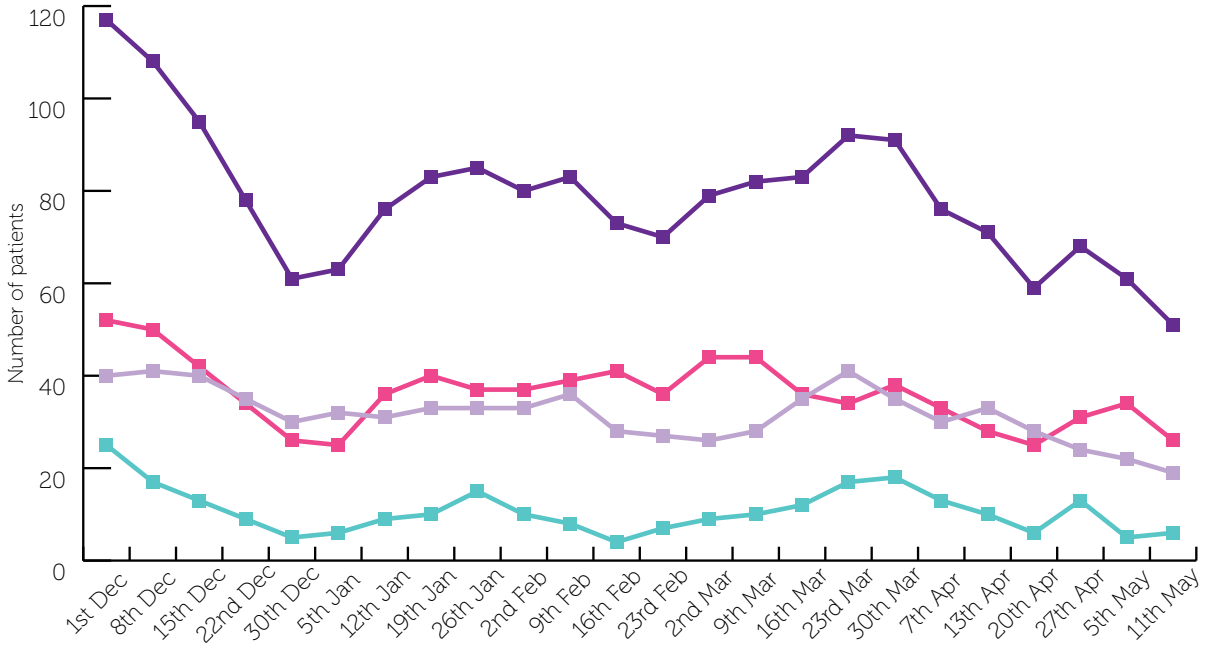
- Delayed discharges of over four weeks' duration show a general downward trend from 2010, apart from a sharp increase in January 2014. Staff told us that this was due, in part, to a halt on admissions to some care homes in parts of the city. Chart 3 below shows that lack of availability of care home places was one reason for the January 2014 increase. The other reason was delays in the assignment or completion of community care assessments.

- The number of delayed discharges of over six weeks' duration have generally been consistent (apart from a less pronounced January 2014 increase).

Chart 2 also shows that the Partnership only met the Scottish Government's delayed discharge target once, in April 2011. At that time, the delayed discharge target was no delays over six weeks' duration. The Partnership has never met the current Scottish Government's target of no delayed discharges over four weeks' duration. The Partnership has the largest number of older people in Scotland. This means that, at any one time, large numbers of older people across Glasgow need a social care package to allow them to be discharged from hospital. This makes it difficult for the Partnership to fully meet the Scottish Government target of no delays over four weeks.

The Partnership was working with the Scottish Government's joint improvement team to make sure that as many older people as possible, who were evaluated as ready for discharge from hospital, were discharged within 72 hours. There is evidence that the longer an older person spends in hospital when they do not need to be there, the harder it becomes to discharge them home. Chart 3 (latest local data) shows the Partnership's good progress ensuring that older people who were fit for discharge were discharged within 72 hours, with a 56% reduction in the number of patients who were not discharged within 72 hours.

Chart 3: Number of patients breaching 72 hr discharge excluding MH, AWI and <65 split by sector. From 1 December 2014 to 11 May 2015

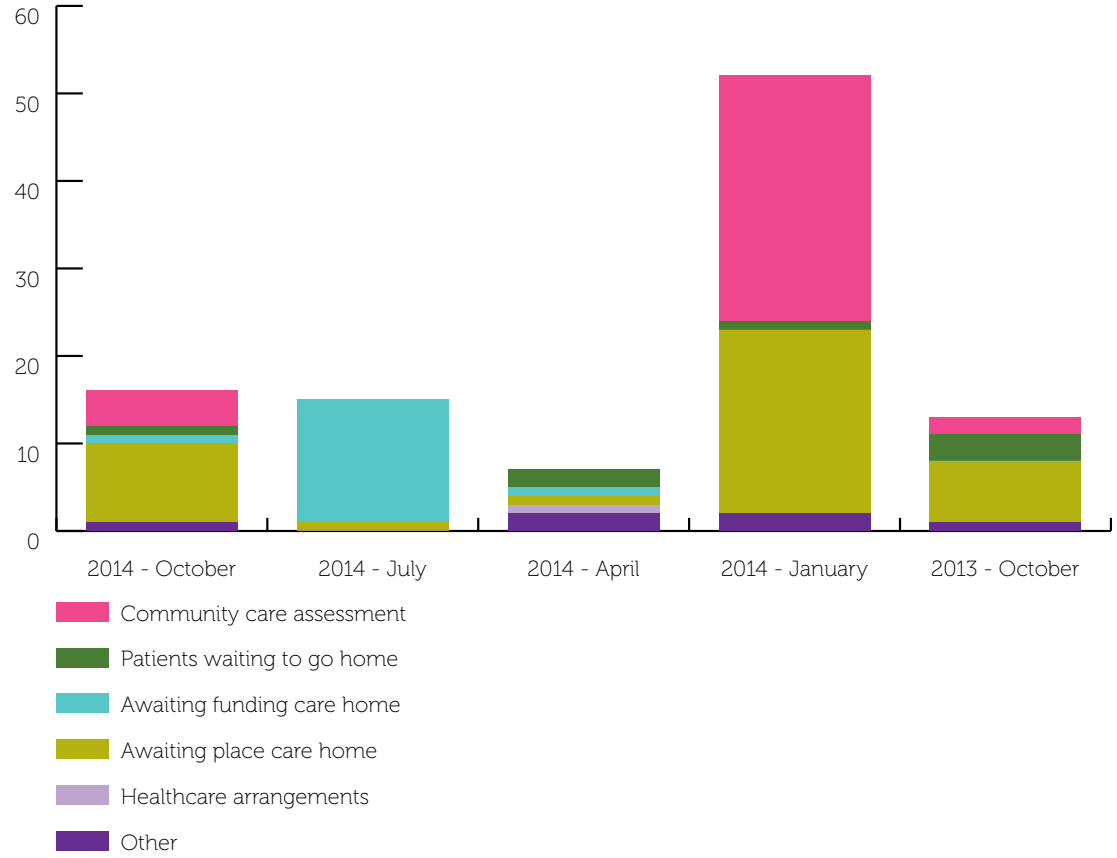


Total patients	117	108	95	78	61	63	76	83	85	80	83	73	70	79	82	83	92	91	76	71	59	68	61	51
South Sector	40	41	40	35	30	32	31	33	33	33	36	28	27	26	28	35	41	35	30	33	28	24	22	19
West Sector	52	50	42	34	26	25	36	40	37	37	39	41	36	44	44	36	34	38	33	28	25	31	34	26
East Sector	25	17	13	9	5	6	9	10	15	10	8	4	7	9	10	12	17	18	13	10	6	13	5	6

Source: Glasgow Partnership Edison Report

We were told about the Partnership's use of step-down beds. These enabled older people to be discharged from an acute hospital bed before either returning home (the ideal scenario), or being placed in a care home. Some staff we spoke with expressed concern that too many older people placed in a step-down bed ended up in a care home or back in hospital, rather than back in their own home. Ten percent of older people placed in step-down beds returned home (the partnership's target was 30% returning home). Of the 90% who did not return home, most were placed in a care home and some went back into hospital. Step-down beds were only available in some parts of the city, for example the North East.

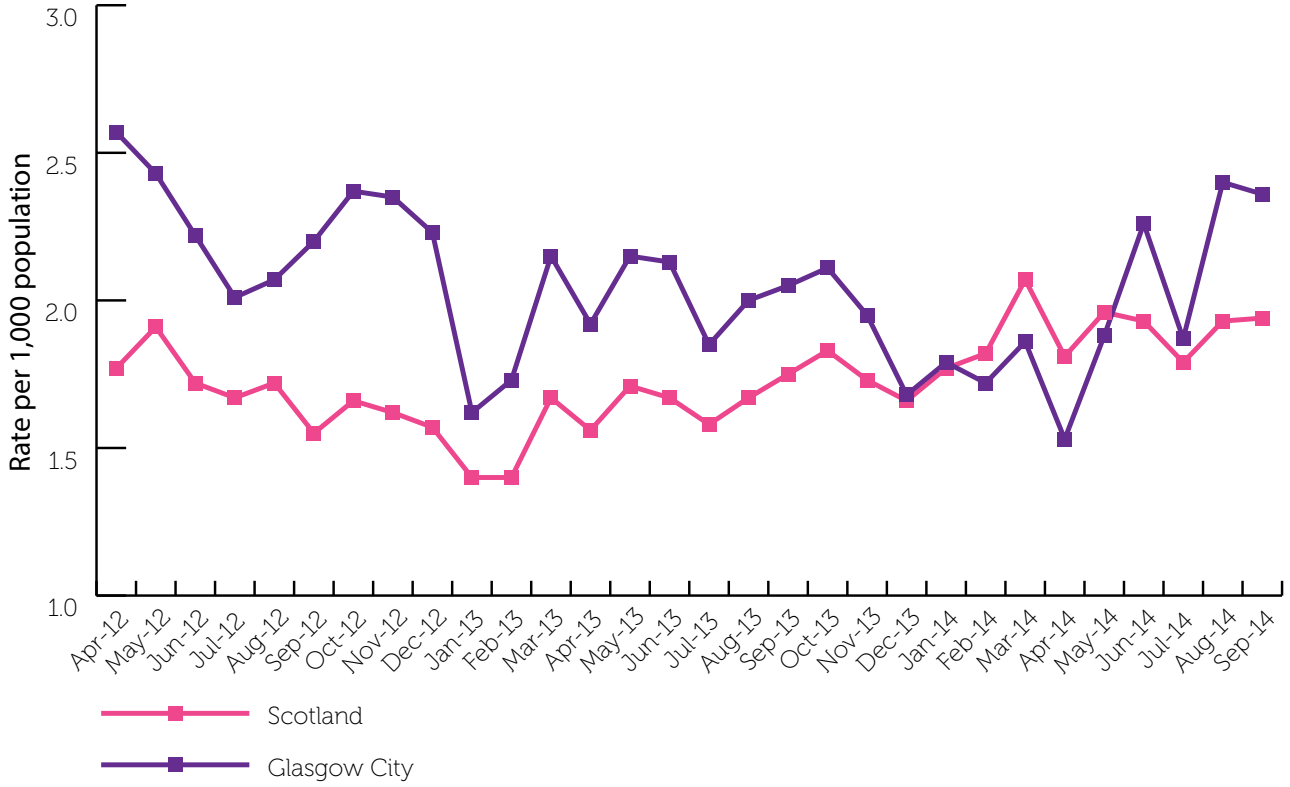
Chart 4: Glasgow, reasons for delayed discharges of over four weeks' duration



Source: Information Services Division

Chart 4 shows the reasons for the Partnership not reaching the Scottish Government's no delays over four weeks target from April 2013 to October 2014. The most common reason for this target not being met was the non-availability of care home places. Either no places were available or there were insufficient funds to pay for the care home places needed. We attended a meeting of a resource allocation group which, amongst other things, handled the admission of older people to care homes. It was clear that, due to financial constraints, there was a restriction on the number of older people that could be admitted to care home in any one month. Some older people who needed a care home place had to be managed at home with the provision of community support services. Another factor, was that some older people occupying an acute hospital bed could not be admitted to the care home of their choice. The Partnership had robust protocols designed to make sure there were no undue delays due to older people and their families waiting for the care home of their choice.

Chart 5: Glasgow City, bed days lost to code nine delays



Source: Information Services Division

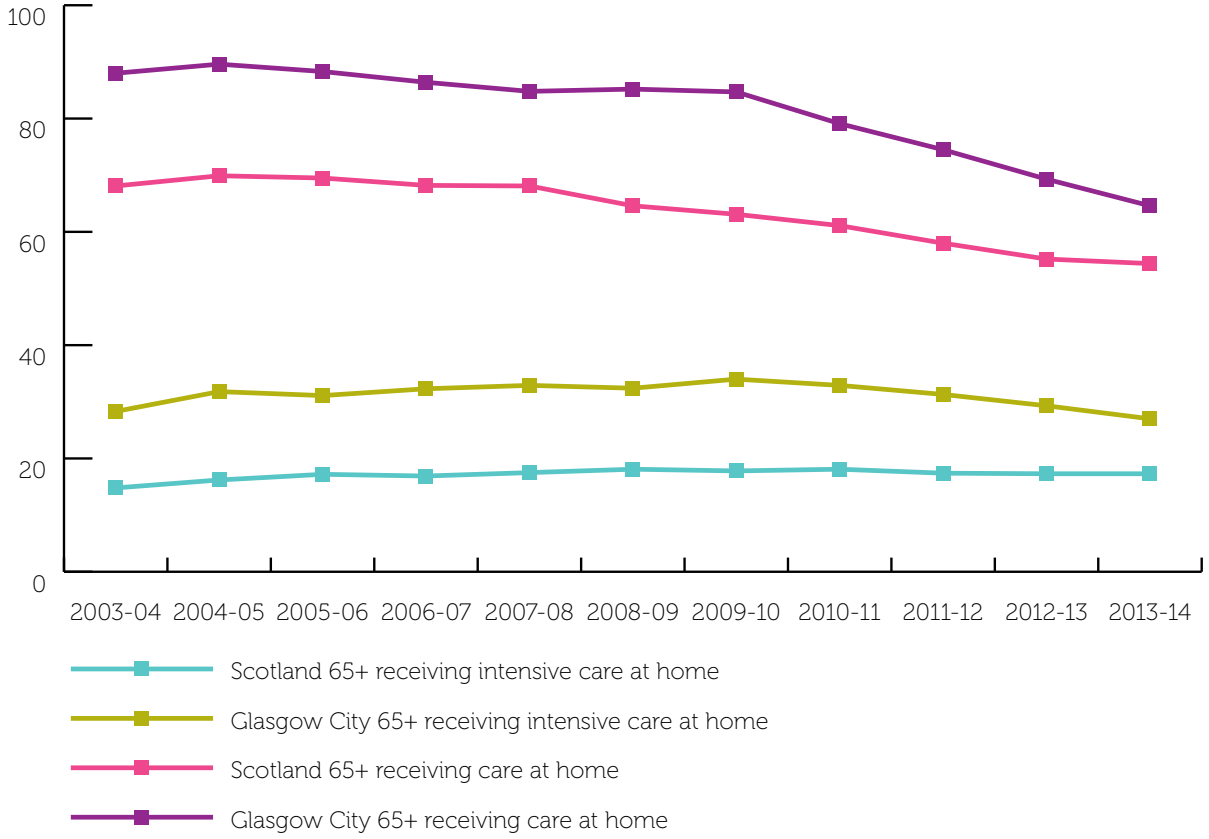
Chart 5 shows the Partnership's variable performance (against the Scotland average) on bed days lost to code nine[4] delayed discharges. The Partnership had made reasonable use of Section 13ZA of the Social Work (Scotland) Act 1968. This allows (under certain circumstances) individuals who lack capacity to be moved from an acute hospital bed to a care home, without using court powers to ensure the move is legitimate. The Partnership had set up a successful power of attorney campaign. This aimed to encourage individuals, while they have capacity, to grant power of attorney to their desired proxy. This meant that older people occupying an acute hospital bed who lacked capacity could be moved to a care home with the approval of their attorney. This had helped the Partnership to manage code nine delays.

Provision of care at home services

Care at home is care and support for people in their own home to help them with personal and other essential tasks of daily living.

[4] Patients whose discharge is delayed for reasons linked to the Adults with Incapacity (Scotland) Act 2000 and for reasons related to the availability of specialist healthcare facilities

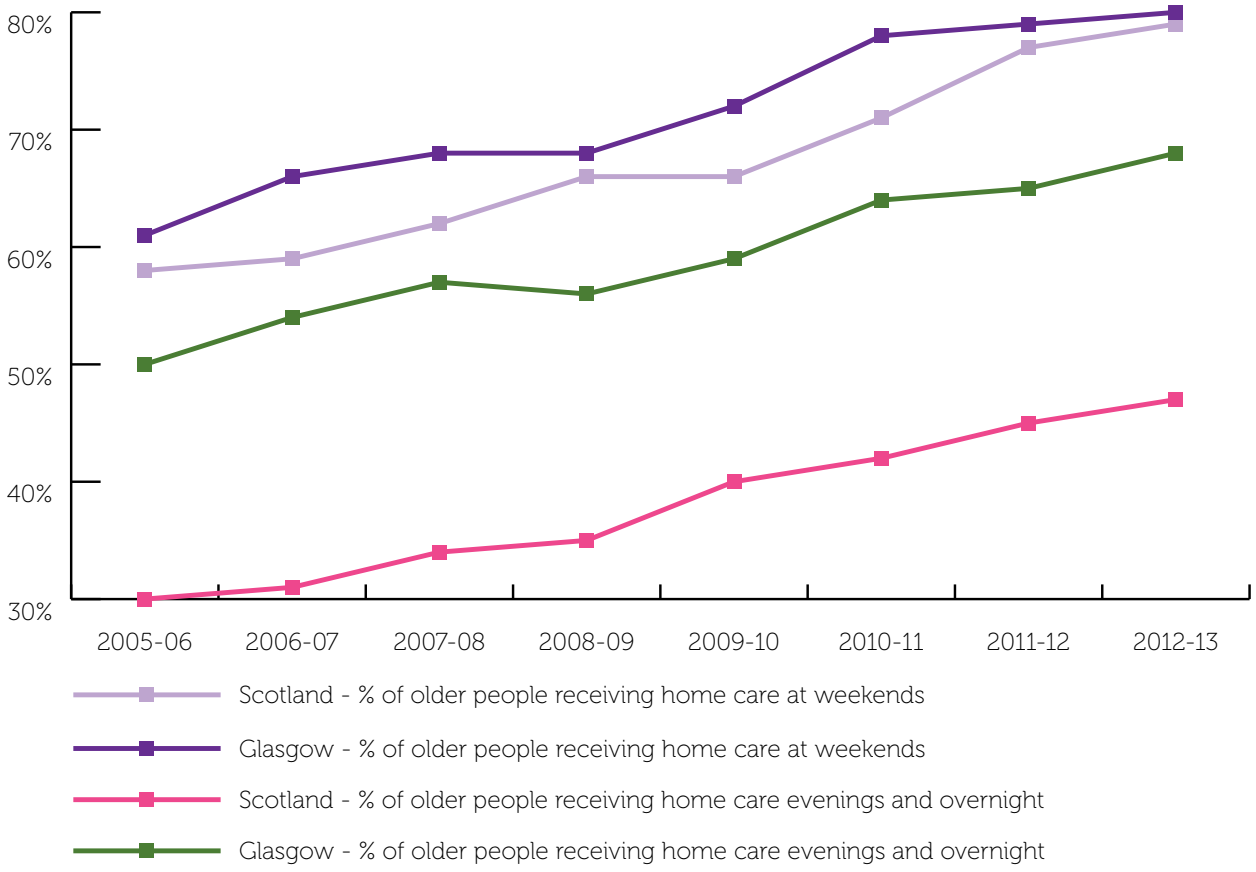
Chart 6: Glasgow, provision of home care and intensive care at home to older people per 1,000 population 65+



Source: Scottish Government

Chart 6 shows the Partnership's performance on delivery of care at home services to older people. Proportionally, more Glasgow older people received care at home and intensive care at home services than older people in the rest of Scotland. These services were provided promptly and delivered positive personal outcomes for a high proportion of recipients (5,337 older people in March 2014). From 2009–2010, there had been a downward trend in the provision of care at home and intensive care at home services in Glasgow. This was probably due to the success of the Partnership's extensive reablement initiative. This aimed to support older people to be able to self-care and live independently at home, and reduce their dependency on the continued use of care at home staff to support them.

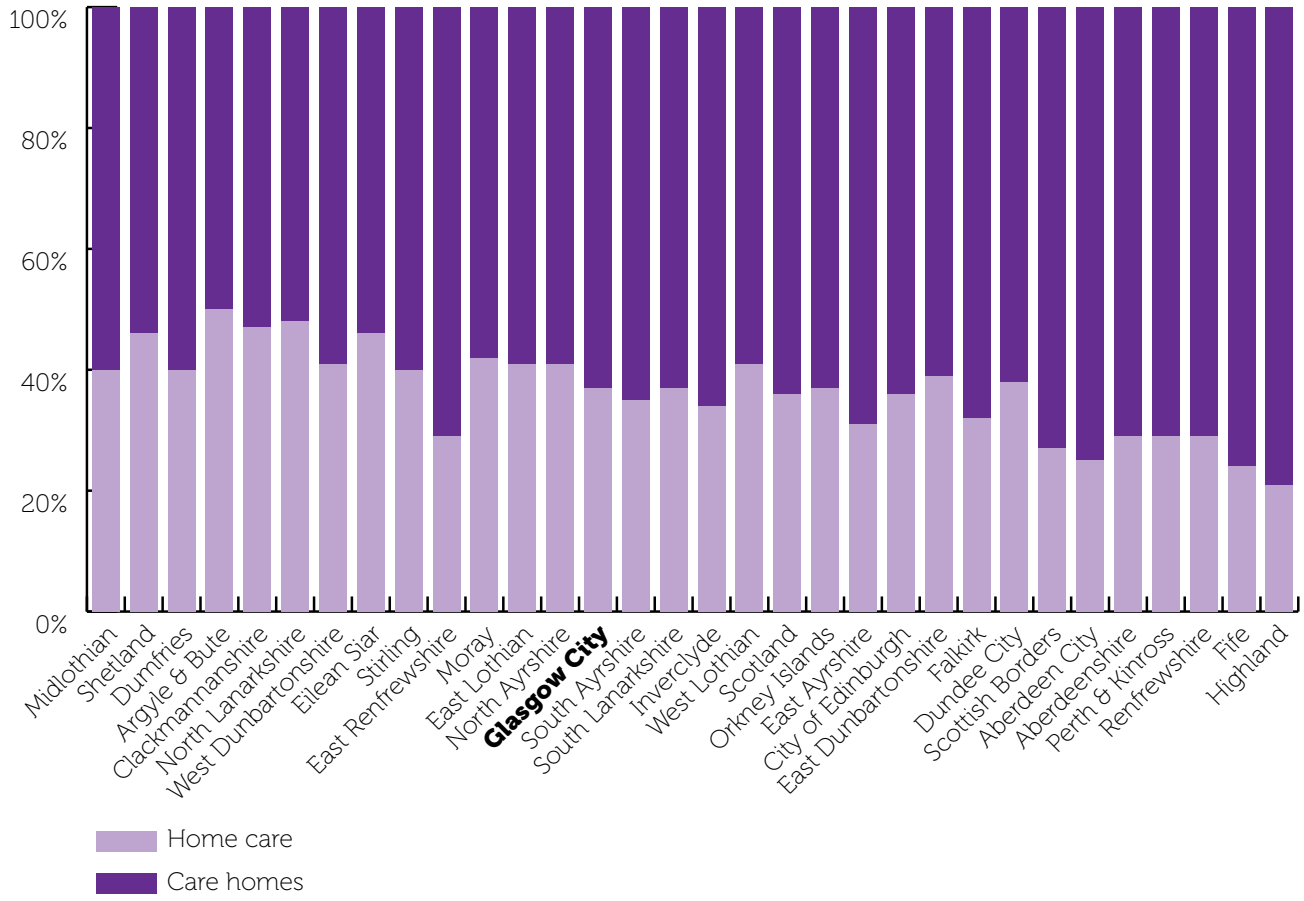
Chart 7: Glasgow number 65+ care clients receiving care at home evenings/ overnight and weekends as percentage of clients



Source: Scottish Government

Chart 7 shows that the Partnership delivered evening, overnight and weekend care at home support to older people at levels above the Scotland average. This meant that many older people received care at home support when they needed it.

Chart 8: 2014 balance of care between older people living at home with intensive home care and older people living permanently in care homes



Source: Scottish Government

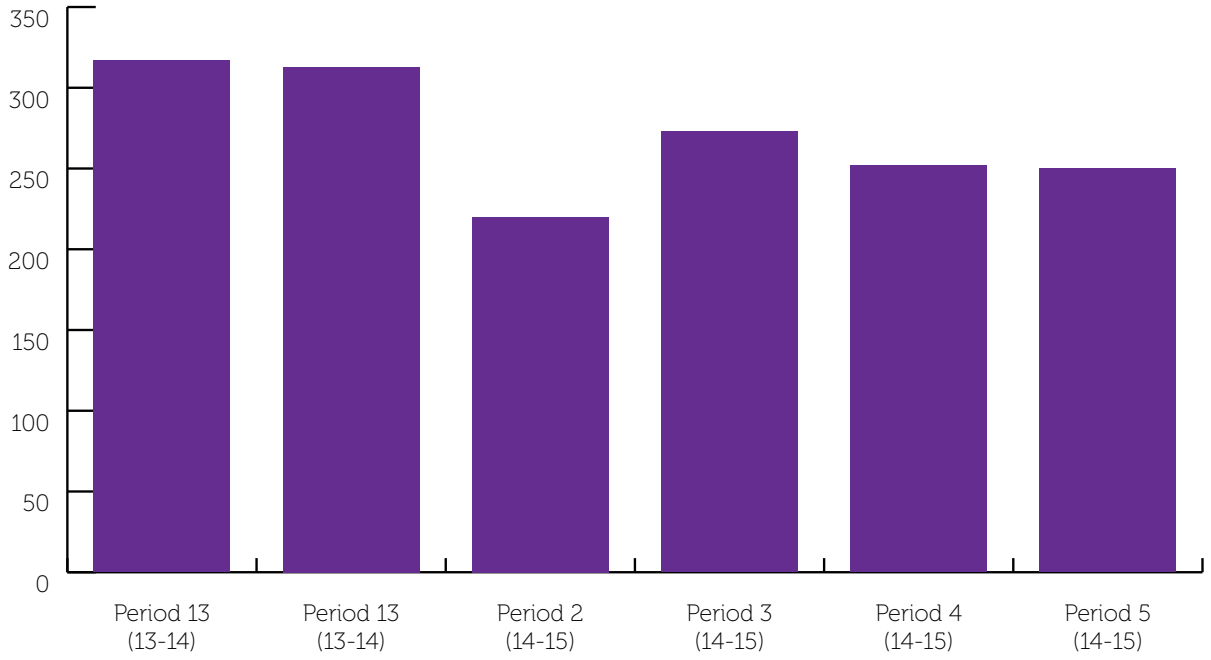
Chart 8 shows the Scottish Government's measure of balance of care for older people. This is the ratio of percentage of older people who reside permanently in care homes over the percentage of older people who receive intensive care at home services (more than 10 hours). The Partnership's higher than average placement of older people permanently in care homes was offset by its higher than average provision of intensive care at home services.

Reablement

Reablement is the delivery of intensive and specialist care at home support, often delivered alongside intermediate care services such as physiotherapy, occupational therapy and rehabilitation. This is normally delivered for a prescribed period of up to six weeks and it aims to help people regain confidence, and focuses on skills for daily living. It can enable people to live more independently and reduce their need for ongoing services and supports.

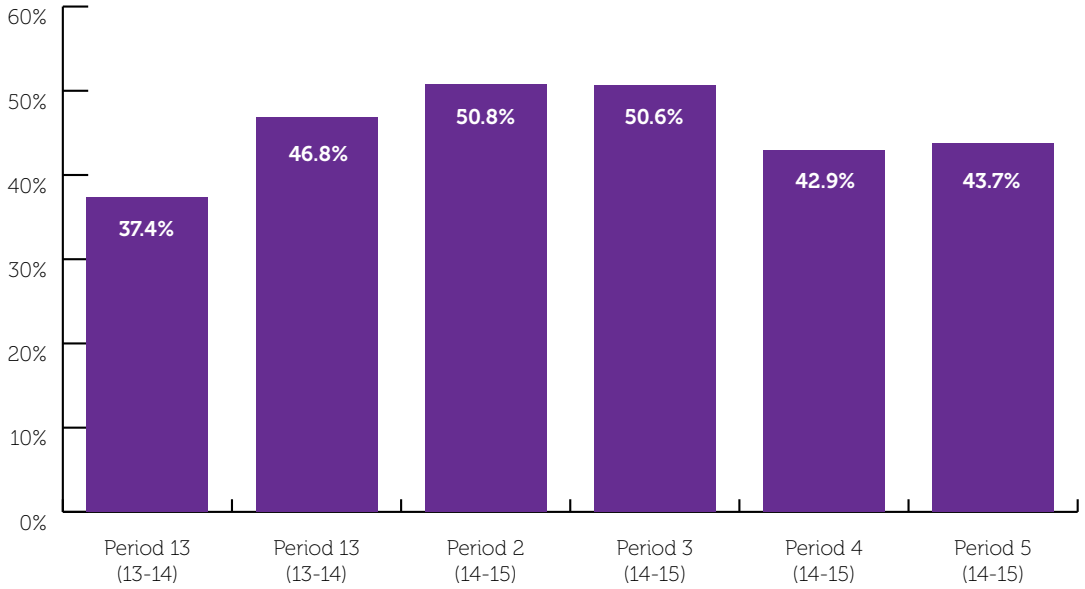
The Partnership had invested a considerable amount of effort and resource into delivering timely, effective reablement for large numbers of older people. All older people who were in hospital and were referred for social care support on discharge were automatically referred to the Partnership's reablement teams. Older people received a timely and potentially extensive short-term package of social care and other supports such as occupational therapy or physiotherapy to enable them to go home. We met with a number of older people who had benefitted from reablement. They all praised the quality of the service they received, the positive outcomes that the service delivered for them, and the caring, committed and competent staff who gave them the support they needed. "I don't know what I would have done without the caring staff who supported me" was a genuinely and consistently expressed view from older people we met during our inspection who had received reablement support.

Chart 9: Glasgow, number of referrals to reablement



Source: Social work services performance reporting

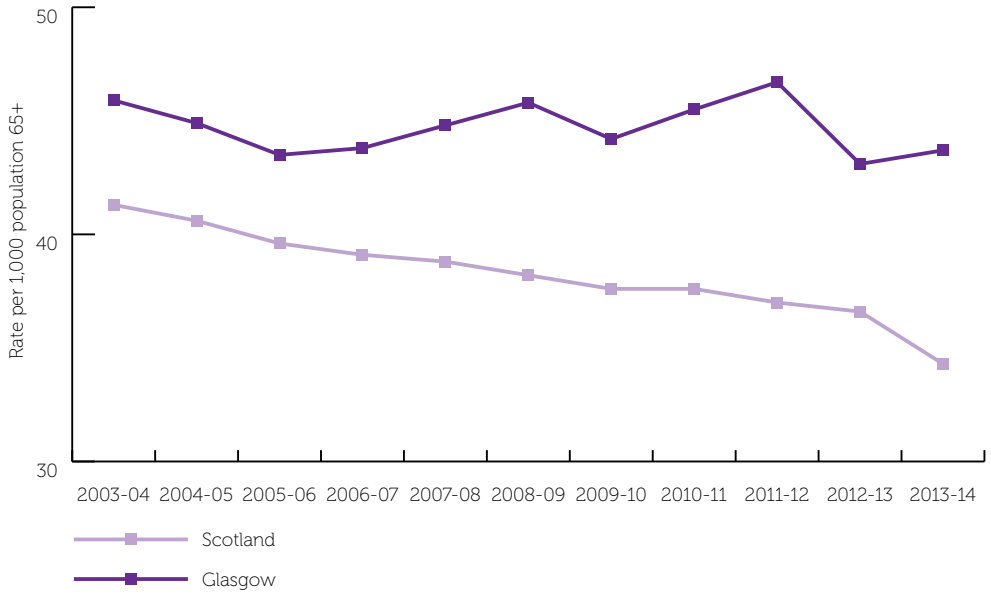
Chart 10: Glasgow, aggregate percentage reduction in care hours following reablement



Source: Social work services performance reporting

Charts 9 and 10 show the Partnership's performance on delivering high numbers of reablement episodes and reducing the number of post-reablement care hours needed by some older people who had received reablement support.

Chart 11: Permanent residents 65+ of care homes supported by Glasgow City Council rate per 1,000 population 65+



Source: Information Services Division

Care homes

Chart 11 shows that the Partnership placed higher numbers of older people in care homes compared to the Scotland average. Reasons for this given by health and social work services senior managers included the long-term impact of deprivation and the associated poor morbidity of the Glasgow population. We considered that room for improvement was needed. The Partnership should reduce its dependency on in-house and purchased permanent care home places for older people and support more of them to live independently at home, while respecting their choice.

Table 1: Performance of regulated services for older people run by Glasgow City Council

Glasgow - performance of regulated services run by the Council (at January 2015, source: Care Inspectorate data)

Grade 1 Unsatisfactory	Grade 2 Weak	Grade 3 Adequate	Grade 4 Good	Grade 5 Very good	Grade 5 Excellent

Care homes (percentage of services achieving grades1-6)

Care and support						Environment						Staffing						Management and leadership					
1	2	3	4	5	6	1	2	3	4	5	6	1	2	3	4	5	6	1	2	3	4	5	6
0	8	38	38	15	0	0	0	31	54	15	0	0	0	31	46	23	0	0	31	15	38	15	0
%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%

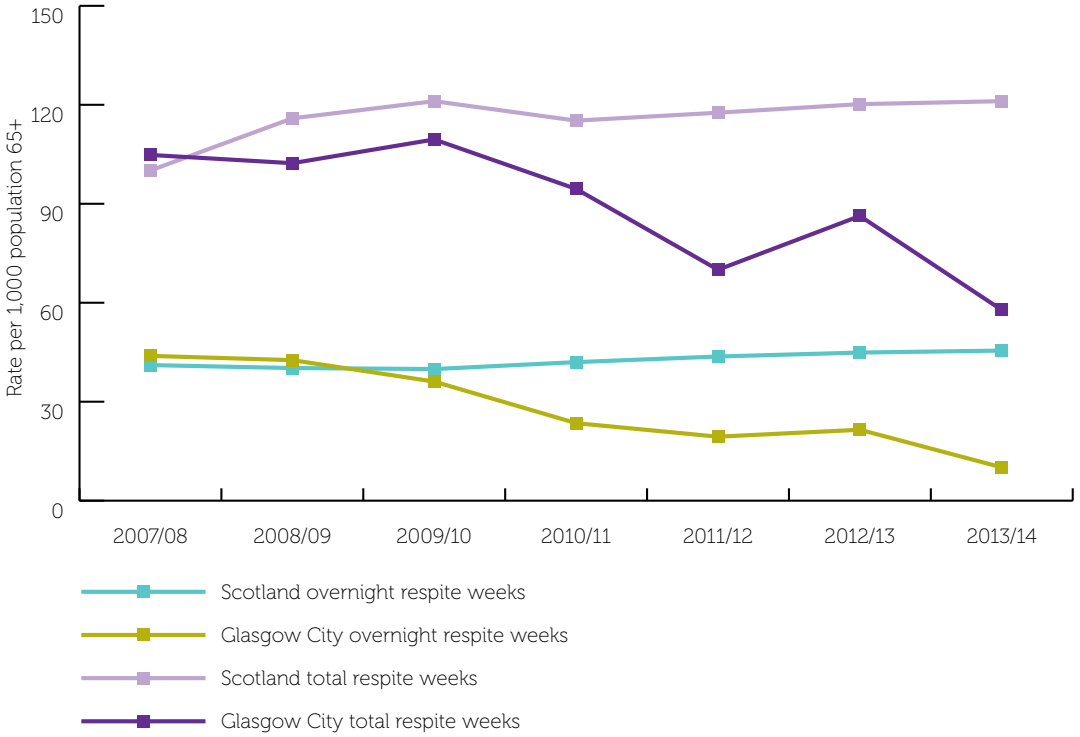
Support services for older people, not care at home (percentage of services achieving grades 1-6)

Care and support						Environment						Staffing						Management and leadership					
1	2	3	4	5	6	1	2	3	4	5	6	1	2	3	4	5	6	1	2	3	4	5	6
0	0	10	29	57	5	0	0	5	33	57	5	0	0	0	48	48	5	0	0	14	52	33	0
%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%

Table one shows a summary of the grades the Care Inspectorate assigned to regulated services for older people run by Glasgow City Council. While these services delivered good outcomes for many older people, the aggregate of inspection grades indicates performance of the Council's regulated services for older people was an area for improvement.

Respite care for older people and their carers

Chart 12: Glasgow, total respite weeks for 65+ and overnight respite weeks by 65+



Source: Scottish Government

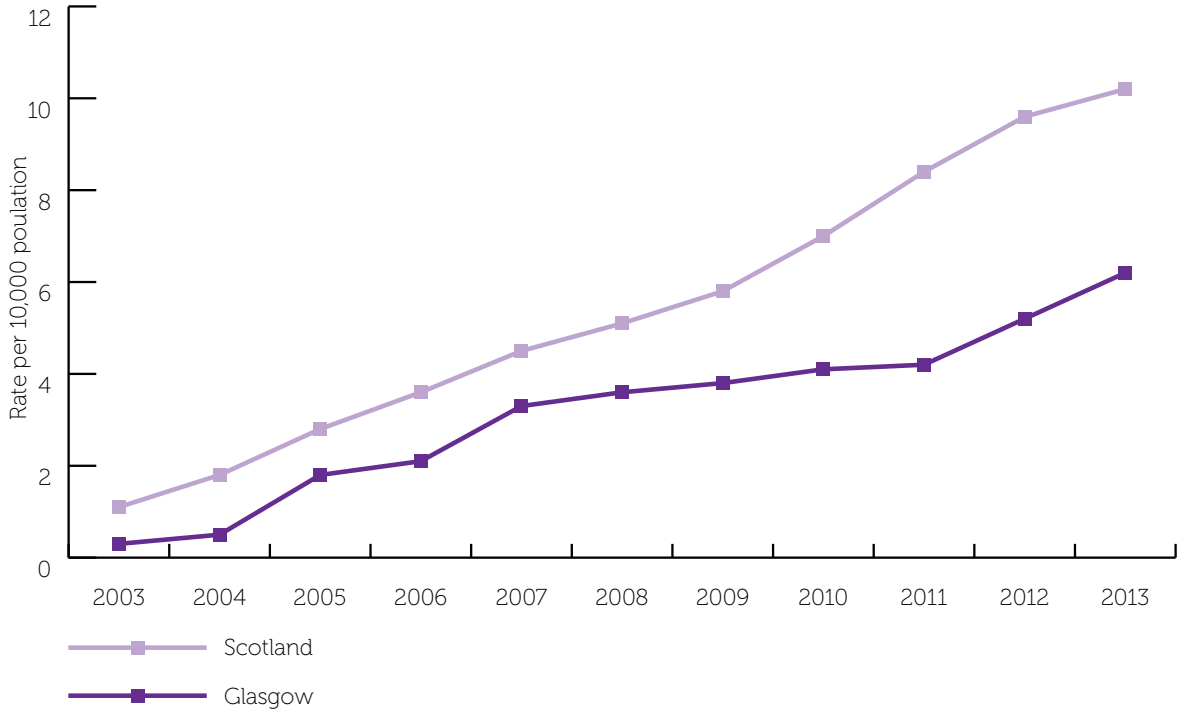
Chart 12 shows a significant downward trend in the Partnership's respite provision for older people and their carers. In recent years, the Partnership delivered respite for older people and their carers at a level significantly below the Scotland average. We met with a group of carers who cared for frail older people and older people with dementia. They all told us about the difficulties getting respite, the reduction in the Partnership's respite provision, and the negative impact this had on them as carers and the older people they cared for, as they felt increased stress and pressure as a result. Carers told us that the Partnership had capped respite at a maximum of 14 days each year and managers confirmed that this was the norm.

Self-directed support

Self-directed support means the ways in which individuals and families can have choice about the way support is available to them. It includes a range of options for exercising those choices, including direct payments. Since April 2014, councils have a statutory duty to offer the four self-directed options[5] to older people and other adults who need social care services.

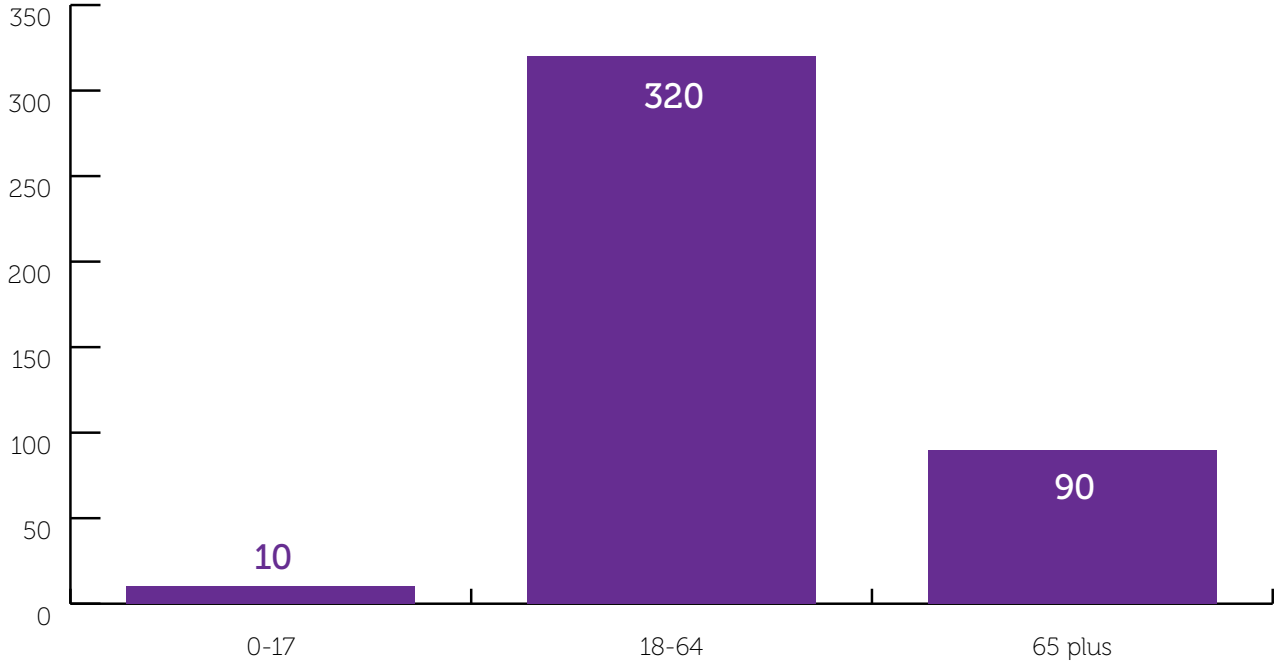
[5] 1 direct payment, 2 individual choses services and service providers, 3 local authority arranges services, 4 mixture of 1 to 3.

Chart 13: Glasgow, service users in receipt of direct payments



Source: Scottish Government

Chart 14: Glasgow 2013, provision of direct payments by age group



Source: Scottish Government

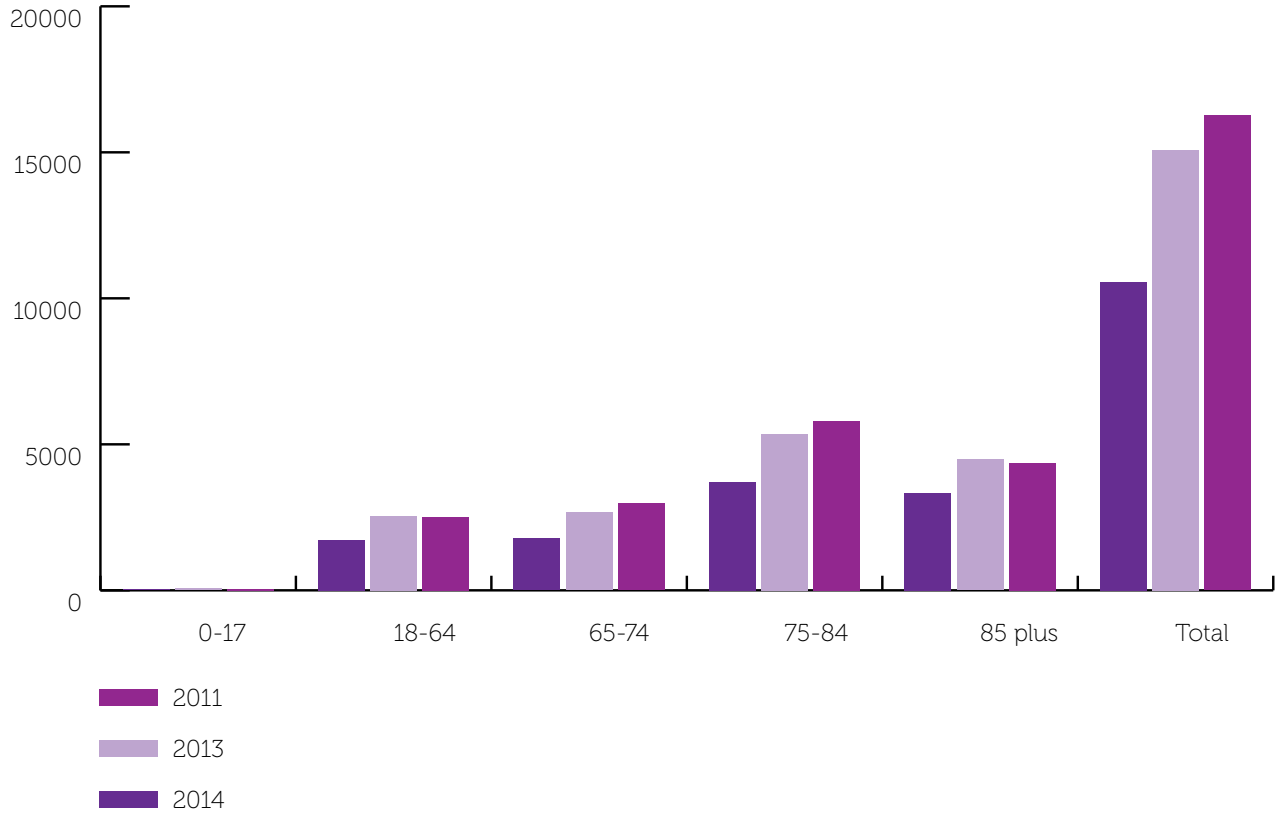
Charts 13 and 14 show the Partnership's progress with the overall delivery of direct payments and the delivery of direct payments to older people. See Quality Indicator 5.4 for discussion of the issues pertaining to the Partnership's delivery of self-directed support to older people.

Telehealthcare and telecare

Telehealthcare assists the self-management of patients' conditions and may include video-conferencing, older people's remote consultations with health professionals or environmental monitoring devices installed in older people's homes.

Telecare is equipment and services that support people's safety and independence in their own home. Examples include community alarms,smoke sensors and movement sensors.

Chart 15: Glasgow, community alarm and telecare provision trend by year and age group



Source: Scottish Government

Chart 15 shows a significant downward trend in the provision of community alarms and telecare services to older people (and other client groups) from 2011 to 2014. Staff told us that they thought increases in charging for these services was the cause of the reduction.

1.2 Improvements in the health, wellbeing and outcomes for people and carers

Outcomes are the changes in individuals' lives that are a result of the services they receive. Outcome-focused assessments and care plans emphasise the desired positive changes the individual wants and the provision of services that are designed to achieve these changes.

Chart 16: File reading results on the range of positive outcomes delivered by health and social work services for individuals

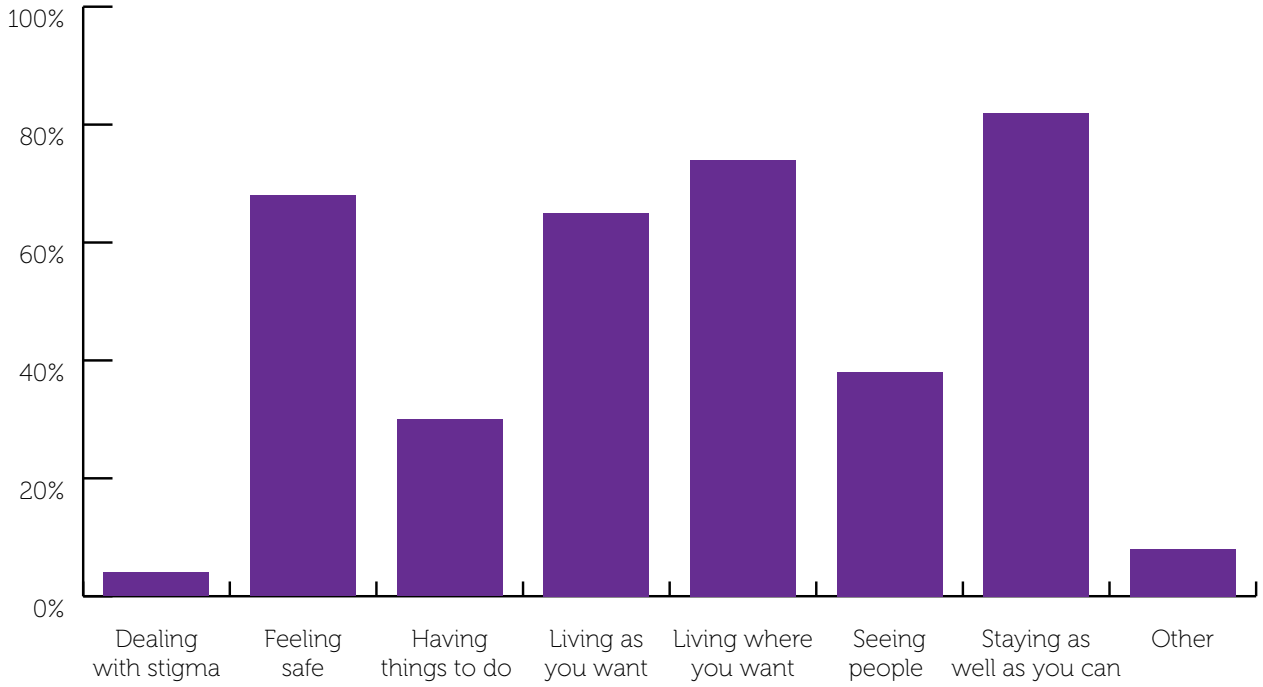


Chart 17: Results of Glasgow joint inspection staff survey on outcomes for older people

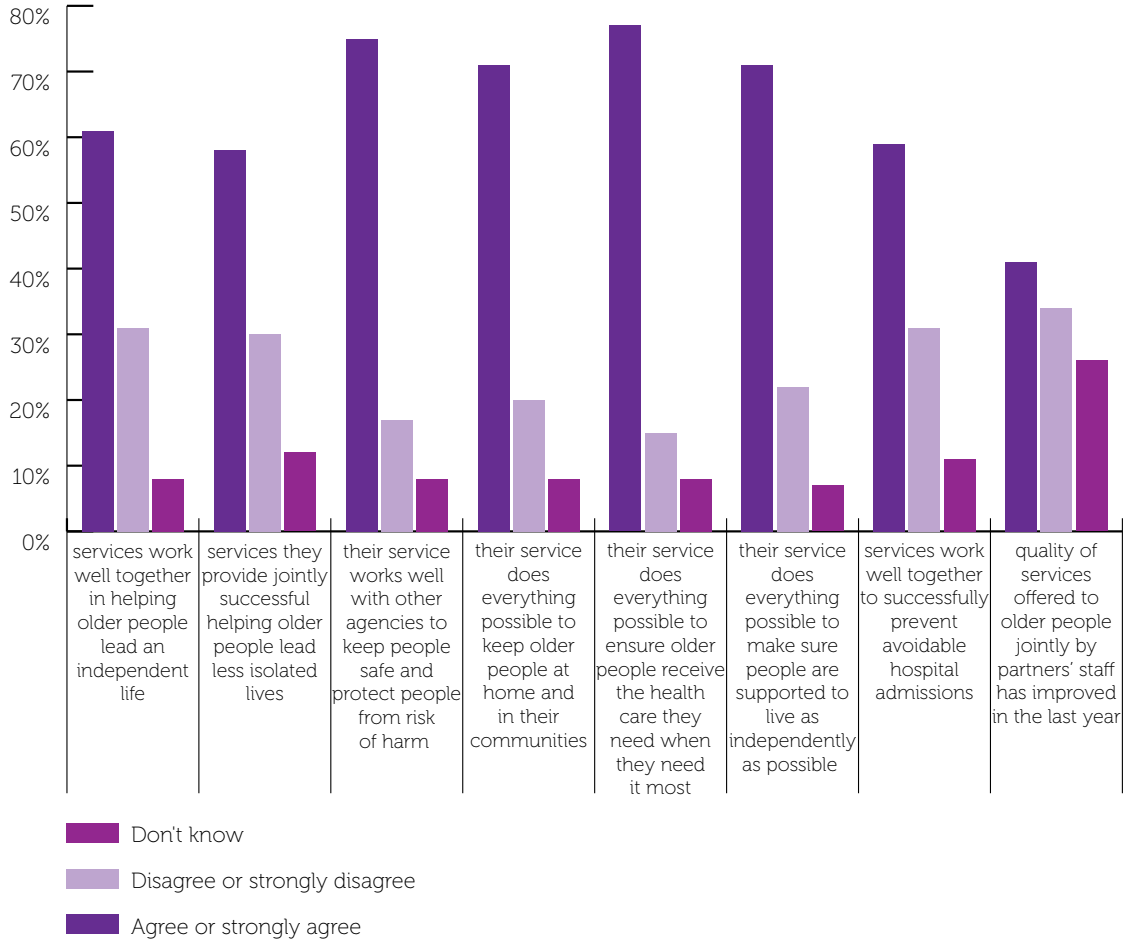


Chart 16 shows the positive results on outcomes for older people from the health and social work services records we read. The Partnership delivered positive personal outcomes for 93% of these older people.

We met with a large number of older people who told us that the health and social work services they received kept them safe, enabled them to live independently at home, kept them as well as possible and enhanced their wellbeing.

Staff responses on delivery of outcomes for older people were relatively positive (chart 17).

Outcome-focused care plans

For over half (58%) of the older people whose records we read, their primary care plan was not outcomes-focused, as they did not set out the individuals' desired personal outcomes. The Partnership needed to improve in this area.

Quality indicator 2 – Getting help at the right time

Summary

Evaluation – Adequate

Older people and their carers were generally happy with the services provided to them by the Glasgow Partnership. They felt these services improved their health and wellbeing.

Good progress had been made in the development of the carers' pathway. The Partnership was working hard to make sure it identified and supported carers at the right time, with 6,220 new carers identified through the pathway from 2012-2015.

An extensive range of services had been developed across the Partnership to support older people to maintain their independence and feel supported in their own home. However, the majority of these initiatives were pilot projects, were time-limited and were not accessible to all older people due to where they lived. Therefore, the Partnership should consider how it will achieve sustainability for these initiatives and ensure equity of access to these services.

2.1 Experience of individuals and carers of improved health, wellbeing, care and support

An outcome-focused approach

From the health and social work services records we read, we saw evidence of good personal outcomes and positive changes for older people after intervention by health and social work services.

We saw positive personal outcomes being achieved for many older people. (Chart 16.)

Amongst other funding streams, the Glasgow Partnership received transformation funds from the Scottish Government. Using these funds, the Glasgow Partnership, the third sector and the independent sector had developed many initiatives and pilots across different localities. These were focused on improving outcomes for older people by reducing social isolation, increasing physical and mental activity and managing long-term conditions. The following are some examples of what we found.

- The Visibility project was an early intervention project which targeted people aged 55 years and over who had experienced deterioration in their sight but had not yet registered blind or partially sighted. This project offered emotional support, advice and practical support to help people come to terms with their condition and make the most of the sight that they still had. The Glasgow sensory impairment social work team worked closely with this project. They provided aids and adaptations to encourage independence to enable individuals to remain at home.

- The Art of Wellbeing project was an arts-based project based in the North West of the city. It provided arts and social activities for older people, with the aim of reducing social isolation and promoting movement and activity.

Older people who attended some of the activities associated with these initiatives told us that they contributed very positively to better outcomes for them. They helped to reduce social isolation, increase their activity levels and empower them to have more controlover their condition. The majority of these initiatives were were time-limited pilot projects.

Improving care and support for older people

The Partnership piloted an initiative at Glasgow Royal Infirmary where older people bypassed the accident and emergency department and were assessed in a frail elderly unit. This was a medical assessment unit and older people could then have access to appropriate staff from older people's medicine services. Staff told us that this unit has resulted in fewer admissions of older people to Glasgow Royal Infirmary. Following an evaluation of this unit, the Partnership planned to extend this initiative to other acute hospitals in Glasgow including the new Southern General Hospital when it was opened.

A six-bedded step-up care service was located in a care home in the North East of the city. This service aimed to prevent hospital admission by providing short-term care and support to older people for up to 15 working days. The service was led and managed by health rehabilitation services with dedicated social work services input. Referrals made to the step-up care service came from a variety of sources such as the GP, the NHS rehabilitation service, the consultant in older peoples medicine, day hospital, or social work services. Staff from the service told us that they also regularly received referrals from the frail elderly assessment unit. They told us that the two services worked well together to prevent admissions to the hospital.

The Partnership planned to roll out step-up care as part of the overall expansion of intermediate care.

Supporting carers

Older people and their carers told us they were generally happy with the services provided to them. They told us they felt that the services they received improved their health and wellbeing. From our scrutiny of health and social work services records, we saw that where carers had a carers assessment, the subsequent support provided had led to improved outcomes for almost all of the carers.

Most staff agreed that the views of carers were fully taken into account when planning, and supporting older people. Carers also have a legal right to have their own needs assessed if they so wish. From our review of health and social work services records, we found a large proportion of carers (67%) should have been offered a carers assessment. However, there was no evidence that this had been done. The Glasgow Partnership should make sure that all of the offers of a carers assessment are properly recorded.

In Glasgow City, access to services and support for carers was provided through a one-stop shop approach known as the carers' pathway. This gave carers from all care groups access to a range of services and support. This included income maximisation, where staff helped older people to access welfare benefits, emotional support, short breaks, advocacy, training, information and advice, and peer support. The Partnership felt that its current support to carers was good, as did a number of carers' groups that we spoke with. There was a strong emphasis on ensuring social work services and health professionals, including primary and acute care staff, routinely identified carers early at the point of a cared for person's diagnosis or initial contact with services. They should then be signposted towards the carers' pathway.

Carers and staff were extremely positive about the Partnership's approach to providing help and support for newly identified carers with the introduction of the carers pathway. However, carers and carers groups said that, although there had been an increase in new carers assessments and identifying carers at an earlier stage, support provided to existing carers was not always reviewed. They were concerned that existing carers were not signposted for help and support from services. Carers previously supported should be linked to a carer centre where they can return at any time should their needs change.

Recommendation for improvement 2

The Glasgow Partnership should ensure that all carers are offered a carers' assessment in line with legislation and that these are regularly reviewed, and ensure that carers linked to a carers' centre can seek a review should their needs change.

The Partnership had developed emergency plans for carers. The emergency plan detailed the steps that should be taken in the event of an unexpected crisis to make sure the cared for person was safe and well. This social work services initiative, funded through the change fund, employed two emergency planning workers to support carers to complete emergency plans. Once completed, these were stored electronically on social work services systems and could be accessed out of hours. This support had reduced anxiety and increased confidence for carers, and made them feel more secure and supported in their role.

Glasgow City Council had introduced a carers' privilege card. This provided a range of discounts, including Glasgow Life gym membership, cinema entry, parking, a range of other services and access to council staff benefits. Over 7,000 carers' privilege cards had been distributed to carers across the city.

Using change fund monies, the Partnership had provided an alternative to residential-based respite for older people with low level care needs through the development of the 'Good Morning Service'. This offered a call service to older people when carers were taking short-term breaks. Volunteers were linked to older people and called them to make sure they were well and ask if they needed any help or support. This gave carers peace of mind that someone was available nearby when they were away.

In Quality Indicator 1, we reported that Glasgow was significantly below the Scotland average respite provision for Scotland. Carers and staff we met told us about concerns they about access to respite including:

- increased stress and uncertainty due to a reduced level of respite
- a cap on the level of respite they could receive
- difficulties in securing planned respite, even when dates were notified well in advance.

Carers told us that being able to get some respite from their caring role was very important. Older people, carers and staff told us that respite care across the Partnership had been reduced. Carers, who had previously been able to access six to eight weeks of respite care, found that they could no longer get this. Two weeks now was the average amount of respite that could be accessed. We were told by staff and carers that respite places could no longer be booked in advance. Concern was also expressed about the time it took to confirm respite places and dates. This reduction in access and the new arrangements for booking respite had caused anxiety and increased stress for carers.

Carers whose respite had been reduced told us that sleep deprivation was one of the most significant causes of pressure on carers and respite provision was invaluable in helping them manage and cope with the stress of caring.

The increase in the range of services charged for, had led to some older people choosing fewer services. This then increased the strain for some carers. Some carers had felt it necessary to reduce the number of days of service that they and the person they cared for received.

2.2 Prevention, early identification and intervention at the right time

Supporting people with long-term conditions

An increasing number of people are living with long-term conditions, such as diabetes and asthma.

We found that the Partnership had made good progress with providing help and support to older people with long-term conditions. A number of active ageing classes within communities and classes for people with long-term medical conditions had been set up. These classes supported participants to exercise at a level appropriate for their functional ability and this helped participants carry out daily activities more easily. All reablement service users were offered access to these services on completion of reablement.

From our staff survey, the majority of staff felt that services worked well together to support people's capacity for self-care and self-management. Staff agreed that services worked together to enable people with long-term conditions and those with dementia to remain active. It was clear that staff had a good understanding and knowledge of activities available for older people to manage their condition and how they could access these activities.

The Partnership's many initiatives around management of long-term conditions and building community capacity delivered good outcomes to older people. These enabled older people to have more control and choice by planning for their preferred support and care intervention should there be a deterioration in their condition or a carers crisis. However, the Partnership recognised that further development of anticipatory care plans was needed.

Telecare

Telecare is an alarm system with a 24-hour call handling and response service. The service is mainly used as an emergency contact service by people who live alone but can also support people who have serious mobility and/or medical problems. A variety of telecare devices are available which make sure that people are safe in their own homes. The most common devices are a pendant alarm, an alarm unit and a smoke detector. The community alarm telecare service was operated by Cordia, who provided the service

on behalf of Glasgow City Council. Older people and their carers told us they were generally happy with the telecare service provided by Cordia. They also told us it was a valuable and reassuring support.

However, staff told us that, since the introduction of the charging policy for telecare services, many older people had cancelled telecare due to the financial cost (see chart 15 in Quality Indicator 1). Cordia's annual report (2012-2014) stated that there had been a 30% increase in people cancelling their community alarms and telecare service due to the charging policy. Cordia stated that the most vulnerable service users retained their telecare service.

Implementing Scotland's National Dementia Strategy 2013-2016[6]

The Partnership was making progress in implementing Scotland's National Dementia Strategy 2013-2016. It was achieving its targets for diagnosing people with dementia and offering them post-diagnostic support. Post diagnostic support services were in place across the Partnership. Older people, carers and staff spoke positively about post-diagnostic support. However, in some areas we found that some older people with a diagnosis of dementia were having difficulty accessing day care services. This was due to waiting times for social work assessments and waits for specialist dementia day care services. We read records that showed there were some older people waiting for assessment where critical or substantial needs had been identified. Health and social work services staff told us that waiting times had impacted on carers as older people had excessive waits to be assessed and allocated day care services. This resulted in increased pressure and stress for the carer. Staff made use of interim solutions such as short breaks to support older people and their carers. The Partnership should monitor waiting times for day care and their impact.

Access to psychological therapies for older people

Health improvement, efficiency, access to services and treatment (HEAT) targets are an internal NHS performance management system that supports national outcomes. NHS boards are accountable to the Scottish Government for achieving HEAT targets.

We saw that the Partnership was meeting the Scottish Government's HEAT 18-week target for referral to treatment for psychological therapies. A number of initiatives had started, funded by the change fund, aimed at improving access to psychology and psychological therapies for older people. These included:

- a full-time permanent older people's psychologist based in the community
- a temporary assistant psychologist appointed to look at stress and distress training

[6] Scotland's national dementia strategy; Promoting Excellence: A framework for all health and social services staff working with people with dementia, their families and carers, Scottish Government June 2011

with plans to deliver this training to staff in wards for those with dementia across Glasgow
- training for staff in the structured psychosocial interventions in teams (SPIRIT) initiative) which trains mental health staff in the use of cognitive behavioural therapy
- access to cognitive stimulation therapy for older people with mental health conditions.

The Partnership told us that the source of funding for these initiatives and posts was time limited as they were funded by the change fund. The partnership told us that funding would continue through the intermediate change fund during 2015 and 2016.

Anticipatory care planning

An anticipatory care plan anticipates significant changes in an older person (or their care needs) and describes action, which could be taken, to manage the anticipated problem in the best way. This should take place through discussion with the individual, their carers, and health and social care professionals.

Anticipatory care planning is more commonly applied to support those living with a long-term condition to plan for an expected change in health or social status. It also incorporates health improvement and staying well.

We found variations in how anticipatory care planning was being developed and accessed across the Partnership. During our review of health and social work services records, we did not see many anticipatory care plans. Through discussion with community health staff and GPs, it was clear that anticipatory care plans were being completed. Staff groups we spoke with expressed positive experiences of anticipatory care plans, with district nursing seeing this as a pivotal part of care provision.

However, access to this information was restricted to certain staff groups as anticipatory care plans were held on the GP electronic system alongside key information summaries. These summaries allowed healthcare professionals to record and share important information about people with complex care needs or long-term conditions.

Staff told us that this restriction in accessing an older person's anticipatory care plan was detrimental to effective joint working and the delivery of the best possible outcomes for the older person. ACPs were at an early stage of development at time of inspection. Different models of anticipatory care were funded through the change fund and these had been evaluated.

From speaking with staff, older people and carers, it was clear that staff from social work services had limited involvement in anticipatory care planning. The Partnership

recognised that further development of anticipatory care plans was needed. The Partnership had made plans to develop a more streamlined and multi-agency approach to anticipatory care planning across the city. A one-year anticipatory project had been planned using Integrated Care Fund monies.[7] This project was planned to commence in 2015. While a city-wide approach had been agreed, senior managers told us that a final decision on the anticipatory care model had yet to be agreed.

Recommendation for improvement 3

The Glasgow Partnership should continue to develop anticipatory care planning for older people, ensuring a more streamlined, standardised and multi-agency approach, with anticipatory care plans that are accessible across the partnership.

Palliative and end-of-life care

We saw that good progress was being made in delivering palliative care for older people across Glasgow. Palliative care services were flexible and responsive. NHS Greater Glasgow and Clyde had developed a palliative care website. This useful website provided information on palliative care for patients and carers. This included links to resources, local services and the latest news on palliative and end-of-life care developments. The website also had a section for health professionals with the most up-to-date access on resources available for their patients, as well as opportunities for their own learning and development. Staff told us that where palliative care needs had been identified, health and social care services worked well in supporting the patient and carer with a range of services, including overnight services, to allow people to die at home.

NHS Greater Glasgow and Clyde, in partnership with Marie Curie and other local providers, had set up a fast-track discharge service in the north of Glasgow. This was in line with the end-of-life care objectives in the Scottish Government's palliative care plan.[8] This supported patients with palliative care needs and their families with in the patients' own home by providing a service which met both their health and social care needs. This service was seen as extremely successful and, following evaluation, plans were under way to extend this service across the city. However, until this evaluation was completed, it was not clear when this service would be extended.

District nurses visited hospital wards before patients were discharged from hospital. Hospital staff also spent time with district nurses in the community. This helped to

[7] The Integrated Care Fund is a new source of specific Scottish Government funding for adult social care replacing previous change fund monies and is intended for long term care across all adult care groups.

[8] Scotland's palliative care plan Living and Dying Well: Building on Progress. Scottish Government, January 2011.

facilitate better understanding and share learning and experience of supporting older people at the end of their life.

Intervention at the right time

Across Glasgow, hospital staff and rehabilitation staff were able to directly order care at home services without going through social work services. Care at home services could be ordered up till 10.00pm. This enabled older people to be discharged home from hospital when medically fit, with care at home services capable of being in place within four hours of discharge. The rapid access to care at home helped to free up beds in acute wards more quickly. Cordia, the largest care at home provider in Scotland, provided a range of care at home services on behalf of Glasgow City Council. Older people, carers and staff all spoke favourably of this city-wide quick access service. They told us that it enabled older people who were able to return home to be discharged quickly knowing that support and help would be in place.

We found that older people and carers were happy with the amount of personal care and support received from Cordia staff. Older people and carers told us that, although there was generally consistency of Cordia staff providing care, this was not always the case. Occasionally, care at home staff were deployed whom the older person did not know. Carers told us that this was very unsettling for older people who had dementia. We also heard from carers that changes in the timing of visits at the weekend would result in changes to routines for both the carer and the older person. As staff who were not familiar with the older person had to read their care plan before carrying out care duties, this also impacted upon the time allocated to spend with and care for the older person. Cordia focused on achieving general consistency in providing staff within the limitations of the rota system. Cordia advised that they were about to implement new major organisational development plan which would introduce more flexible rotas.

The reablement service worked in partnership with Cordia to support older people to enable them to get home from hospital. Other services such as occupational therapy and physiotherapy were set up swiftly for older people when reablement was required. We met with older people who had experienced the reablement process and found the service to be valuable and supportive. Cordia's reablement staff had been trained in the referral pathways for the 'Good Move' project. This was an initiative to reduce social isolation, improve activity levels and support the management of long-term conditions. We discuss this initiative more in Quality Indicator 4.

A number of staff across the Partnership told us that there were difficulties getting occupational therapy assessments for older people in the community. In some cases, this resulted in older people struggling to manage at home. There were difficulties in accessing aids and adaptations to help people to safely remain at home. Occupational

therapists gave us examples of where care at home packages had to be increased due to the lack of aids and adaptations.

Staff said that social work occupational therapy services designated older people as priority 1–3 depending on how critical their needs were. Priority 1 classifications were palliative care needs, continence difficulties and high falls risk. Priority 2 classifications were general bathing requirement and general transfer difficulties. Due to lengthy waiting lists only people classed as priority 1 or priority 2 received an occupational therapy assessment. Priority 3 had needs that were classified as low risk and had lengthy waiting lists for assessment and some did not receive an occupational assessment as a result.

The social work services occupational therapists in some localities also told us that the budget for equipment and adaptations had run out and no new funding would be available until the next financial year. Across the Partnership, we heard that due to the lengthy waits for an assessment from a social work occupational therapist, some health occupational therapists from psychiatric services were asked by social work services staff to carry out assessments on the older person. We heard that this was because health occupational therapists had budgets available for the provision of equipment and adaptations.

Recommendation for improvement 4

The Glasgow Partnership should make sure that older people have timely access to occupational therapist assessments to enable them to get the support they need to remain within the community.

NHS Greater Glasgow and Clyde had developed for GP practices an effective service for patient medicines management and reviewing patients with multiple medications . This promoted safe, effective, evidence-based use of medicines for patients considered most at risk of adverse effects. A number of GP practice clinical pharmacists also provided input into the multidisciplinary medication review process. They also delivered medication reviews for at-risk patient groups, including patients in residential care homes.

The Glasgow rapid response and resettlement service (GRRRS) was a good example of the Partnership and the third sector working together to develop and deliver an initiative that could improve the health, wellbeing and outcomes for older people (see good practice example on page 41).

The First Through the Door initiative encouraged all agencies to take a proactive approach to identifying older people who may be vulnerable and would benefit from some level of support. This involved a range of statutory services, housing providers and

third sector organisations who were given training on how to identify older people that would benefit from additional support.

The Partnership provided a community falls prevention programme. This consisted of a specialist team of technicians, occupational therapists, physiotherapists and pharmacists. The team visited the older person at home and, following a home assessment, provided a programme suited to the older person's own needs . This service promoted independence and improvement in physical health and helped older people to manage their fear of falling. Through speaking with staff, it was clear that the service was well used by community staff. They thought it was invaluable in helping to maintain an older person's safety and independence once they were susceptible to falls. Due to eligibility criteria, older people could only be referred to the service if they had experienced a fall. Therefore, older people deemed at risk of falling but who had not yet had a fall could not access this service.

2.3 Access to information about support options including self-directed support

The Partnership started offering self-directed support options for older people on 1 April 2014. From our review of health and social work services records, we found that 76% of older people were not offered self-directed support options where we would have expected them to be offered. We met with self-directed support development officers from Glasgow City Council. They told us that self-directed support was being delivered to older people through Glasgow City Council's 'personalisation' model. Personalisation is a social care approach described by the Department of Health as making sure that "every person who receives support, whether provided by statutory services or funded by themselves, will have choice and control over the shape of that support in all care settings".[9] Glasgow City Council's personalisation model has seven steps to complete with the person completing the steps being supported to do so by social work services. It involves self-evaluation, devising and agreeing a care plan and allocated budget, and regular review of the plan to ensure it is working.

Glasgow City Council's social work services had adopted a targeted approach to self-directed support for older people. This made a distinction between those with non-complex and complex social care needs. (This will be discussed further in Quality Indicator 5). Those that presented with more complex needs would be referred immediately for a social work assessment and this would be carried out within the personalisation framework, be allocated an individual budget and have an outcome-based support plan put in place.

9 An introduction to Personalisation. Department of Health (2008)

All older people go through the reablement route. Older people with non-complex needs who complete the reablement process and require a continuing mainstream low level service would be offered the four options for self-directed support at their first care service review.

Carers, older people and advocacy groups told us they were concerned that self-directed support would be used solely as a money saving exercise to reduce expensive care packages, as only complex and expensive care packages would go through the personalisation process. Concerns were also raised about the choice of care providers for older people. Cordia mainstream care at home services were the main provider of care at home in Glasgow.

Older people, carers and staff said that Glasgow City Council had introduced a charging policy for day care attendees in April 2014. This meant a number of older people no longer attended day care services, or had reduced the number of days that they attended. There was general dissatisfaction from older people and carers at the way the charging policy had been introduced and the limited availability of information. Older people and carers spoke about a lack of clarity and support about the means testing assessment element.

We spoke with older people who attended a new day care service. Following the planned closure of the day centre, older people who had attended this centre now had to make their own way to a central pick-up point to be taken to the new day centre. All other older people were picked up from their homes. Older people we spoke with were unhappy about this, and it had resulted in changing the number of days and times they attended. Staff told us that this was an agreement made at the time of the day care centre closure as the older people affected were outwith the catchment area. However, this decision would be reviewed.

Example of good practice

The Glasgow rapid response and resettlement service combined supported patient transport with follow-up help for older people discharged from accident and emergency departments and wards. The primary aim of this service was to help prevent avoidable admissions and re-admissions to hospital and promote resettlement at home by providing practical and emotional support. This service provided two trained patient transport crew (2.00pm–2.00am, seven days a week) to return the patient home. Patients were then helped to settle back into their home and, where needed, provided with a short period of support to assist their independence and enable them to remain at home. This service was initially funded by change fund monies. The Partnership had agreed that the service would continue and a commissioning process was underway.

Quality indicator 3 - Impact on staff

Summary

Evaluation – Adequate

Staff across the Glasgow Partnership were committed to providing high quality support and services to older people. Staff in more specialist teams were most positive about the difference they were making to the lives of older people.

However, morale was relatively low among some staff groups across the Partnership. This was more widespread within social work services.

The consistency and frequency of communication and joint engagement with staff across all sectors needed to improve.

Staff across health and social work services had mixed views on joint working. There were positive working relationships among health and social work practitioners but these varied between teams and within the three sectors of Glasgow (North East, North West and South Glasgow).

3.1 Staff motivation and support

Motivation

In assessing how the Partnership was progressing against this quality indicator, we looked at a range of documentation submitted by the Partnership. This included employee surveys carried out by Glasgow City Council and NHS Greater Glasgow and Clyde. During our inspection, we also carried out our own staff survey and had face-to-face meetings with 382 staff. This included a range of managers and staff groups from across health and social work services.

Our staff survey was sent out to 2,363 staff, with 665 (28%) responding. This broke down to:

- almost two-thirds (65%) of the 665 respondents were employed by the NHS
- 31% were employed by the Council
- the remaining 4% were employed in 'other sectors' such as GP practices.

Most staff who responded to our staff survey were motivated and committed to providing high quality care and services. Results from our staff survey showed that:

- 86% of staff said that they enjoyed their work

- 75% agreed they were well supported in situations where they may face personal risk
- 69% of staff said they felt the service had excellent working relationships with other professionals (23% disagreed with this view)
- 65% felt valued by their immediate managers (26% disagreed).

Staff morale across the Partnership was higher within more specialist teams, carer services and those in more specialist posts. For example, we met staff from Social Care Direct. This was a call centre for referrals to social work services. Staff were enthusiastic, had a clear direction and sense of responsibility, role and ownership of their service. We also met staff from the step-up care service who were well motivated and there was good communication across different staff groups in this service.

In contrast, we met with a range of frontline staff and managers from across health and social work services, who were responsible for delivering a range of services for older people. They told us about a number of demotivating factors which they said impacted on their ability to do their job. These included:

- the level of uncertainty over health and social care integration plans
- increased pressure as a result of increasing workloads
- pressure to make financial savings.

Whilst a relatively small number of staff had been identified to move to Cordia, social work frontline staff we met were particularly concerned and anxious about the intention to move staff. Cordia provided a range of care at home services on behalf of Glasgow City Council. This independent customer service/business support service operated as an arm's length external organisation (ALEO). The social work services frontline staff that would transfer into Cordia were responsible for completing less complex care at home assessments for older people and other client groups. Staff who were transferring were worried about the impact this might have on their ability to be responsive and provide flexible services when trying to improve outcomes for older people.

Staff we met expressed similar views to the responses to staff surveys carried out by the Partnership. A staff survey carried out by Glasgow City Council in 2012 found 67% of staff believed the experience of working for the council had deteriorated. A staff survey carried out by NHS Greater Glasgow and Clyde in 2013 showed that 89% of staff were happy to go the extra mile at work when required. However, only 43% of staff thought that they could meet all the conflicting demands on their time at work.

We were also given information on workplace stress surveys carried out by Glasgow community health partnerships across North East, North West and South Glasgow during December 2013, January and April 2014. Staff across different specialisms were represented, including those who worked within older people and physical disabilities

teams. Staff responded positively about peer relationships and support from frontline managers. Most responded less positively about the volume of work and insufficient opportunities to question managers about changes at work. While we read that action plans from these surveys were being developed to address areas identified for improvement, no evaluation of progress was available.

The Partnership was robust in monitoring staff attendance with levels within social work services in 2014–2015 showing slight variation across services from 4.7% and 7.1%. Staff sickness levels within health for the city were an average of 5.5% with a national NHS Scotland target set at 4%.

Some frontline social work staff told us that they had experienced difficulties in sustaining their motivation due to the frustration at recently introduced changes in the resource allocation and assessment systems that they used daily.

Teamwork

Staff were clear about their own roles and responsibilities, but were often less clear about those of their colleagues across the Partnership. However, they observed a loss of opportunity for more strategic joint working since the dissolution of Glasgow's five community health and care partnerships in 2010. Staff were hopeful that joint working was likely to improve as services became more joined up after integration
Of the staff who responded to our survey, 76% agreed or strongly agreed that they had access to effective line management (regular professional specific clinical supervision within the Partnership). Sixty three per cent of those who responded agreed their workload was managed to enable them to deliver effective outcomes to meet individual's needs. This percentage was lower for social work services staff. Thirty-seven per cent agreed that there was sufficient capacity in the service to undertake preventative work. Reasons given by staff we met across the Partnership for this included difficulties in finding time to prioritise preventative work when there were many complex cases waiting for assessment.

Some health service managers spoke positively about their work with older people but were less positive about other aspects of their work. This included duplication of work effort and assessment processes. A number of frontline health and more specialist staff groups said they were not being enabled to use their specific skills. We found most staff were uncertain about what the future integration might mean for their work.

We talked to a wide range of frontline staff across the Partnership who described the lack of communication from senior managers about proposed changes to structures and service delivery. Some concerns were also raised from acute service staff about the need

for improvement in communication within health services. They suggested there was a lack of clarity around general issues such as the definition of intermediate care .

Senior managers we spoke to were aware of the uncertainty amongst staff and of the need for good communication and to be open and transparent in their dialogue with staff across the Partnership. They believed they communicated well. They described efforts they were making to improve communication.

Within health, an open invitation from the interim chair of the shadow integration joint board had been issued to all staff to attend briefing sessions on integration with the chief officer designate.

We also read Issue 2 of the Social Work Services Staff Newsletter July 2014 which included a wealth of relevant information. Health staff had access to the staff net (Greater Glasgow and Clyde internet home page) and were kept informed through team briefings. Senior staff also said that the progress of integration of health and social work and communication were standing items at the senior management team meeting. Senior managers were taking steps to improve communication. This was important as staff that feel well informed are more likely to demonstrate commitment to an organisation. However, the role, profile and visibility of senior managers in supporting and communicating with employees to promote the delivery of effective services should be developed and enhanced as integration progresses.

Learning and development

Learning and development opportunities varied between health and social work services, across teams, staff groups and within the three sectors of Glasgow. From our staff survey, and from meeting with a range of health and social work services staff, health services staff were more positive about development opportunities open to them. More specialist staff, such as lead pharmacists, described good access to learning with opportunities to test and change services. Some senior health services staff we met described opportunities for senior managers to shadow and question the executive director and saw this as a positive way of improving their learning. We read NHS Greater Glasgow and Clyde's Facing the Future Together strategy[10]. This encouraged the whole organisation to work better together.

Frontline social work services staff described variable development opportunities across the Partnership. Some staff told us they had less opportunity to access meaningful training than previously. Social work services staff said they had less opportunity for professional development and less control over their work than previously.
Glasgow City Council and NHS Greater Glasgow and Clyde community health

[10] Facing The Future Together' 2012, NHS Greater Glasgow and Clyde corporate strategy.

partnership had separate learning and development plans. However, these were yet to be embedded. Senior social work services managers told us that protected learning, workshops and discussion forums were being rolled out to support teams and allow them to have
time together.

Example of good practice

Staff spoke positively about the designated carer teams in place across Glasgow. These teams were very enthusiastic and passionate about taking forward carer services and had a strong commitment to driving forward further improvement. Good joint working between social work services, the NHS and third sector carer partnership leads was evident in taking this whole systems approach with clear pathways forward.

Recommendation for improvement 5

The Glasgow Partnership should take immediate action to improve the engagement with frontline practitioners and their managers. They need to improve quality, consistency and frequency of communication and engagement with staff across all sectors. Thereafter the partnership should put systems in place to measure if the desired improvements are realised.

Quality indicator 4 – Impact on the community

Summary

Evaluation – Good

The Glasgow Partnership was committed to developing community capacity for supporting older people across Glasgow. A good range of community supports was already in place to enable older people to have healthy and fulfilling lifestyles at home or in a homely setting in their local community.

A variety of pilot projects had been funded through change fund and transformation fund monies. The Partnership had consulted with local communities about meeting the health and social care needs of older people. Glasgow Council for Voluntary Services facilitated a series of engagement events for older people, carers and providers to inform and develop future service improvement plans and priorities.

Elected members and senior managers from health and social work services acknowledged that they needed to do more to develop a cohesive approach to locality planning and community capacity building.

4.1 Engaging with the community

The Partnership was committed to engaging with the public and local communities about meeting the health and social care needs of older people in Glasgow. Older people and carers were delegates on local and city-wide committees for older people and consultation forums.

We read the Partnership's draft joint strategic commissioning plan for older people. This was co-produced with the third and independent sectors. There was a clear theme of building community capacity in the plan. We were impressed by the Partnership's commitment to redesigning future care services for older people to shift the balance away from institutional settings to supporting older people to live at home.

The Partnership had invested in the third sector as a key partner to sustain and grow new community-based services for older people. Third sector and independent sector reference groups were involved in the planning for Reshaping Care for Older People. There was a good history of community involvement in Glasgow. Dedicated workers had also been appointed to improve engagement with the third and independent sectors. A compact with the third sector, published in 2009, had helped to consolidate

their engagement. Some third sector initiatives received funding, at least in part, from the change fund to deliver community supports to older people .

Planning for Reshaping Care for Older People had input from third sector and independent sector reference groups. Glasgow Council for Voluntary Services led on the community capacity-building programme on behalf of Glasgow's third sector. This assisted with the early intervention and prevention agenda. Reshaping Care for Older People had a strong focus on tackling social isolation, maximising independence and improving the health and wellbeing of older people. This was a good example of how the Partnership supported older people to have active, healthy and fulfilling lifestyles. The Partnership had sought the involvement of older people and carers in the future design of services in their local community.

The reshaping care for older people group used a co-production approach to develop services for older people and enhance community capacity.

Following consultation, the Partnership intended to amend the draft joint strategic commissioning plan by 1 April 2015. The Partnership's equality impact assessment of previous public engagement activity revealed that local events were not enough to reach the number of older people affected by the changes. A programme of roadshows in shopping centres, libraries and health centres was underway to improve and develop future engagement activity. The Partnership had also produced a detailed web based services directory called Your Support Your Way which included extensive information about how to access health and social care services across the city.

The key messages from the Partnership's consultation were that people supported the Partnership's vision and direction for the plan. However, respondents were anxious about its delivery in the current economic climate and the level of need in Glasgow. Overall, people wanted more detail about how the Partnership would bring about the proposed changes and what this would mean for their local communities.

Glasgow Council for Voluntary Services supported a mix of small local groups and bigger national provider organisations with their funding bids and business models. This ensured there was a focus on key priorities and outcomes. A city-wide third sector mapping exercise, completed in 2012, highlighted the scope and variety of small non-commissioned services such as lunch clubs and befriending services that relied on volunteers.

Senior managers within the Partnership said the structure and leadership across the localities was progressing. The locality planning group produced a comprehensive report about its progress, which outlined the plans to develop a management structure to support health and social care partners with locality planning. The draft structure

continued with three service delivery sectors - North East, North West and South Glasgow. In our staff survey, we asked about community involvement.

Partnership managers and staff acknowledged that some areas had a better range of resources for older people than others. For example, a South sector care and repair project provided a handy-person service for minor adaptations. This was funded through change fund monies, but was not a city-wide service. The Partnership was carrying out an evaluation of change fund initiatives across the city. It had identified the need to carry out some additional targeting of services particularly in the North East sector as this was less well resourced.

Older people told us they were very satisfied with the community support services available to them. They spoke highly about the assistance they received from staff and volunteers to enhance their quality of life and wellbeing.

The carers' centres helped carers to access a range of services to support them in their caring role. This included training in understanding dementia, and moving and assisting techniques. Community nurses funded by the carers information strategy were co-located in social work services carer teams and they worked closely with the carers' centres to monitor and review the individual health care needs of carers and to provide support and advice about their health and wellbeing. This was a positive approach to enhancing carers' wellbeing and addressing their physical and mental health needs.

Community initiatives

The Third Sector Transformation Fund (change fund monies) supported third sector initiatives to enhance community capacity to support older people and improve their health and wellbeing.

The Transformation Fund supported 20 organisations from the third sector to deliver projects for older people and carers in the city. These helped to deliver positive outcomes for older people. Some examples of projects included the following.

- Castlemilk Pensioners Action Centre assisted older people to live independently at home. This community-based centre offered a range of activities including subsidised cafes to support healthy eating, advice, guidance, companionship and a variety of entertainment and learning opportunities.

- The Glasgow Food Train provided a volunteer-led grocery shopping delivery service to local older people in the South sector who were experiencing difficulty with shopping. This vital service promoted partnership with local supermarkets

with additional arrangements made as necessary to support older people from ethnic minority backgrounds. There were plans to extend this service across Glasgow.

- The Carers' Emergency Planning Service supported carers to develop emergency plans and this included a carer emergency card. This was highly valued by carers as highlighted in outcomes evaluations.

- Southside Housing Association had identified a number of older vulnerable people resident within their housing stock. The housing association had taken action to reduce social isolation by developing four community bases for their older tenants.

- Glasgow Association for Mental Health provided over 2,000 hours of community-based support every week to older people in Glasgow. The organisation had expanded its range and volume of services and had developed a 'Calm Project' in the North of the city. The aim of the project was to improve the mental health and wellbeing of older people by supporting them to gain skills in managing stress through complementary therapies and mindfulness.

Example of good practice

The Good Move project was a change fund initiative to launch a campaign to advertise the various activities available for older people in Glasgow. There was an emphasis on early intervention to prevent health difficulties and reduce health inequalities for older people.

The aim of the programme was to encourage older people to remain active with the support of free, coach-led physical activity. Vitality classes designed specifically for older people with long-term medical conditions included local and volunteer-led health walks in the city's parks. The service was free and available across Glasgow.

Example of good practice

The Power Of Attorney Public Awareness Campaign provides a good example, related to individuals who lack capacity, of a whole systems response to AWI delayed discharges. It was anticipatory and supported people to take control of their future affairs while seeking to reduce the risk of unnecessary future hospital delays due to incapacity.

The campaign used television and radio channels, phone boxes, bus shelters and digital screens in GP surgeries. It commenced December 2013 and is supported by a telephone helpline, dedicated website and Twitter.

Quality indicator 5 – Delivery of key processes

Summary

Evaluation – Adequate

A good range of information was available to older people referred for services about how to access support. Social care direct provided an efficient first point of contact for many individuals and agencies. However, waiting times for assessment and the availability of some services meant older people and their carers sometimes had to wait too long to get the services they needed.

Financial pressures also meant that sometimes older people had to wait until funding was available to access the support they needed.

Effective processes were put in place by Glasgow City Council to support adults at risk of harm and management of risk was improving. However, managers and staff were concerned about some delays in progressing adult protection referrals.

Older people were prioritised, as part of the reablement approach, for assessment and support.

5.1 Access to support

A good range of public information was available through Glasgow City Council's website. This provided details of the health, care and support services available to older people and their carers. It also included information about eligibility criteria, charging policies and personalisation, as well as the range of care and support services in different localities. Links to the most recent Care Inspectorate report for registered care services provided easy access for individuals to information on the quality of these services. However, some of the information available online for older people was out of date.

The Council also needed to be clearer in the information that it provided to make sure that individuals making a referral or being referred for assessment were aware of timescales and likely actions.

The Council's eligibility criteria set out the different priorities that it considered. Priority was given to people who had critical needs that indicated there were major or substantial risks to the individual's independence or health and wellbeing. These risks meant there was a need for the immediate or imminent provision of social care services.

Some frontline health services staff we spoke with were unaware of the changes to the social work services' eligibility criteria. The Partnership needed to make sure health services staff were fully briefed on any changes to social work services eligibility criteria and relevant service changes.

Frontline social work services managers told us that sometimes older people assessed as having a critical or substantial need (priority 1 or priority 2) had to wait for assessment., In these situations, services were provided to the older person and their carer to meet needs and mitigate risk until the assessment was completed and the subsequent level of support needed was identified. Health staff also told us there were increased waiting times for social work assessment, even for some high-priority individuals. Information provided to us by social work services showed that around one third of people initially assessed by Social Care Direct as having substantial needs waited for one month or more for further assessment of their care and support needs. We were concerned that the Council did not routinely gather information about waiting times to determine the impact on individuals and inform service prioritisation, planning and review.

Recommendation for improvement 6

The new Glasgow Health and Social Care Partnership should routinely gather and report on comprehensive data on the numbers (and eligibility criteria categories) of older people waiting for an assessment or review, the length of time they have to wait, and the length of time for service deployment following completion of their assessment.

Financial pressures meant that sometimes older people had to wait until funding was available to access the support they needed. We observed staff having to make decisions about which individuals should be prioritised to receive services. Social work services needed to clearly inform older people when they did not meet the eligibility criteria for assessment and subsequent service provision. These older people should then be given information about mainstream services and community supports to help to meet their needs, as some older people did not understand where to find information from existing sources.

Glasgow City Council sought to minimise the impact of the introduction of charges through an appropriate income maximisation approach with a means test that set a £15 limit on charging and a waiver of charges.

Glasgow Community Health Partnership provided a range of information on its website about services available in each locality, as well as some links to community-based activities. Community health services also had eligibility criteria and published response

times on their website. Some had options for self-referral, for example the rehabilitation service.

Access to social work services was mainly through Social Care Direct. This was a centralised call centre that screened all referrals to social work services. A dedicated line was available for professionals to call to help them make referrals quicker. The 'Your support your way' online information portal helped staff direct older people to the range of suitable services in their local area. However, the portal could be improved to highlight where further assessment was required to access some of the services. Social Care Direct had been in operation for two years and had improved access to initial assessment for a number of older people. The service was being reviewed to consider what worked well and what could be further improved. This review would need to consider the effectiveness of the signposting and early intervention elements of the service as well as its response to adult protection referrals.

Many social work services staff spoke positively about the screening services provided by Social Care Direct. This reduced the range of referrals to social work teams. Staff in Social Care Direct carried out some initial screening of assessments before those individuals that required further assessment were passed to social work teams. However, some health and social work services staff expressed concern about delays in referrals being passed to them when further assessment or services were needed. Social Care Direct did not regularly meet its own target response times. This included both general referrals and referrals about adults at risk of harm. Staff in Social Care Direct carried out some initial screening of assessments before those that required further assessment were passed to teams. An interim increase in staffing had helped to reduce some of these delays. Referral pathways were being considered as part of the review of the service.

Managers in social work services needed to improve their communication with the main referring agencies to ensure that all involved were aware of the work carried out by the Social Care Direct service.

We found some differences in the availability of services and waiting times for services across the different localities. Day care provision across Glasgow had been reduced through the closure of some services although befriending and home care were used where appropriate to support older people with assessed needs who were on waiting lists for day care. Approximately 250 older people were waiting for day care services and 40% had been waiting for three months or more. Waiting times varied across the city. Older people had to wait longer in the south due to a lower level of day care provision. Older people with critical and substantial needs and people with dementia were prioritised for day care support and may impact further on the length of delays. The Partnership was testing some new models of care and support. This meant that, in some areas, additional

services and support options were available. Discussions on when or how these options of care and support would be extended across Glasgow had not concluded.

5.2 Assessing need, planning for individuals and delivering care and support

We saw assessments in both the health and social work services records we read. The assessments in the health records mainly related to people's individual health conditions. Our findings on assessments were mainly positive in that:

- 92% of records contained an assessment and the majority of these were up to date
- 96% of the assessments took account of the individual's needs
- 60% of the assessments we evaluated as very good or good quality and none were evaluated as unsatisfactory.

The use of personalised approaches to assessment and care planning was well established in Glasgow. This approach was aimed at supporting older people to maintain their independence. The Partnership was beginning to shift to early intervention and preventative support to enable more people to receive the right service,at the right time, to deliver the right outcomes. Direct referral from hospital to Cordia and the reablement service had helped many older people with less complex needs to get timely access to these supports. This then helped them to quickly achieve their desired outcome of returning home.

A range of in-house audits of records had helped managers understand how well assessment and planning processes worked. Over the last few years these audits have sampled the case records of around 500 individuals. From the health and social work services records we read, we saw evidence of management scrutiny of files in only 21% of the records we reviewed. Some positive improvements had been put in place following these in-house audits, for example improved risk assessments and recording.

We found that staff shared information held in records routinely but did not work together as often when jointly preparing shared assessments. The majority of older people's records we read had some evidence that health, social work and other services shared information to help inform the care and support needs of these individuals. In our staff survey, less than half of the staff agreed that key professionals work together to inform a single user friendly assessment. Staff in focus groups we held also confirmed this.

Staff in both health and social work services were not clear about how referrals were progressed from initial point of contact to the delivery of services. The processes put in place to manage resources meant that staff often had to pass re-assessments through numerous panels before a service could be agreed. Even after the assessment and service requirement was agreed, there could be a further delay in the older person getting the service they needed when there was a waiting list for services such as care at home.

From our review of health and social work services records, we found:

- 31% of individuals had a comprehensive care and support plan
- 47% had a care plan, which was not comprehensive
- 22% did not have a care and support plan.

Chronologies can give an early indication of emerging patterns of concern and risk. In general, a chronology should be prepared for individuals:

- who have complex circumstances
- are subject to significant risks
- have had a lot of involvement with social work and health services over a lengthy period or where professional judgement determined a chronology was necessary.

From the health and social work services records we read where we considered a chronology was needed, only 5% had a chronology of key events. For 58% of the records, we considered that a chronology was not needed. Of these records that had a chronology less than half of the chronologies were of an acceptable standard. Managers needed to make sure that proper chronologies were in place and were used effectively in the planning of support for older people and the assessment of risk.

Recommendation for improvement 7

The Glasgow Partnership should make sure that proper chronologies are prepared and placed in the individuals' electronic or paper record.

People who were being discharged from hospital and who required support following discharge were either referred directly to Cordia if they were returning home, or were placed in a care home for further assessment or reablement. This allowed more time to see how much support they might need in the future.

Many of the care plans for people referred to Cordia were task based and were not focused on individuals' desired positive personal outcomes. However, this part of the system worked well. Cordia managers told us that no older people were waiting for their care at home service. Staff reported there were delays when older people requested a review. Discussions were under way to transfer some assessment and planning staff into the Cordia service. Discussions were not at a stage where we could determine the potential impact of this proposed development.

The managed medication service, supported by training from NHS pharmacists, effectively supported frontline care at home staff to administer some medications and enable older people to return or remain at home. Staff were trained to meet older people's medication needs and were supported until competent and confident.

We heard from a range of staff about the level of engagement with carers through carers support teams and carers' centres. However, there was little or no evidence of this in the records we read. The Partnership needed to improve how it recorded the impact of its support to carers including how the information was used where carers completed self-assessments.

5.3 Shared approach to protecting individuals who are at risk of harm, assessing risk and managing and mitigating risks

A well-structured and shared approach to adult support and protection arrangements was in place. The Partnership had clear multi-agency adult support and protection guidance. It had recently published the learning from two significant case reviews to help with its continued improvement identifying and supporting adults at risk of harm. The adult support and protection committee and adult protection locality forums had prepared improvement plans for their approach to supporting adults at risk of harm who lived at home and those who lived in care homes. A service user sub group had been formed and service users had felt more confident to be formal members on committee following this involvement.

In our reading of files we found that:

- 72% of case records with protection-type risk identified (current or potential issues regarding adult protection or protection of the public) had risk assessments
- we rated 83% of the protection-type risk assessments as good or better, with 17% rated as adequate or less
- 83% of the protection type risk assessments had evidence of multi-agency input
- in 89% of the applicable records, the timing of the most recent assessment was in keeping with the needs of the older person
- we rated 63% of the protection-type risk management plans as good, with 37% rated adequate or less.

We found there had been a considerable improvement (from previous external scrutiny exercises conducted by the Social Work Inspection Agency) in the number and quality of risk assessments.

We also considered non-protection type risks such as the risk to a frail older person at risk of falling and suffering an injury, or the risk to an adult with dementia at risk of wandering and experiencing harm.

- Fifty per cent of case records with non-protection type risk identified had a risk assessment.
- Sixty-one per cent of the non-protection type risk assessments had evidence of multi-agency input.
- The timing of 88% of the non-protection type risk assessments was in keeping with the needs of the older person.
- We rated 67% of the non-protection type risk assessments as good or better, with 33% rated adequate or less.
- We rated 72% of the non-protection risk management plans as good or better, with 28% rated adequate or less.

Where risk assessments were completed, these were accessible to relevant social work services staff and Cordia staff on CareFirst, the social work services electronic information management system.

More work was needed to make sure that sufficient information was gathered at the initial referral stage. This would enable a quicker response and make sure that adults at risk of harm were not left unsupported. Dedicated locality teams carried out initial assessments of high priority (priority 1) individuals. This included adults at risk of harm.

Management teams in each locality monitored the adult support and protection processes and identified areas of variation in practice. This work included different approaches to carrying out case conferences. Some areas reported a low number of case conferences taking place. There was an increased number of referrals of adults at risk of harm from Police Scotland. Social work services managers were working with Police Scotland to agree an improved referral process.

5.4 Involvement of individuals and carers in directing their own support

Self-directed support (SDS) is about offering individuals and their carers choice, control and flexibility over how their support is planned and provided. Practitioners must have regard to the set principles when engaging with older people who are assessed and who then require support. To do this, local authorities must promote a variety of providers of support and a variety of support options.

Since 2010, there had been a phased roll-out of personalisation in Glasgow starting with adults with physical or learning disabilities.

The Partnership had clear policies and procedures for accessing self-directed support. These were supported by an online self-assessment tool available to download from the Council's website.

The process involved in the delivery of SDS for every individual requires a co-produced assessment of need, allocation of an individual budget, offering the four options outlined in the legislation and the development of an outcome-focused support plan.

We found that older people were being prioritised for assessment based upon whether they had complex needs or required long-term support. In response to the high volume of referral annually to Glasgow social work services, access to SDS was being managed by prioritisation. The Partnership told us this was in order to achieve a fair and equitable basis for the implementation and delivery of SDS in Glasgow.

The emphasis in Glasgow was to focus on recovery, reablement, rehabilitation and recuperation. By channeling all older people through the reablement route, older people with complex needs were to be referred immediately for social work services assessment and this would be carried out within the personalisation framework. The Partnership stated that "older people with non-complex needs who completed the reablement process and required a continuing mainstream low level service would be offered the SDS four options at their first care service review". Senior managers confirmed that "Cordia staff, following transfer of assessing staff in 2015 would through their normal review activity, highlight those cases which would be shared with social work services via the agreed interface/ referral process. Social Work Services staff will then take the appropriate action as per existing Glasgow city Council Social Work Services practice in relation to SDS".

In addition, senior managers stated "the operational procedures in relation to review activity would be used to ensure that all service users receive written notification of upcoming review and their right to choose their support provider via personalisation at the end of reablement. Service users would receive a leaflet explaining their options and in advance of a review assessment meeting. Social Work Services would also monitor and review the application of the above process".

When we talked to third sector and independent sector staff they expressed doubts that large numbers of older people would have access to self-directed support in the future. Partnership staff told us that the opportunity for older people to manage self-directed support was compromised by a complex process to administer. Older people were also offered limited choice in care providers.

Advocacy providers said that older people with care packages of under 23 hours' care supplied each week could only use services provided by Cordia, unless the care package was assessed as having complex support needs.

The Partnership successfully involved older people in their care and treatment. From the health and social work services records we read, there was evidence that services actively sought the views of the most of these older people at the assessment, care plan and review stages. This was confirmed by the older people and their carers we met. They told us they felt very involved in the assessment of their needs and the development of their care plan. However, others told us that some of their choices were limited, including the time that they received support.

We found the offer of independent advocacy was considered by staff. Sixty seven per cent of applicable older people had received advocacy support. For 83% of these individuals, the advocacy had helped them to articulate their views.

Support to carers was well embedded and was delivered through Glasgow Carers' Partnership, which was intended to bring together health, social work and the network of carer centres. This was underpinned by a universal offer of information and advice to all carers in the city through a telephone information and support line, a carer's information booklet "Are you looking after someone?" and a carer self-assessment form. The carers' initial screening process determined a priority rating based on the risk to sustainability of their caring role. Carers identified as Priority 1 and Priority 2 were offered a statutory carer's assessment and, if required, services provided to support the carer. Carers assessed as Priority 3 were signposted to carers' centres, condition-specific organisations, and/or community supports. However, social work services needed to improve their recording of the outcomes of completed carers' assessments .

Quality indicator 6 - Policy development and plans to support improvement in service

Summary

Evaluation – Good

The Glasgow Partnership had set out a clear overall direction for the future planning and delivery of services for older people. However, some of the plans lacked detail on how they would be achieved. The Partnership did not have joint formal strategies and costed action plans for themes such as carers, dementia, palliative care, telecare and management of assets. The Partnership needed to update its strategic priorities for these areas in the context of health and social care integration. A programme of service reform had been prioritised using the joint services development plan.

Using change fund monies, the Partnership had taken a joint approach to the deployment of resources to support improved personal outcomes for older people. This was beginning to be used to inform the future shape of health and social work services.

A wide range of performance information was produced, reported and made available for the Partnership's senior and local management, as well as elected members and NHS board members. A draft joint performance framework linked to national outcomes was being developed. The Partnership needed to be sure that the framework contained challenging but achievable targets.

We saw evidence of cross-sector engagement and involvement of health and social work partners in joint strategic commissioning. The Partnership needed to develop its commissioning approach to support its commitment to further shift the balance of care.

6.1 Operational and strategic planning arrangements

The Community Planning Partnership had set out its joint vision for Glasgow in the single outcome agreement. This identified 'vulnerable people' as one of its main three themes. A 'One Glasgow' planning approach was being set out by the Community Planning Partnership (see Quality Indicator 9.2). Informed by the single outcome agreement, the plans for services for older people were set out in the following documents:

- the Partnership's joint strategic commissioning strategy
- the Partnership's joint adult services plan

- NHS Greater Glasgow and Clyde's corporate plan
- Glasgow City Council's strategic plan.

The draft joint strategic commissioning strategy for older people, 'Reshaping Care for Older People', was published in February 2013. The strategy was then circulated widely for consultation. It contained overviews of health and social work needs analysis, the strategic direction and identified strategic priorities. It also set out an implementation plan and financial information. A finalised plan was not yet produced following consultation. The strategy's key themes were to:

- enable older people to exercise choice and keep control over their own lives
- support older people, carers and communities in improving their health and wellbeing
- provide older people and their carers with access to care and support when needed
- change the focus of care towards early intervention, preventative and anticipatory care to support older people and their carers to live independent lives in their own communities
- provide access to hospital services and care home services when needed, and support people to recover following discharge.

We found that the draft joint strategic commissioning strategy gave a clear view of the direction of travel. However, it lacked some of the detail on how this would be achieved. This restricted its use as a delivery management and accountability tool. It did not contain detailed costings, delivery timescales were not always clearly identified, and areas for growth or disinvestment were not always clarified. Commissioning officers and managers we met acknowledged this.

Planning for the future effective and cohesive delivery of services took place on a care group basis. An individual planning and implementation group for older people (Reshaping Care Strategy Group) was set up as well as separate cross-cutting themed groups for carers (Carers' Planning and Implementation Group). In each locality, a carers' forum informed the carers' reference group. In turn, the carers' reference group informed the carers' planning and implementation group. The older people's planning and implementation group, and the carers' and service user involvement groups reported progress every six months and every year respectively to the adult services executive group who in turn reported to the Joint Partnership Board.

The Partnership was working towards developing a locality-based approach for the planning and delivery of services. Partnership agencies had the same geographic locality boundaries. This should make the planning and delivery of services more straightforward. As locality plans developed, the Partnership needed to set out a quality assurance framework for localities.

At the time of our inspection, the Partnership did not have joint formal strategies and costed action plans for themes such as carers, dementia, palliative care and telecare. For example, the lack of an overall strategy for telecare meant the Partnership had not engaged with the third and independent sectors on the development of services. This excluded nearly half the overall provision of housing support from joint development of telecare services. The Partnership needed to update its strategic priorities for these areas in the context of health and social care integration timescales.

Health and social work services had carried out some work on the development of joint strategic needs assessments. However, this was at a relatively early stage. Senior staff told us they thought there was enough existing information available to set the strategic direction.

A clear joint approach was needed to improve the joint management of assets, such as premises. Joint capital investment was on a project by project basis rather than as part of a jointly agreed strategic approach. Plans were in place to develop new services using the West of Scotland Hub, a structured development service organisation which delivered some co-located services through public and private partnership. There also needed to be links between assessing future demand for services and corresponding capital investment. A substantial new build programme of care homes was in place too. Glasgow City Council had provided significant investment in directly provided older people's residential and day care services through Tomorrow's Residential and Day Care Modernisation Programme to improve the environment within which services were provided to the highest quality. The standard of buildings was regarded as crucial in providing staff with appropriate resources to deliver high quality services.

The Council recognised that investment in buildings alone would not achieve the clear strategic vision to improve the health and wellbeing of our service users and carers in line with national outcomes. This investment in new care homes was to provide rooms for residents that could both cater for all levels of dependency and allow the resident their own space and privacy ensuring older people are supported effectively within these community based resources and not admitted to hospitals inappropriately.

6.2 Partnership development of a range of early intervention and support services

Across health and social work services, the development of services included a major emphasis on reablement and rehabilitation, alongside care at home and telecare that helped to support older people to remain independently at home. The tiered eligibility for services model formed the basis of the approach to early intervention and prevention. This aimed to provide an incremental approach to the delivery of care and support.

Through the change fund, the Partnership had taken a joint approach to the deployment of resources to support improved outcomes for older people. This funding had been used to test different working models for care and support. The Partnership had used the Scottish Government's joint improvement team's evaluation tool to review and evaluate the progress of individual change fund projects. This was beginning to be used to inform the future shape of how health and social work services would be delivered. Learning from change fund investments had led to service redesign in areas such as:

- prevention of falls
- reablement
- rapid response and resettlement
- supporting carers
- medicines management.

The Partnership's change fund expenditure supported preventative and anticipatory care, and care and support at home. Some change fund projects had a clear health promotion and prevention approach. However, more work was needed to set out how change would be implemented using the approaches that had been tested.

Health improvement staff were increasingly engaged at an early stage to support older people to live independently at home. They worked closely with older people on the personal outcomes they wished to achieve, staff reported they had helped to reduce the level of support needed by older people.

6.3 Quality assurance, self-evaluation and improvement

A wide range of performance information was produced, reported and made available for the Partnership's senior and local management, as well as elected members and NHS Board members. A suite of performance information based on local plans, national and local indicators formed the basis of the approach. These were made available at locality and sector level in organisational performance reviews.

All council services produced an annual service performance and improvement report. This reported progress on the delivery of the Council's strategic plan, alongside single outcome agreement and service priorities. Social work services also provided information on areas included within the council's 'corporate scorecard'. This included attendance management, budget monitoring and complaints. Progress on the delivery of the social work element of the Council's service reform programme was reported every four weeks to the Council's management group. Organisational performance reviews were held for each of the three localities and 'direct services' every six months.

The Council had detailed locality service monitoring information available on services such as:

- care homes
- care at home services
- adult support and protection
- assessment and review
- personalisation
- occupational therapy
- carers
- complaints.

There was uneven performance between localities. The Partnership's own targets were not being met in areas such as:

- reviews of older people's care
- delayed discharges
- reablement
- personalisation
- adult support and protection.

The Partnership's performance indicators tended to focus on input and output measures rather than the quality of the service.

Arms-length organisations such as Cordia, which provided care at home services and telecare, and Equipu, which provided telecare equipment had detailed monitoring activity. Again, these were mostly focused on output monitoring. There was a need to incorporate more personal outcomes based information into the monitoring and performance activity.

Social work services performance officers told us that the CareFirst system had brought about challenges for performance monitoring. They were concerned about the quality of data input. They told us that the ability to accurately monitor service delivery was adversely affected as a result. The Partnership needed to address this.

NHS Greater Glasgow and Clyde carried out organisational performance reviews every six months. These included national HEAT targets, NHS board and local community health partnership key performance indicators, as well as outcomes for each of the NHS board's priorities. These were:

- early intervention and preventing ill health
- shifting the balance of care
- reshaping care for older people
- improving quality, efficiency and effectiveness

- tackling inequalities
- promoting an effective organisation.

The community health partnership reported performance on its development plan. A performance scrutiny group reviewed its performance on issues such as:
- finance
- development plan delivery
- staff governance
- organisational development
- service improvement and quality.

Service monitoring information was available in themes including:
- reshaping care for older people
- improving quality, efficiency and effectiveness
- tackling inequalities
- promoting an effective organisation
- capital projects.

Based on the community health partnership's own target information, progress was being made in areas such as reducing emergency inpatient and delayed discharge beds days occupied, as well as diagnosis of dementia. Further improvements were needed in meeting its own targets in areas such as staff appraisal knowledge and skills framework, and attendance management.

Local monitoring arrangements were also in place within each locality sector. A sector variation report was produced. However, some of the actions had unclear or incomplete baseline or monitoring information. Clinical governance was reviewed through a separate forum.

Like many Partnerships across Scotland, work on developing the joint integration scheme was taking place. A draft joint performance framework linked to national outcomes was also at an early stage of being prepared. This would help the Partnership to identify areas where performance was improving or where improvement was needed.

Joint performance measures would be based on national and local indicators. This would cover areas such as:
- reshaping care for older people
- reablement
- carers
- telecare
- long-term care

- adult support and protection
- national HEAT targets.

It was intended that the joint performance framework would focus on personal outcomes as well as input and output measures. Outcome-focused and qualitative measures were still to be agreed. These would then be extended out across all externally commissioned services. The Partnership needed to be sure that the joint performance framework contained challenging but achievable targets.

In recent years, the Council had carried out major service reviews in areas such as day care and residential care. Action plans had been produced to progress the findings of their evaluations. The council had an ongoing self-evaluation programme. This had recently covered topics such as staff supervision, and assessments and outcome-focused approaches. At the time of the inspection, children's services were prioritised for self-evaluation. It was anticipated that future self-evaluation activity would include integrated working in health and social work services. However, a start date for this self-evaluation had not been determined. The Council also had a practice audit programme. Recent audits had included appropriate admissions to 24-hour services for older people. 'Scrutiny' sessions had taken place, for example on personalisation and had included representatives from council staff and the third sector. Senior social work services managers told us that audit and review of case files was already in place.

Examples of direct service user feedback included annual Council household surveys. Satisfaction levels with social work services were similar to the Scottish average at 55%. NHS Scotland carried out an annual survey of patient experiences. Results for NHS Greater Glasgow and Clyde showed levels of satisfaction broadly comparable with Scottish averages.

The Partnership had carried out service mapping and some needs analysis exercises to inform the draft joint strategic commissioning strategy's priorities for improvement. However, we were unclear how information from service user feedback was used to improve and assure practice or to strategically develop services. The Council had a detailed strategic risk management register which identified possible risks and mitigating actions. Health and social work services managers and staff recognised that more needed to be done to evidence the outcome and impact of some of the supports delivered to older people and their carers. Links between learning from self-management and self-directed support initiatives could be used better to inform this work.

6.4 Involving individuals who use services, carers and other stakeholders

Both health and social work services had policies for engaging with people who were using their services, as well as with other stakeholders, including staff and external service providers.

However, senior managers needed to better engage and communicate with staff and other stakeholders on the future direction of health and social work services and how change would be implemented. Results from our staff survey showed that:

- 41% of staff agreed that the views of older people and their carers who used services were taken into account fully when planning services at a strategic level
- 40% of staff agreed that there were effective partnerships which focused on delivering key policies and plans for older people and included relevant stakeholders
- 38% of staff agreed that priorities set at partnership, team and unit levels reflected jointly agreed plans
- 34% of staff agreed that the views of staff, service users and their carers were taken into account when planning services at a strategic level.

We found that senior managers felt involved in development and improvement activity. However, frontline staff were less positive about their involvement in development and improvement activity.

Overall, independent sector providers considered the Partnership could offer them more support to improve their performance. Commissioning officers told us that consultation and engagement with providers tended to be one-off events with care home and care at home providers rather as part of ongoing forums. Such forums could help to look at the requirements of providers including those outwith the care home and care at home sectors, for example training requirements. We found that engagement with service providers could be improved. This would make sure they were better engaged in reshaping how they provided services to meet future challenges.

Housing staff reported that they welcomed the attempts made to enhance their participation in joint planning on issues such as housing support and supported living. However, they wished to have a closer involvement with the setting of priorities across the wider joint commissioning agenda. The Council's local housing strategy had identified housing access and support as a major theme. This included working with the Partnership to develop and improve services for older people. The Council's draft strategic housing investment plan had set aside a proportion of available capital investment (13%) for housing for people with particular needs, including older people.

A proportion of the transformation fund monies had been aimed at services delivered by local housing providers, including health promotion and condition self-management. At the time of the inspection, the Council was consulting with stakeholders including service users on redesigning housing support services including sheltered housing. There was a perception from housing support providers that this would lead to a substantial reduction in services.

6.5 Commissioning arrangements

Joint strategic commissioning means all the activities involved in the Partnership jointly assessing and forecasting needs, agreeing desired outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place.

The Scottish Government expected health and social care partnerships to produce joint commissioning strategies for older people's services during 2013. Informed by Scottish Government guidance, these aimed to set out jointly assessed and forecasted needs, desired outcomes and plan the nature, range and quality of future services. This strategy should focus upon delivering improved outcomes for older people and carers through better aligning investment with what the evidence tells about the needs of service users in local communities through strategic plans. In 2014, additional Scottish Government guidance advised that these plans were to be developed further to include detailed financial planning as well as extending to all adult groups. This would be a joint strategic commissioning plan.

Implementation of the Partnership's draft joint strategic commissioning strategy for older people included supporting the care at home, care home and housing support markets. However, some service providers told us that they were not always fully consulted and involved in how services might be reshaped or enhanced.

The Council had a comprehensive contract management framework. This included very detailed contract compliance procedures, including contract monitoring and service review. Each care group had dedicated contract compliance officers. Commissioning officers told us that externally commissioned services had quality assurance measures in place as part of contractual compliance procedures. However, the contract management framework was not being implemented as it should. As a result of this, a Council internal audit had identified that the Council was exposed to risks. These risks included:

- the inability to deliver best value due to service reviews not being carried out in line with the framework
- external providers not delivering on improvement actions within deadlines

- service deficiencies not being investigated comprehensively
- providers' financial viability not being tested thoroughly.

To minimise the risks, the Council had identified a series of recommendations for improvement with delivery timescales.

When meeting with Cordia staff, we heard that service user feedback was a key element in how the service was delivered and developed. They carried out a manual questionnaire survey of all service users with around a 38% response rate. They also held service user focus groups twice per year and Cordia staff reported positive results of their survey with high levels of service user satisfaction at the services being provided by Cordia (94%).

It was unclear how contract values for each service were reported to elected members and NHS board members. Commissioning officers told us that individual contract amounts were aggregated for reporting purposes. The Partnership needed to be more transparent in reporting to elected members and NHS board members the detail of contract values of each provider and service in keeping with the principles of 'following the public pound'[11].

At the time of our inspection, the Partnership was carrying out a tendering exercise to procure care and support, day opportunities and short breaks for a range of care groups, including older people, to stimulate the market and extend choice. The aim of the exercise was, in part, to help provide a larger infrastructure for the development of personalised services. For care at home services, the Council's own arms-length provider, Cordia, had a very significant market share. Although other service providers did exist, they had a very small market share. Some had closed due to a lack of demand.

At the time of our inspection, the council was proposing that a number of social work services staff transfer to Cordia. This would include some staff responsible for assessment functions. The Council's contract with Cordia needed to ensure that the roles and responsibilities were clear. The Council had taken steps to ensure there were no potential conflicts of interest between Cordia's role as a provider and the Council's statutory assessment and care management role. These steps had included operational procedures outlining the obligations of both parties and the interface arrangements between Cordia and Social Work Services. Governance and scrutiny of Cordia's performance by Social Work Services was planned at a number of levels, including monitoring reports at political level, routine executive director-level strategic meetings, formal contract management and through local operational care management interfaces.

11 The Convention of Scottish Local Authorities / Accounts Commission 'Code of Guidance on Funding External Bodies and Following the Public Pound 1996' sets out the principles of best practice when councils establish funding relationships with external organisations.

A recent tender exercise held in early 2014 for care home services was stopped following challenge from some providers. The Partnership had decided to continue with the national care home contract during 2014–2015. The Partnership needed to detail how it will pursue its care home choice, quality and cost agenda beyond this date.

Senior managers reported that Integrated Resource Fund Framework information was considered in planning resource allocation, particularly the use of resources at GP practice level. However, it was uncertain to what degree it had, as yet, been useful to help inform financial planning and budgeting.

To date, joint strategic commissioning activity had primarily focused on older people's services. We saw evidence of cross-sector engagement and involvement between health and social work partners. Further work was required on how joint strategic commissioning developments would be progressed and how these would be led. The Partnership needed to develop its commissioning approach to further shift the balance of care.

In line with Scottish Government guidance, the Partnership should produce a 'SMART' (specific, measurable, achievable, realistic, time-bound) joint strategic commissioning plan. This should make sure that future joint commissioning plans for older people give more detail on:

- how priorities are to be taken forward and resourced
- how joint organisational development planning to support this is to be taken forward
- how consultation and engagement are to be maintained
- full and detailed costed action plans, including plans for investment and disinvestment based on identified future needs
- expected outcomes.

Quality indicator 7 - Management and support of staff

Summary

Evaluation - Adequate

Some staff recruitment and retention services across health and social work were being reviewed. New staffing structures were being shared with staff. Restrictions applied to recruitment in social work services to mitigate budget pressures. This was having a negative impact on staff's ability to deliver the volume of work required of them. Views varied across the Partnership on whether recruitment practices had been successful.

The Partnership had focused on developing its leadership programmes and strengthening senior management skills. Training and development opportunities were generally good, although some social work services staff were less positive about recent training opportunities than health services staff.

The Partnership had not yet established a strategic approach to joint training and development, and support of staff. Frontline social work services staff were circumspect about the range and quality of training offered to them.

7.1 Recruitment and retention

We read a range of comprehensive and clear policies and procedures about recruitment and retention. Within Glasgow community health partnership, NHS Greater Glasgow and Clyde, and social work services, there were concise written policies and processes in place to support safe recruitment in order to protect service users, including older people, and to help retain staff. Less positively, we found limited evidence of any initiatives to develop a joint approach to recruitment and deployment of staff. However members of the Partnership's shadow integration joint board told us they were beginning to work towards a single workforce plan. This plan would support staff terms and conditions of employment that would remain the same for both organisations.

We read detailed and up-to-date individual workforce plans. Health and social work services partners acknowledged these plans were separate in terms of staffing numbers and roles. However, some managers told us some joint operational policies and priorities were being produced. The community health partnership had an up-to-date and detailed learning and education and development plan (2014–2015). Glasgow City Council had an

employee performance improvement framework, which linked to its 2012–2017 strategic plan.

Social work services managers told us the workforce planning group was responsible for prioritising vacancies and made decisions about any critical posts that needed to be filled. They believed there were no issues with filling vacancies and that the organisation was large enough to enable resources to be moved around. Health and social work services had separate measures in place to address areas of particular staff shortages and pressures. Senior managers across the Partnership told us there was not a large staff turnover in their individual organisations. They thought this was partly due to good staff terms and conditions of employment. We found evidence to confirm that retention of staff within the Partnership was generally good. Over the period 2012–2013, health staff turnover was 7.09%, and the overall staff turnover rate for social work services was 3%. This was replicated across a range of more specialist teams, for example Cordia also reported low staff turnover at 0.6%. Social Care Direct reported no issues with recruitment and had good retention of current staff.

However, these findings contrasted with the views of most frontline social work services staff and team leaders we met. They told us that vacancies across a number of areas were not being filled, with recent recruitment drives failing to recruit new workers to posts. Social work services staff believed that restrictions applied to recruitment to mitigate budget pressures within social work services was impacting on the pressure on staff and increased volume of work carried out by frontline staff. This, and the movement of some staff to more specialist teams, had resulted in some older people's teams being depleted of staff.

Managers reported that community health staffing was stable, with limited use of agency staff. Older people's mental health teams used agency nurses to fill vacancies on occasions. Some health services staff told us that posts were generally slow to be filled, for example one team was about to fill a nursing vacancy after a delay of one year. Agency staff had been used to backfill frontline health vacancies. However, a recent policy update stated that agency staff should not continue to be used in this way. Staff comments from the community health partnership stress surveys mirrored the view that carrying vacancies had a negative impact as it created unrealistic demands on staff in post. Senior managers told us that (in common with many other areas in Scotland) there were some difficulties recruiting GPs. In addition, Social Work Services residential staff told us that they also had vacancies within their service. This had resulted in reduced numbers of senior social care workers being appointed.

There had been some good initiatives in recruitment to more specialist posts. We also

heard about a positive drive towards joint recruitment to some posts. A head of primary care and community services was recently appointed on a fixed term contract.

The Partnership was piloting a new 72-hour fit for discharge initiative in North East Glasgow. Three resource workers had been recruited to work in the acute hospitals and provide information, advice and support, assessment and discharge planning for older people.

Some staff based in more specialist teams told us that, while restrictions applied to recruitment to mitigate budget pressures, managers could apply for special consideration to be given to some posts. As a result of this, more occupational therapists had recently been appointed to support enablement and rehabilitation teams. Staff in specialist teams were very positive and enthusiastic about their work and clear that the services they provided made a positive difference to older people's ability to live more independently.

7.2 Deployment, joint working and team work

Members of the Partnership's shadow integration joint board told us that the Partnership had put senior management staff arrangements in place. A process was in place to match senior staff in to joint posts within the new structure, and the results of this matching process were expected to be published by late 2014. We attended some senior managers meetings with representatives from health and social work services who were working together to plan for future services. Senior managers told us of the multi-agency groups being developed to focus on key themes including intermediate care, and implementation of the comprehensive 72-hour fit for discharge initiative.

Social work services had shed approximately a quarter of its staff over recent years through early severance exercises. This included key posts such as frontline managers. Some managers felt these staff losses had negatively impacted on the delivery of services. Other managers reflected that the service now had more qualified staff in post and there were more efficient working practices. NHS Greater Glasgow and Clyde and the Council's social work services used a resource allocation model to distribute staff resources. This involved equating staff needed for each sector, based on population and a range of other local indicators.

The national Modernising Nursing in the Community programme was established by the Scottish Government to provide support and direction to community nursing. A review of the community nursing service was under way in Glasgow.

Managers across the Partnership told us they were working to make sure teams had the right blend of professionals to deliver services effectively. They were also working

to give employees roles that reflected their level of competence and qualifications. For example, Cordia had 250 specialist staff delivering reablement effectively. Cordia managers spoke positively about the benefits to older people of having specialist staff with a good skill mix in the teams. Managers told us that, where there were new joint initiatives, staff were being specifically recruited. However, other staff we spoke with raised concern about the lack of consistent practice and described recruitment inconsistencies across Glasgow.

Cohesive joint working between health and social work services had been developed within the reablement service. Rehabilitation teams from the health service worked effectively with care at home staff to support older people to live independently at home, and maximise their capacity for self care. Frontline reablement staff spoke positively about their work. They believed reablement and rehabilitation services were good examples of efficient joint teams. They acknowledged some variations in how the services operated across Glasgow, but said that they all operated efficiently. A Glasgow-wide reablement/rehabilitation steering group monitored the difference these teams were making to older people. Health and social work services staff worked well with Cordia to deliver effective reablement to older people.

From the health and social work services records we read, we saw evidence of joint working or multi-agency working for 80% of older people. From our staff survey, 79% of staff agreed or strongly agreed that they felt valued by other practitioners and partners when working as part of a multidisciplinary or joint team. Sixty-nine per cent of staff agreed or strongly agreed that they felt the service had very good working relationships with other professions.

All staff we met were clear about their role and responsibilities and were aware of the need for the focus of their work to shift to delivering the positive personal outcomes that older people desire. Health and social work services staff described how they worked well together to achieve positive outcomes for older people and their carers. Managers across the Partnership were aware of the need to consider changes to team deployment as a result of changes in legislation and continued pressure on services. For example, they were considering how staff could be deployed more effectively to manage the process of older peoples' timely discharge from hospital. As this was at an early stage of development, it was not clear if a dedicated team would complete assessments or whether links would be made from existing care managers within social work teams.

Health and social work services staff were mostly positive about the support they received from their immediate line managers. This was supported by staff survey results from health services and the Council, as well as results from the Council's self-evaluation exercise to look at the management function of supervision.

Recommendation for improvement 8

The Glasgow Partnership should develop a joint workforce development strategy during the first year of integration, which sets out clear joint priorities. This should identify possible staffing shortfalls and outline measures to address these as the integration of health and social care agenda progresses.

7.3 Training, development and support

NHS Greater Glasgow and Clyde and the Council's social work services had their own arrangements for supervision and appraisal. Managers understood the importance of supervision (or equivalent) and delivered this regularly. Staff understood and worked within delegated limits of authority. Staff demonstrated a sound knowledge and understanding of the values and principles of person-centred and outcome-focused approaches. From our staff survey, 71% of staff agreed or strongly agreed that they had good opportunities for training and development. Results were lower for social work services staff.

Clear single agency strategies were in place to develop staff. The Partnership had supervision and employee development systems in place. These attempted to link individual performance to service objectives.

Social work services had recently carried out a thorough and detailed staff supervision self-evaluation exercise across adults and children's services which confirmed that the management function of supervision was given priority and was well embedded in practice. We read reports on an extensive social work services self-evaluation exercise carried out in 2013. This looked at the quality of support and supervision provided to staff. Positive results were found on the substantial emphasis placed on the management function of supervision.

The main focus of supervision was discussing caseloads. The inclusion of professional development plans was less apparent during supervision sessions, although this varied depending on the line manager. NHS Greater Glasgow and Clyde had staff personal development plans and review processes in place. The NHS knowledge and skills framework (KSF) was used to support staff learning and development. Glasgow City Council was implementing a performance improvement framework. This linked to its supervision and personal development plan processes.

Results from Glasgow City Council's own 2012 staff survey showed that only 46% of social work services staff had completed a personal development plan. From the NHS staff survey carried out in 2013, 82% of NHS Greater Glasgow and Clyde staff said they had received a knowledge and skills framework review or had a personal development plan meeting within the previous 12 months. Only 44% of health services staff thought it had helped improve how they did their job. Results from the community health partnership stress surveys showed that only 53% of staff saw a link between supervision and personal development plans. A number of staff from across the Partnership told us they found it difficult to take time away from their work to carry out training due to work priorities. Social work service managers were trying to promote a workload performance tool. However, implementation of this tool had been limited. They acknowledged that the tool was more helpful when used with unqualified staff.

An NHS Greater Glasgow and Clyde five-year workforce development plan 2013–2018 was in place to deliver services in line with the dementia strategy. Key stakeholders were consulted, and local authority partners and the third sector were included in this plan. The development plan was clear and concise as to how NHS Greater Glasgow and Clyde planned to develop, enable and equip their workforce; it was also encouraging to see that the plan, in line with the Promoting Excellence Framework (NES and SSSC), made a commitment to train all staff that may have contact with a service user with dementia including reception staff, and patient services staff. This training was for health staff only and did not include local authority partners or the third sector. However, when we met with social care services staff, we heard that training courses on understanding dementia were offered routinely to all social care staff. We were told by staff that there were very limited opportunities across the Partnership for joint development events.

Glasgow City Council had a Delivering Tomorrow's Council programme to support the development of senior managers. This had been designed as a direct result of the findings from the 2012 staff survey. NHS Greater Glasgow and Clyde also had management and leadership development provision. This included tutor-led courses as well as a wide range of materials to support leadership and management development.

Joint performance and monitoring officers for older people had good access to training. However, they acknowledged difficulties in finding the time to attend due to their workloads.

Care at home staff received and valued training advice and support from the step-up service. Cordia staff were trained and monitored in medicines management and administration by lead pharmacists as required. Cordia staff had their own bespoke training programme. We were told by managers that the reablement teams were perceived as having more professional status, more autonomy and ability to make

decisions, partly due to this training.

In contrast, the majority of frontline social work services and residential staff told us that training and support was of a variable standard and was less accessible. Single agency training courses were offered to staff on understanding dementia. More specialist training was provided for staff in residential settings. However, staff told us that, in comparison to previous years, general training and development opportunities had diminished. Some recent training courses, such as moving and handling, had been cancelled.

A range of training and support was available to staff involved in adult support and protection work. However, evaluations from recent training events showed a mixed response from staff on their confidence in dealing with adult protection. Members of the adult support and protection committee told us that training and development of staff and their attendance at development events continued to be a challenge. We were told about a multi-agency training group, chaired by social work services staff, which was looking at the delivery of joint training.

Social work services managers' views appeared disconnected from frontline staff views about the quality and range of training offered. Managers believed there was a good range of training available, with investment and support into training staff. They gave examples such as the self-directed support training and training to improve the quality of assessments and risk assessments. However, frontline staff described a recent reduction of opportunities for professional development. They told us that when training opportunities had been available they were often unable to attend because of workload pressures.

Quality indicator 8 – Partnership working

Summary

Evaluation – Good

The Glasgow Partnership had made progress developing joint financial arrangements. However, there were considerable financial pressures affecting both health and social work services that will need to be addressed.

Both health and social work services had a commendable history of achieving savings targets. As the budgets continued to decrease, savings would become more difficult to achieve. Senior managers acknowledged that service redesign would be needed.

The Partnership was moving in a very positive direction in relation to information and communication technology development. However, it acknowledged that the resourcing for developing information systems had been difficult. This had delayed activity in some areas.

In terms of partnership working, the impact of the dissolution of the five community health and care partnerships in 2011 in Glasgow was still keenly felt by staff. This would present a considerable challenge for the effective delivery of health and social care integration, and consistent, effective operational joint working between health and social work services staff.

8.1 Financial performance of Glasgow City Council and NHS Greater Glasgow and Clyde

Glasgow City Council had identified a total spending gap of £43 million for 2013–2015. This would be met by planned efficiency savings of £22.1 million in 2013–2014 and £20.5 million in 2014–2015 from service-specific programmes and corporate council-wide projects. For 2014–2015, these were broadly similar to 2013–2014 and included:

- £13.7 million in savings from service reforms
- £1.0 million from efficiencies
- £5.8 million from reviews of commissioning and charging policies.

The social work services budget for 2013–2014 was overspent by £5.4 million. This was attributed to overspends on homelessness, personalisation and older people's care. The latest social work services budget monitoring report to the end of September 2014

showed that the expected outturn was a £2.8 million overspend. Of this, £874,000 and £747,000 was attributed to children's services and to homelessness respectively.

An action plan was in place to mitigate the budget pressures outlined. This was as follows:

- review of purchased services
- review of personalisation, including high costs homecare packages - a full year budget pressure of £3 million remains in personalisation.
- review of home care
- review of new demand, focusing on critical risk
- further restrictions applied to recruitment
- review of transport costs
- work in partnership with City Building to ensure a more efficient turnaround in homelessness temporary furnished flats, reducing the requirement for more costly bed and breakfast accommodation
- a more robust approach to non-payment of care charges.

As part of the planned action above, the Council had recently approved the transfer of additional services to Cordia. This was due to take place in October 2014. However, this had been delayed due to ongoing discussions with the trade unions and was now scheduled for implementation in 2015–2016. The aim of this change was to make reablement the first step for everyone requiring care at home support. The council was anticipating an increase in capacity of up to 10% of the budget to be achieved through targeted efficiencies in year one, enabling higher numbers of older people to be supported at home within the same overall budget.

In relation to the review of purchased services outlined in the action plan, the Council's internal audit section had reviewed adherence to the Council's contract management framework within social work services. Their assessment was that the control environment was unsatisfactory. Serious control deficiencies existed with the social work services' application of the contract management framework. The Council had also withdrawn from the new contract management framework that it was developing for purchasing older people's residential and nursing care. The Council was now relying on the National Care Homes Contract[12]. From discussions with senior managers, this contract had been extended for one year. However, the annual chief social work officer report of August 2014 reported that the National Care Homes Contract value was concluded after the council budget was set in February 2013. This had impacted negatively on the budget by £2.5 million.

[12] The National Care Home Contract (NCHC) for Care Homes for Older People was established by COSLA in 2006/07 as a model contract to be used by local authorities for the purchase of care home places for publically funded clients.

Within Glasgow community health partnership, the main cost pressures for older people's services were currently in the North East of the city. This was mainly attributed to the delay in the capital programme and the costs associated with still maintaining Parkhead Hospital, Glasgow, and the wards at Ruchill Hospital, Glasgow. There was a shortfall of approximately £600,000 for 2014–2015. This was likely to be met by non-recurring savings.

Delayed discharge was a significant challenge facing NHS Greater Glasgow and Clyde and the Council's social work services. Financial pressures were now being felt by services at the start of the financial year. This was a trend which was causing concern. With the opening of the new South Glasgow University Hospital in June 2015, there will be a reduction of 300 acute adult hospital beds across Glasgow. Progress was being made to reduce the number of delayed discharges. Additional funding of £700,000 had been provided by NHS Greater Glasgow and Clyde. The Council had also provided an additional £3 million in 2014–2015 to bring forward the early introduction of new step-down care services as part of the reablement model.

Nationally, discussions were under way to address these budget pressures. The concern was that current services cannot sustain the current and increasing level of savings required. Service redesign would be required. The Council had recently started this process with changes to housing support for older people. This had resulted in a reduction in the budget for housing support of £2 million for 2015–2016. The rationale for reducing care home expenditure was to re-direct funding towards the Council's savings targets and into other models of support. These would be a better strategic fit with the Council's vision for older people services. This included reablement and care at home services, step-down care and day care services, and use of telecare.

Capital programme

Both NHS Greater Glasgow and Clyde and the Council had their own capital and asset management plans. The Council had a substantial capital programme for older people's services. There was a £65 million capital programme to build eight new residential care homes and day care centres. The new care homes would provide 600 spaces with the aim of improving choice and quality for older people. NHS Greater Glasgow and Clyde's revised capital budget for 2014–2015 totalled £179 million. This would be reduced to £82 million in 2015–2016 and £72 million in 2016–2017. The main capital project was the construction of the new South Glasgow University Hospital. There was evidence of delays in some capital projects currently carried out by both partners. These delays may have an adverse impact on revenue expenditure.

Joint capital planning between NHS Greater Glasgow and Clyde and the Council currently took place on a project by project basis rather than as part of integrated plan through the HUB initiative. This is a Scottish Government initiative to deliver, through a joint venture between public and private sector bodies, facilities, facilities management, strategic service planning, and asset planning and delivery. HUB projects are intended to support long-term investment in community infrastructure for local authorities, NHS boards and other public sector bodies across Scotland. There were currently two projects ongoing in Glasgow at Woodhill and at the Gorbals. A third project was being developed at Parkhead Hospital.

The Community Planning Partnership executive group had recently agreed to set up a capital planning working group for Glasgow. This would lead to the development of a joined-up approach to capital planning across Glasgow. However, it was too early to assess the impact this group would have on capital programmes within the city.

Joint commissioning strategy

A draft joint strategic commissioning strategy for older people's services had been prepared for 2013–2016. There was some evidence of joint financial reporting in the strategy. A joint financial report was prepared and submitted to the adult services executive group. This group was set up to consider adult services within the city. The purpose of the joint financial report was to inform the group of the financial performance within Glasgow community health partnership and Glasgow social work services in relation to adult services at care group level. The overall adult services net revenue budget for 2013–2014 was £505.4 million. The budget allocation for the community health partnership was £248.6 million and for social work services was £256.7million.

The Integrated Resource Fund Framework figures prepared for Glasgow City showed a spend of £1,480,809,788 for 2012–2013. This was £814,912,062 (55%) for institutional-based care and £665,897,726 (45%) for community-based care. These figures had been used to develop the draft joint strategic commissioning strategy and other care groups planning. Older people's services were considered to be making more use of the Integrated Resource Fund than any other service area. This was used to get a feel for the forecast data and to set out pathways for levels of consumption and the strategic direction of services and finances. This highlighted that neither partner would have the funding in the future and that the current levels of services might not be sustainable.

Change Fund

Since 2011–2012, the Scottish Government had provided specific funding through the change fund to help and support Partnerships to move to more community-based care.

The Scottish Government expected the change fund to be used as 'bridging finance' to enable the redesign of services and facilitate achievement of national policy. It was also expected the monies should be used to influence decisions on the nature of Partnership spending, with a significant shift to anticipatory and preventative approaches to achieve and sustain better outcomes for the care of older people.

Access to the funding required the formation of a formal partnership involving the NHS, local authorities and third and independent sectors. Within Glasgow, this had been carried out through the reshaping care strategy group. By the end of 2014-2015, the Partnership would have received £33.94 million in funding. Work was now under way to evaluate the projects and develop exit strategies for them. However, at the time of the inspection, this was at a very early stage. An additional £13.27 million of Integrated Care Fund monies may be available to further support some change fund projects. However, this was not a replacement for the change fund as it was not specifically aimed at older people, but as a support for adults with long-term conditions.

Health and social care integration

In February 2014, Glasgow City Council and NHS Greater Glasgow and Clyde approved the establishment of a 'body corporate model' with for health and social care integration. This would be a full and equal partnership between both parties with all current social work services included. It involved the setting up of an integration joint board. This board would be a strategic and commissioning body with responsibility for overseeing the delivery of health and council social work services to meet the agreed strategic priorities.

A shadow integration joint board had been established. This met for the first time in June 2014. A governance model for the board had been prepared and work was now under way on developing an integration scheme and a strategic plan for the shadow integration joint board. Dedicated working groups were set up to focus on planning and performance, and locality planning. These groups reported to the integration project team and, in turn, to the integration strategic governance group .

Overall, health and social care integration was seen by both partners as a positive development. However, both partners acknowledged that it will not completely address the continued increases in demand for service.

Financial arrangements

The Scottish Government's integrated resources advisory group was set up to provide guidance on the financial requirements for integration. Further guidance was also

provided in a Regulation Relating to Public Bodies (Joint Working) (Scotland) Act 2014. The financial requirements included:

- financial regulations
- financial planning
- financial management and reporting
- accounting requirements and systems
- insurance and risk management
- internal and external audit
- asset use issues
- the treatment of underspends and overspends.

The Partnership had set up a health and social care integration technical finance working group. Work was now under way with three finance workstreams to develop the integrated resources advisory group guidance and clarify the services which would be included within the scope of the shadow integration joint board. Both the Council and NHS Greater Glasgow and Clyde would maintain their own financial ledgers, with budgets being aligned rather than pooled. A new chief finance officer post would be created to manage both budgets. Guidance on budget virements would be considered under the current finance workstreams.

8.2 Information systems

A number of information technology solutions were being explored by the Partnership to support better workflow across the systems. A joint information and health systems group was taking forward activity from the NHS Greater Glasgow and Clyde data sharing partnership. This partnership comprised of NHS Greater Glasgow and Clyde and the five local authorities within the NHS board area. The joint information and health systems group had senior representation from NHS Greater Glasgow and Clyde and the Council services. The terms of reference for this group were amended last year to reflect the period of transition prior to full integration of health and social care .

We saw that progress was being made to integrate CareFirst, the social work case management system, into NHS Greater Glasgow and Clyde's clinical portal. This would mean that information would be more readily accessible and available to health services staff. CareFirst had also recently been updated to provide a single source of comprehensive data so that all system users would have access to consistent data. The update was also used as a catalyst to look at how information on adult support and protection was recorded and shared, as well as how to improve and change the associated paperwork and electronic system.

These developments were hoped to reduce duplication of information, aid better collaborative working and improve outcomes for older people. However, a number

of staff we spoke with were very concerned about the difficulties presented sharing information between health and social services staff. Despite both organisations having security compliant email systems, some staff told us they were not permitted to use these systems to share information about service users. This was due to data protection and service user/patient confidentiality protocols. This was having an impact on delayed discharges. Senior managers across both organisations told us that information could be shared through the secure email systems. However, a considerable number of staff were not aware of this. This meant that a lot of information about older people that could have been shared between health and social work services to facilitate better joint working was not being shared. We found a varied understanding of what could and could not be shared through the secure email systems.

The Partnership was moving in a very positive direction in relation to IT development. However, it acknowledged that the resourcing for developing information systems had been difficult, and this had delayed activity in some areas. However, there were some key areas of activity, such as the appointment of a dedicated programme manager and a technical analyst specifically working on integration issues, which would help drive developments forward.

Recommendation for improvement 9

The Glasgow Partnership should reinforce and communicate their organisation's information sharing protocol so that there is a shared understanding among all staff about the confidential information they are permitted to share through secure email systems.

8.3 Partnership arrangements

Compliance with integration delivery principles[13]

The Care Inspectorate and Healthcare Improvement Scotland are required by the Public Bodies (Joint Working) (Scotland) Act 2014 to review and evaluate if the planning, organisation or co-ordination of social services, services provided under the health service and services provided by an independent healthcare service is complying with the integration delivery principles.

[13] Section 31 of the Public Bodies (Joint Working) (Scotland) Act 2014 states in summary: high quality integrated, effective, efficient, and preventative services should improve service users' wellbeing, take account of their particular needs and characteristics, where they live (locality), their rights and dignity, keep them safe, involve them and engage with their communities.

From 2006 to 2011, there were five community health and care partnerships in Glasgow City. These partnerships between health and social work services had integrated commissioning and service delivery.

While both organisations were keen to retain the five partnerships, the Council also wished to action inspection and audit recommendations. Therefore, it put forward the option of a revised scheme of establishment[14]. This was seen as a means of retaining the five partnerships with incremental social work budget and managerial devolvement. However, NHS Greater Glasgow and Clyde felt this option would not be viable. The community health partnership were established to provide health only services and social work services were returned to their previous functions.

During the inspection, it was clear that the impact of the dissolution of the community health and care partnerships was still keenly felt by staff. Despite having a strong legacy of joint working on the ground, it was inevitable that the new health and social care partnership would have to put into place strong joint strategic governance arrangements. These would need to demonstrate shared and agreed aims whilst allowing each organisation to retain their own strategic functions. Senior management staff in both organisations acknowledged that, in moving forward, they would have to demonstrate joint decision making, clear lines of accountability at both a central and local level, as well as jointly agreed budgetary and management arrangements at locality level.

The chief officer designate of the shadow integration joint board stated that they hoped to learn from the experience of the community health and care partnerships. They were confident that there was a shared vision which had been absent with the community health and care partnerships. They believed the shadow integration joint board would be fundamental in ensuring that the Partnership would deliver on the shared aims.

The shadow integration joint board presented as a cohesive, mature, well-functioning group. There was appropriate representation of stakeholders within the group. Glasgow City Council's executive director of social care services had been appointed chief officer designate in July 2014. They appeared confident in their role in getting the shadow integration joint board to the point of being functional as an integrated joint board.

The Partnership's draft integration scheme would be completed and submitted to the Scottish Government by end of January 2015. The integration scheme was a high level document. A body of work was being developed through key workstreams that underpinned the integration scheme. This would provide a degree of assurance to the shadow integration joint board.

[14] The basis for the creation of any CHCP is a Scheme of Establishment. This details the responsibilities, structures, financial and governance arrangements for the Partnership.

The Partnership had carried out a lot of work within these workstreams, which reported to the shadow integration joint board. A project management approach was being taken with the workstreams. However, while strategies from these workstream groups were now being produced, it was still difficult to see the full direction and intent of the Partnership. The chief officer designate acknowledged this. However, they felt that the Partnership's focus at the moment was on bringing key personnel together to look at the workstream issues and to develop and embed these groups. These issues included information communication and technology, personnel, finance, clinical and professional governance, and workforce planning.

The Partnership felt that key to delivering the integration scheme was good locality planning. Critical to this was good locality work and the Partnership intended to build on this. Many staff we spoke with felt that there was already good locality work in some areas. The Partnership was committed to ensuring that all key locality stakeholders were engaged and involved. It intended to put frameworks in place that would identify communities of interest as well as geographical groups.

However, in terms of locality planning, it was acknowledged that the structure and leadership across localities still needed to be developed.

The Partnership was proposing that the localities would be the three geographical sectors currently delivering services (North East, North West and South Glasgow). Budgets would then be devolved to these three areas. Recruitment was still to take place for the management teams who will work with stakeholders in the localities. They would ensure that locality planning aligns itself with the strategic planning of the Partnership.

The Community Planning Partnership had been considered key in locality planning as it brought together community interests together with partnership representatives to jointly plan services . It was recognised that the Community Planning Partnership had to work more effectively with local community groups representing older people's interests particularly for vulnerable communities. There was also a need to further develop the engagement of, and focus on, GP practices and how they were included within locality planning. GPs we spoke with were very keen to be involved at an early stage. This would ensure they were involved in informing and shaping locality planning.

Quality indicator 9 – Leadership and direction that promotes partnership

Summary

Evaluation – Good

The Glasgow Partnership's vision for integrated health and social care services was well developed. This was outlined in its draft joint strategic commissioning strategy. The actions and aims from the vision reflected national and local priorities. This vision for joint working was owned by Partnership senior and middle managers. However, although frontline staff were positive about joint working, the vision was not as clear for many frontline staff.

The shadow integration joint board was committed to the integration of services. It was engaged in debate on specific issues such as care governance and staff governance.

The draft joint strategic commissioning plan had been co-produced by many older people. Other agencies and stakeholders had also been involved. This demonstrated a shared approach to leading strategic development and direction.

The Partnership was confident it would meet the Scottish Government timescales for health and social care integration. We considered the development of a risk register would be beneficial.

The Partnership was concerned about how it would maintain the stability of currently funded services in the community while driving strategic change in service delivery to achieve savings. These concerns were also evident when considering the governance of acute services in future integrated services.

The Partnership had made some progress reducing the number of older people who experienced an unnecessarily lengthy stay in an acute hospital bed.

Staff morale and motivation were being adversely affected by the need to make financial savings. Radical redesign of services has left some staff uncertain about the future. However, leaders were confident that they were working hard to resolve this.

The Partnership had well-developed improvement plans for a variety of workstreams in support of integration. Positive changes had been made to planning structures in organising change and improvement into locality areas. However, these arrangements were at an early stage.

9.1 Vision, values and culture across the partnership

The Partnership was providing services under the health and social care strategy for older people in Glasgow as set out in the draft joint strategic commissioning plan for older people in Glasgow[15]. This was published in February 2013.

The Partnership's vision in this strategy was:

- help older people and their carers take responsibility for their own health so that people can stay healthy, active and live well, be independent, exercise choice and are fully involved and engaged in decisions that affect them
- ensure that health, housing and social care is focused on those older people who are in greatest need because of their health, social and economic circumstances increase our focus on prevention and anticipatory care to help people stay well
- deliver integrated and person-centred care
- build community capacity to ensure older people continue to be contributors to care provision and wider society, to ensure overall community cohesion that achieves a mutual care approach across generations and different sections of society.

Staff from the Partnership and the third sector told us the strategy was informed by extensive consultation with older people, carers and other key stakeholders as well as with Partnership staff.

The Partnership told us the strategy was developed to ensure new and more effective ways would be used to make sure that older people would receive a service which kept them safe, promoted independence and wellbeing. These aims were stated in the City of Glasgow joint adult services plan vision[16]. This sets out a model of health and social care that improves the outcomes of vulnerable adults and older people. The key objectives of this were:

- early prevention and harm reduction
- providing greater self-determination and choice
- shifting the balance of care
- enabling independent living for longer
- quality care management.

The Partnership had developed a cohesive joint approach to developing integrated health and social care services in the future. However, our findings from the staff survey were

[15] 'Let's make Glasgow a great place to grow old ' Joint Strategic Commissioning Plan 2013-2016 for older people in response to the Scottish Government's Reshaping Care for Older People initiative.
[16] Glasgow City Joint Adult Services Plan 2013/15

mixed in relation to the development of integrated services.

Forty-eight per cent of staff thought that there was a clear vision for older people's services with a shared understanding of the priorities. Twenty-seven per cent disagreed or strongly disagreed and 25% said they did not know.

More than half of the Partnership staff (54%) thought that the vision for older people's services was set out in comprehensive joint strategic plans and strategic objectives with measurable targets and timescales. Sixteen per cent disagreed or strongly disagreed and 30% did not know.

9.2 Leadership of strategy and direction

A shadow integration joint board had been established in June 2014. This was comprised of board members from NHS Greater Glasgow and Clyde and elected members from Glasgow City Council, as well as representation from service users, third sector provider organisations, and staff from NHS Greater Glasgow and Clyde and Glasgow City Council. The shadow joint integration board was supported by officers from health and social work services. The Partnership had recruited a jointly accountable officer who was originally a member of the Council's senior management team.

The shadow integration joint board's primary remit was to advise on the creation and development of an integrated health and social care partnership and the integration joint board. To do so, the shadow integration joint board was to function as a full and equal partnership between Glasgow City Council and NHS Greater Glasgow and Clyde while operating within the existing council and NHS strategic frameworks. The shadow integration joint board had developed an initial integration work plan. It expected to develop the integration scheme and integration strategy in time to meet the deadlines for submission to the Scottish Government (1 April 2015). This work plan included a preparatory period to support shadow Board members to help them fulfil their roles. The integration work plan included eight key workstreams:

- quality care and professional governance
- finance
- human resources
- locality planning
- organisational development
- governance and accountability
- communication
- performance and planning workstream
- establishment of a body corporate model.

We observed meetings of the shadow integration joint board. The level of commitment shown by board members for the integration of services was clearly evident. There was a willingness to engage in debate on specific issues such as care governance and staff governance.

The Partnership had committed to develop a detailed workforce plan for both organisations. However, the development of this plan was expected to take a considerable period of time in order to resolve issues in relation to terms and conditions of employment for staff. Work had been carried out to develop firm proposals for recruitment to joint posts at management level. However, challenges remained in the development of joint recruitment processes.

The Partnership acknowledged that the pace of progress in the development of the integration work plan was slow in some areas. A project management approach was being taken to the eight workstreams. Senior managers told us that the focus was on bringing key personnel together to look at the issues. Most workstreams had made some progress in forming plans for key activities in the coming months. However, considerable challenges remained with the timescales for introduction of health and social care integration. Key strategic decisions remained outstanding. Each project workstream identified risks in its regular reports to the shadow joint integration board. However, no overarching risk management plan was in place to address issues that might impede implementation.

Senior managers identified a significant risk with the Partnership possibly not having adequate time to consult on the Partnership's draft joint strategic commissioning strategy. Any delays in the approval of the integration scheme could lead to delays in forming the integrated partnership with the necessary powers to adopt the joint strategic commissioning strategy.

The complexity of integration was made more difficult by the need to coordinate strategic development with the five other local authorities within the NHS Greater Glasgow and Clyde boundary. Joint work was taking place in the finance workstream across the six local authorities. They were submitting their draft integration schemes to NHS Greater Glasgow and Clyde's Board for approval within similar timescales.

We saw that the shadow integration joint board was working well with senior officers to enter a state of readiness for the move to integrated services in 2015. However, there were areas where the shadow integration joint board would benefit from having stronger risk management frameworks in place. This would help to steer and direct the changes needed to be made within the challenging timescales. The shadow integration joint board should take steps to develop more robust risk management frameworks.

Recommendation for improvement 10

The Glasgow Partnership should ensure that development of a comprehensive risk register is aligned with the shadow integration joint board's function in overseeing the integrated arrangements and onward service delivery. This should be maintained when the integration joint board is established.

We found that third sector groups and older people had increased expectations following development of the draft joint strategic commissioning plan for older people and the Community Planning Partnership's 'One Glasgow' plan. The One Glasgow plan had a vision of improved prevention and early intervention for older people's services. Some third sector groups told us they hoped there would be a stronger emphasis in joint commissioning plans on early intervention and prevention within localities. Whilst acknowledging that the shift in emphasis was difficult when the Partnership had to make difficult decisions on priorities for spending, the third sector groups were anxious that the current level of commitment to early intervention and prevention would be able to continue. Elected members were aware of the need for community capacity building and the development of locality planning within communities. This had been a focus for elected members for a number of years. Elected members told us that they relied on Council officers to provide the direction, leadership and vision for taking forward the capacity building within communities.

The integrated care fund administered by the Community Planning Partnership was under review. A move from one- year to three-year funding was anticipated. Third sector organisations viewed this as a positive move to add stability to the funded organisations. However, service providers told us there was uncertainty as to what level of grant funding was available for allocation to partnership initiatives in the 2015-2016. This made it difficult to plan for reduction or development of services in time to meet the statutory requirements such as giving notice to staff under employment legislation.

From attending the Partnership's executive group, we saw the partners worked well together and were focused on issues of integration planning and finance. This was outlined in the Glasgow City joint adult services plan 2013–2015. We saw this group carrying out detailed financial management, including having an overview of each areas' actions in controlling cost.

We were not clear how the senior managers within the Partnership were communicating their immediate plans to meet demanding financial targets in the coming year. We were told by service providers of an example where there had been no consultation from the Council before charges for services were introduced.

Wider communication was managed through the health and social care communication plan which had a more strategic role. The shadow integration joint board had plans in place to develop locality-based working and support but these were at an early stage of implementation with lack of attention given to realistic timescales thus the plans were not SMART. Results from our staff survey showed that:

- 40% of staff agreed or strongly agreed that there was a strong positive engagement between the partners and local third sector groups
- 25% disagreed or strongly disagreed, and 36% said they did not know.

Housing providers were key strategic partners in taking forward the move towards integration. They were involved with the prioritisation of city-wide supported accommodation for vulnerable older people, and development of proposals for intermediate and anticipatory care. Senior managers from the Partnership were expecting the proposals to be funded through the Integrated Care Fund. A review of sheltered housing was under way. This was looking at the most effective and affordable models of housing support for older people. Significant changes to existing provision were anticipated. The use of the Integrated Care Fund to develop intermediate and anticipatory care was critical to meeting the demand created by the reduction in sheltered housing provision. It was uncertain if the need to achieve savings would result in funding reductions for sheltered housing being introduced before alternative capacity was created.

Clinical leaders in Glasgow City were overseeing a number of health led initiatives such as the introduction of the eight pillars model of community support which sets out an integrated and comprehensive, evidence-based approach to supporting people with dementia living at home during the moderate to severe stages of the illness. This model of community support developed by Alzheimer Scotland was being introduced as a pilot in the South of Glasgow.

As clinical leads within their localities, GPs told us they should have a strong role in reshaping local services to support older people in their homes for longer. However, they told us their ability to lead and deliver the reshaping of local services was dependent upon the release of resources from the acute to the primary care sector. Releasing resources from the acute sector was a long-term plan held by the Partnership's senior management. However, GPs were sceptical and thought that this might not be achieved due to the pressures that the acute sector faced.

9.3 Leadership of people across the partnership

The Partnership had held a number of key engagement and consultation staff events. Initially, these were aimed at senior staff to develop the Partnership's shared vision and priorities. An event was held in 2014 with third sector chief executives and officers. This presented the next steps towards integration and the Partnership's plan for developing and working with the third sector. Progress with the development of the integration strategic plans were reported to staff in a series of newsletters. Since September 2013, these had been issued every two months. Staff engagement events had also been held.

Staff engagement regarding integration plans was being addressed at big events. Places were allocated on application. This approach had had limited success as a significant proportion of the staff we met were unaware of the partnerships integration plans.

This was part of an extensive communication plan in support of health and social care integration. Senior staff were confident that staff had been involved and informed about the integration process. Trade unions were involved and sat on the shadow integration joint board. Senior staff told us that staff were being told that things have change and that the shadow integration joint board and senior staff were providing staff with positive and upbeat views about integration. Officers told us there was a shared overall vision within the shadow integration joint board. Senior managers said that they thought this was 'trickling down' to all staff however staff described a lack of communication from senior managers about proposed changes to structures and service delivery.

The Partnership introduced a proposal to integrate the senior management teams into a single structure and to streamline job titles and functions across the senior management grades. The report prepared in October 2014 proposing this revised structure had been shared with senior managers and with social work team managers for comment. The report was described as a setting out the way forward for future Partnership structures. Staff had mixed views on how change was communicated.

Results from our staff survey on how change was communicated to staff and whether their views were fully taken into account showed that 53% of staff thought that senior managers had communicated well with frontline staff, while 37% disagreed and 10% did not know.

Senior managers told us there were challenges in leading change with differing challenges on resources and demographics across the different areas. Results from our staff survey appeared to support this view as only 37% of staff agreed or strongly agreed that changes which affect services were managed well. Forty-six per cent of staff disagreed or strongly disagreed that their views were taken into account fully when planning services at a strategic level.

Social work services planned to transfer staff who carried out care at home assessments for older people and other client groups to Cordia. The transfer arrangements had been under extensive discussions with trade union representatives. As a result, the process had been delayed. Senior managers described workforce motivation as being difficult to deal with due to these delays in implementation, as staff were concerned about the implications for them.

Senior managers and elected members told us that staff were being supported to look at the opportunities within the Council and were being encouraged to be more flexible in terms of their work. They told us that a lot of work was being done to recognise staff. Senior managers told us radical redesign of services had left staff mistrustful. However, they were confident that they were working hard to resolve this.

Elected members told us they were taking every opportunity to spread a positive message about integration and its overall philosophy to staff. They acknowledged it may take time to bring staff on board. However, they were aiming for consistency of message across the Council and NHS board.

9.4 Leadership of change and improvement

Workstream and planning group papers showed a wide-ranging commitment to service improvement activity across the Partnership. Well developed improvement plans were in place for a variety of workstreams. Each workstream reported on progress and activity in organisational performance reviews every three months to the Partnership executive group. The community health partnership reported on performance every year to NHS Greater Glasgow and Clyde. The lead on scrutiny of performance was provided by the shadow integration joint board.

We saw papers that supported the development of change plans for the introduction of health and social care integration. However, a lot of implementation detail still needed to be decided by the Partnership. Managers acknowledged that there were concerns about effective change management. The agenda for integration was challenging and was possibly made more difficult due to the changes in direction taken in the last three years as a result of the dissolution of the five community health and care partnerships in Glasgow.

Managers told us that the rehabilitation and reablement services had shown improvement in the last year, and that joint working was improving in localities. Frontline nursing and social work services staff told us that improvement was hampered by funding restrictions. They said targets were often to address budgetary shortfalls and targets, rather than individual's needs. This meant that staff had less time to develop new ways of working

jointly as they had to focus on immediate priorities. Results from our staff survey showed that 41% of staff agreed or strongly agreed that the quality of services offered to older people jointly by partner's staff had improved over the last year. Thirty four per cent disagreed or strongly disagree and 26% said they did not know.

Locality-based planning and implementation groups were responsible for the delivery of improvements in health and social care, and integration. Membership of these groups included staff representatives and local stakeholders, as well as Partnership officers. The groups had recently been set up and were in the initial phases of considering the localised changes in support of the integration of health and social care.

Previous planning structures had been less successful in incorporating views of staff in to future service planning. Results from our staff survey showed that 34% of staff agreed or strongly agreed that the views of staff were taken into account fully when planning services at a strategic level. Forty six per cent disagreed or strongly disagreed and 20% said they did not know.

The role of the third sector and local communities in developing plans was well defined in the development of the draft joint strategic commissioning strategy. Service users, and carers also engaged successfully with development of the strategy. Staff confirmed that good locality planning was critical to good locality work. Members of the shadow integration joint board told us they were committed to ensuring that all key locality stakeholders were engaged and involved and systems would be put in place to make sure this happened.

Quality indicator 10 – Capacity for improvement

Summary

Challenges remained in delivering continuous improvment in outcomes for older people, particularly in the quality and choice of services available to older people, and in providing access to care.

The Partnership was making good progress towards integration of health and social care. The future redesign of services was a challenge. Good communication with staff and the wider community was needed to alleviate uncertainty and anxiety.

The draft joint strategic commissioning strategy was in place. However, it lacked detail, and key elements such as funding, delivery timescales and areas for growth or disinvestment were not always identified.

The issues of the large scale of service delivery needed, the high levels of deprivation and the associated higher morbidity levels for older people in Glasgow will continue to create challenges in delivering positive outcomes for the high numbers of older people who need health and social work services.

The task of successfully developing integrated health and social care services was made more critical as the Partnership was not meeting a number of existing performance targets for older people. The successful implementation of integration will continue to be a critical factor in supporting positive outcomes for older people.

Improvements to outcomes and the positive impact services have on the lives of individuals and carers

The Partnership was delivering positive outcomes for many older people and their carers. This was evidenced through our analysis of nationally and locally published performance data, documentation submitted to us by the Partnership, results from our review of individuals' social work services and health records, and from views expressed by service users, carers and the Partnership staff we met.

The Partnership provided proportionally more care at home and intensive care at home services to older people than the national average. Care at home services delivered positive personal outcomes for a large number of older people. However, some older people experienced poor outcomes such as those who had their discharge from hospital delayed or who had an avoidable admission to an acute bed.

The Partnership had a number of developments to support older people's independence by reducing social isolation and increasing activity, and helping older people to stay in their own home. However, many of these initiatives were pilot projects, were time-limited and were not accessible to all older people due to where they lived. Further implementation of services from these pilots was not consistently applied. As a result, we were not clear on the equity of access that older people had to services.

We found instances of older people having to stay in hospital while they waited for care home placements. The Partnership's extensive reablement initiative delivered good outcomes for older people. This was clearly supported by successful joint working. A number of initiatives were in place to make sure that older people received the right intervention at the right time with the right outcomes for older people. This included ease of access to care at home services by rehabilitation staff. This speeded up access to care at home support for older people at the point of discharge from hospital.

Effective approaches to quality improvement and a track record of delivering improvement

The Partnership had well-established performance frameworks. A wide range of performance information was produced, reported and made available to the Partnership's senior and local management, as well as elected members and NHS board members. A draft joint performance framework linked to national outcomes was being produced. The Partnership needed to ensure that the joint performance framework contained challenging but achievable targets.

Workstream and planning group papers showed a wide-ranging commitment to service improvement activity across the Partnership. Well-developed improvement plans were in place for a variety of workstreams. Each workstream reported on progress and activity in organisational performance reviews.

A joint financial framework was under development. There was broad agreement for what financial resources were included. Arrangements for financial monitoring were in place and had been adopted by the shadow integration joint board.

A draft joint strategic commissioning strategy for older people was in place. The Partnership anticipated that the strategy would be adopted by the integrated joint board when it was fully constituted.

Effective leadership and management

The shadow integration joint board was effectively supported by the Partnership executive group. Strong working relationships were evident, and these helped the Partnership to manage services, with a shared vision.

However, senior managers we spoke with were aware of the uncertainties among the wider staff group and of the need for good communication. They acknowledged the need to be open and transparent in their dialogue with staff across the Partnership. Communication about the progress with integration of health and social care also needed to improve.

Preparedness for health and social care integration

The Partnership had made good progress in developing joint arrangements for health and social care integration. The governance, planning and development infrastructure for the Partnership was well established. The shadow integration joint board was using a clearly written joint integration work plan with defined workstreams. This was being progressed using a project management approach. This offered a stable base from which future integration work plans would be delivered.

Considerable financial and service pressures were affecting both Glasgow City Council and NHS Greater Glasgow and Clyde. The shadow integration joint board was operating effectively. Decisions were being made on the development of integrated services and the resources to be used for development. Both partners had a commendable history of achieving savings targets. However, partnership working was affected by the impact of the dissolution of the previous five community health and care partnerships in 2010. It was clear that this was still keenly felt by staff. This presented a considerable challenge for the effective delivery of health and social care integration, and consistent effective operational joint working between health and social work services staff.

Future redesign of services was pressing due to continuing financial pressures. Senior managers acknowledged that service redesign would be needed. The capacity of the Partnership was sufficiently stable and robust to weather the onerous financial pressures and deliver the exacting agenda for change.

What happens next?

We will ask Glasgow Partnership to produce a joint action plan detailing how it will implement each of our recommendations for improvement. The Care Inspectorate link inspector, in partnership with Healthcare Improvement Scotland colleagues, will monitor progress. The action plan will be published on **www.careinspectorate.com** and **www.healthcareimprovementscotland.org**

August 2015

Appendix 1 – Quality indicators

<table>
<tr><th>What key outcomes have
we achieved?</th><th>How well do we jointly meet the needs of our stakeholders through person centred approaches?</th><th>How good is our joint delivery of services?</th><th>How good is our management of whole systems in partnership?</th><th>How good is our leadership?</th></tr>
<tr><td>1. Key performance outcomes</td><td>2. Getting help at the right time</td><td>5. Delivery of key processes</td><td>6. Policy development and plans to support improvement in service</td><td>9. Leadership and direction that promotes partnership</td></tr>
<tr><td rowspan="5">1.1 Improvements in partnership performance in both healthcare and social care

1.2 Improvements in the health and well-being and outcomes for people, carers and families</td><td>2.1 Experience of individuals and carers of improved health, wellbeing, care and support

2.2 Prevention, early identification and intervention at the right time

2.3 Access to information about support options including self directed support</td><td rowspan="5">5.1 Access to support

5.2 Assessing need, planning for individuals and delivering care and support

5.3 Shared approach to protecting individuals who are at risk of harm, assessing risk and managing and mitigating risks

5.4 Involvement of individuals and carers in directing their own support</td><td>6.1 Operational and strategic planning arrangements

6.2 Partnership development of a range of early intervention and support services

6.3 Quality assurance, self-evaluation and improvement

6.4 Involving individuals who use services, carers and other stakeholders

6.6 Commissioning arrangements</td><td>9.1 Vision ,values and culture across the Partnership

9.2 Leadership of strategy and direction

9.3 Leadership of people across the Partnership

9.4 Leadership of change and improvement</td></tr>
<tr><td>3. Impact on staff</td><td>7. Management and support of staff</td><td>10. Capacity for improvement</td></tr>
<tr><td>3.1 Staff motivation and support</td><td>7.1 Recruitment and retention

7.2 Deployment, joint working and team work

7.3 Training, development and support</td><td rowspan="3">10.1 Judgement based on an evaluation of performance against the quality indicators</td></tr>
<tr><td>4. Impact on the community</td><td>8. Partnership working</td></tr>
<tr><td>4.1 Public confidence in community services and community engagement</td><td>8.1 Management of resources

8.2 Information systems

8.3 Partnership arrangements</td></tr>
<tr><td colspan="5">What is our capacity for improvement?</td></tr>
</table>

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If you wish to comment about any of our inspections, contact us by emailing **enquiries@careinspectorate.com**, or write to us at the Care Inspectorate, Compass House, 11 Riverside Drive, Dundee, DD1 4NY.

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The Healthcare Environment Inspectorate, the Scottish Health Council, the Scottish Health Technologies Group, the Scottish Intercollegiate Guidelines Network (SIGN) and the Scottish Medicines Consortium are part of our organisation.

Glasgow Joint Inspection – Recommendations for Improvement from CI /HIS

	Improvement Area	Themes	Action Required	Status	Outcome	Time scales	Lead Officer Group
1	The emerging Glasgow Health and Social Care Partnership should increase its efforts to reduce the number of older people admitted to hospital as an emergency or as a repeat emergency.	Early Intervention and Prevention Integrated Care Pathways Step up / Step Down Carers Support Clinical Decision making Acute Strategic Planning	All partners including 3rd Sector require to work in partnership to deliver a public health approach to early intervention and prevention Focus on clinical decision making Glasgow HSCP will along with other HSCPs across NHS GG&C contribute to strategic planning around admissions**.**	Range of work in progress to as evidenced through RCOP Action Plan		on going Dec 2015 On going	Older People's Coordinating Group S Fitzpatrick H McNeil Dr R Groden IPB D Williams

	Improvement Area	Themes	Action Required	Status	Outcome	Time scales	Lead Officer Group
2	The Glasgow Partnership should ensure that all carers are offered a carers assessment in line with legislation and that these are regularly reviewed, and ensure that carers linked to a carers centre can seek a review should their needs change.	Carer identification and recognition Right level of intervention at right time Increase in carer assessments and review of support plans	Develop training plan for SW and CHP staff including E Learning Reissue Carer Assessment Policies & Procedures Ensure CF6 can record carer assessment offered/carer assessment reviewed. Ensure voluntary sector are routinely review carer support plans and move carers on and report on this	Training Plan in development Carer Assessment P&Ps have been reviewed Work in progress to add this functionality to CF6.		Dec 2015	Carer SPG A Cummings
3	The Glasgow Partnership should continue to develop anticipatory care planning for older people, ensuring a more streamlined, standardised and multi-agency approach, with anticipatory care plans that are accessible	Glasgow model of APC Staff Awareness Optimise sharing of information	A Glasgow model of AC is required to merge existing disparate approaches.	A Glasgow model of AC is in development with an AC Coordinator in place funded through ICF to merge existing disparate approaches.		Dec 2015	Jean Blackwood ICF Anticipatory Care Work Stream P Adams

	Improvement Area	Themes	Action Required	Status	Outcome	Time scales	Lead Officer Group
	across the partnership.						
4	The Glasgow Partnership should make sure that older people have timely access to occupational therapist assessments to enable them to get the support they need to remain within the community.	Waiting times Resources Joint working	Review OT workforce availability against OT assessment workload. Develop an action plan that ensures the optimum standards of OT performance including assessment throughput. Evaluate further opportunities for service improvement within an integrated arrangement.	Work has commenced to undertake this review Initial discussions have taken place		Dec 2015	Stephen Fitzpatrick, Head of Service Lead Fiona Brown, Service Manager via OT Managers Forum
5	The Glasgow Partnership, should take immediate action to improve the engagement with frontline practitioners and their managers. They need to improve quality, consistency and frequency of communication and engagement with staff across all sectors.	Communication with practice and front line clinical staff	Develop systems to measure impact of communications Working with OD to build team briefing capacity with managers of front line staff	Communications Strategy and Plan in place		On going	Head of Business Development

	Improvement Area	**Themes**	**Action Required**	**Status**	**Outcome**	**Time scales**	**Lead Officer Group**
	Thereafter the partnership should put systems in place to measure if the desired improvements are realised.						
6	The new Glasgow Health and Social Care Partnership should routinely gather and report on comprehensive data on the numbers (and eligibility criteria categories) of older people waiting for an assessment or review, the length of time they have to wait, and the length of time for service deployment following completion of their assessment.	Need to get Info Systems to develop a report Links to work of SCD reporting too.	CF 6 reports to be developed by SW Info Systems to provide this information	Current reports are under review to determine priorities for new reports		Dec 2015	Head of Business Development A Eccles
7	The Glasgow Partnership should make sure that proper chronologies are prepared and placed in the individuals'	Develop, agree and implement a policy around chronologies	Operational guidance to be developed for SW staff Policy to reflect that these are required for all complex situation where			Sept 2016	A Cummings

	Improvement Area	Themes	Action Required	Status	Outcome	Time scales	Lead Officer Group
	electronic or paper record.		there is significant risk and/or lengthy involvement				
8	The Glasgow Partnership should develop a joint workforce development strategy during the first year of integration which sets out clear joint priorities. This should identify possible staffing shortfalls and outline measures to address these as the integration of health and social care agenda progresses.	Workforce development	Scottish Government Guidance on Integration will be followed and strategy development in Year 1 of integration.	Initial work underway which will feed into a joint plan		June 2016	Chief Finance Officer S Wearing
9	The Glasgow Partnership should reinforce and communicate their organisation's information sharing protocol so that there is a shared understanding among all staff about the confidential information they are permitted to share via secure email	Data sharing	Communication of the protocol to be determined NHS staff training requirements to be determined.	All SWS staff are required to undertake to Gold Data Security Training annually.		Sept 2015	Business Development and NHS IT

	Improvement Area	Themes	Action Required	Status	Outcome	Time scales	Lead Officer Group
	systems.						
10	The Glasgow Partnership should ensure that development of a comprehensive risk register is aligned with the shadow integration joint board's function in overseeing the integrated arrangements and onward service delivery. This should be maintained when the integration joint board is established.	Risk Management	Completion of current work to adapt the specimen Risk Management Policy for Glasgow Completion of a single Risk Register	Work has begun to adapt the specimen Risk Management Policy for Glasgow and to develop the single Risk Register		Within 3 months of formal Integration	Executive Management Team

Glasgow Joint Inspection of Older People Services – Glasgow Defined Key Areas for Improvement / Development

	Area for improvement	**Themes**	**Actions Required**	**Status**	**Outcome**	**Time scales**	**Lead Officer/ Group**
G1	Significantly shift the current balance of care in line with a model promoting prevention and early intervention, optimising the use of "purposeful interventions". Building upon existing service reform initiatives, implement a programme of transformational change capable of meeting health and social care need in the city into the future.	Shifting balance of care Interventions Home Care reform Reablement Intermediate Care Accommodation based strategy	Continued implementation and monitoring of key service reform programme in relation to Home Care, IC and Accommodation based strategies and action plans.	Service Reform program is underway and progress reported and coordinated through Older People's SPG and Coordinating Group		On going	S Fitzpatrick Strategic Head of Older People's Services

	Area for improvement	**Themes**	**Actions Required**	**Status**	**Outcome**	**Time scales**	**Lead Officer/ Group**
G2	Develop a culture of risk acceptance and risk management in line with the above by investing in the development of our workforce at a time of significant change and challenge for them.	Risk enablement	Develop a culture of risk enablement with operational staff from SWS and NHS Agree a risk enablement strategy and action plan Ensure links to accommodation based strategy	Leads for this work have been identified New operational guidance for staff "Support Options guided by Risk Assessment" requires to be implemented across health and social care		Dec 2015	J Kerr M Brannigan
G3	Agree funding and effectively implement the delayed discharge reduction plan, including the programme for expanded intermediate care.	Delays IC 72 hour discharge	Continued testing of IC model and the capacity needs Continued performance monitoring of whole system approach around 72 hour discharge	Delayed Discharge Plan in place Review of IC has commenced New performance monitoring reports are in development.		On going	Operational Group A McKenzie
G4	Finalise a sustainable city-wide model for anticipatory care	*See Improvement Area 3 in JI Improvement recommenda*					

	Area for improvement	**Themes**	**Actions Required**	**Status**	**Outcome**	**Time scales**	**Lead Officer/ Group**
	planning.	*tions*					
G5	Successfully implement personalisation for older people	Older people Personalisation	Work ongoing in respect of implementation and review.	PiD and work plan in place.		On going	J Thomson Commissioning Manager Older People
G6	Develop a more systematic, integrated, outcome focused performance framework.	Joint performance framework Joint reporting Outcomes	Existing performance management processes mapped to National Outcomes. 'Logic' model for integrated performance management develop and reviewed by Shadow IJB. Scottish Government Statutory Guidance expected from later in 2015	Work underway and joint action plan in place		Dec 2015	Joint Performance Group J Cowan
G7	Strengthen housing voice within RCOP at city and sector levels and develop an accommodation-based strategy that	Housing sector engagement Shifting the	This will help facilitate stronger links with and engagement with housing organisations.	Accommodation Based Strategy in place and housing sector engaged on a number of levels		Ongoing	Housing Health and Social Care Group S Fitzpatrick

	Area for improvement	Themes	Actions Required	Status	Outcome	Time scales	Lead Officer/ Group
	optimises the contribution the housing sector can make to shift the balance of care.	balance of care					
G8	Implement the 8-pillars approach based on learning from the pilot initiative, optimising health and social care input.	Living well with Dementia Supporting people at home	Pilot due to finish March 2016 JIT will soon publish feedback from staff and carer focus groups from all pilot sites Evaluation to commence September 2015 and run to March 2016	South area test site has been in operation for 9 months Progress reported through 8 Pillars Steering Group		June 2016	A Cummings J Carson 8 Pillar Steering Group
G 9	Further develop shared financial planning and decision-making, including alignment of budget cycles.	Joint financial planning	Continue to implement and report on progress against action plan	Action Plan in place		Ongoing	Sharon Wearing
G	Establish a continuous	Continuous improvement	Single agency governance boards	New Joint Clinical & Care Governance Board		Ongoing	D Williams Joint Clinical &

	Area for improvement	**Themes**	**Actions Required**	**Status**	**Outcome**	**Time scales**	**Lead Officer/ Group**
10	improvement programme of self-evaluation of individual services across health and social care, building upon existing audit activity.	Self-evaluation Audit activity Quality	will continue to determine single agency priorities.	will determine integrated priorities			Care Governance Board
G 11	Significantly expand the application of assistive technology in relation to both health and social care, building upon the opportunities presented by personalisation.	Assistive Technology	Continue to implement and monitor the TEC Strategy implementation	Technology Enabled Care (TEC) Strategy in place.		ongoing	James Thomson Commissioning Manager Older People
G 12	Building upon the success of recent years, continue to develop new and innovative models of support to carers to help them sustain their caring roles	Carer Supports	Publish Evaluation of Glasgow Carers Partnership Develop carers strategic plan Links to JI Improvement Area 2	Evaluation of GCP out for wide consultation Recommendations to inform Carers SPG Strategic Plan		ongoing	Ann Cummings Carer SPG
G 13	Learn the lessons from the RCOP experience to further	Prevention	Prevention and Early	Early intervention and		June	Fiona Moss

	Area for improvement	**Themes**	**Actions Required**	**Status**	**Outcome**	**Time scales**	**Lead Officer/ Group**
	develop partnership working with non-statutory partners, particularly with regard to evidence-based prevention and early intervention models of support.	and Early Intervention	Strategy highlighted as key priority of work for this group.	Prevention ICF work stream has been set up and Terms of Reference agreed		2016	Early Intervention and Prevention ICF Work stream
G 14	Support elected members and non-executive members of the Health Board to adjust to their new integrated roles and to manage the political challenges associated with a programme transformational change.	Organisational development Transformational change	Continued implementation and evaluation of OD Plan.	Organisational Development plan in place and is currently being implemented		On going	Isla Hyslop Business Development

Partnership Briefing

Joint Inspection of Health and Social Work Services for Older People in Glasgow City

Message from David Williams, Chief Officer Designate

Dear colleague,

As I reported at the time, our joint service provision for older people was inspected by the Care Inspectorate and Health Improvement Scotland in the second half of last year. We now have a final report and this bulletin highlights the main conclusions that the Inspectors reached.

I would like to thank all of you who personally took part in the inspection activity in some way, whether it was to respond to the survey, be involved in the focus groups, organising and hosting meetings or having case files scrutinised. Inspections by external regulatory bodies are a necessary part of our work in health and social care in assisting us to making sure that we provide the best possible service to Glasgow citizens that we can, and your engagement during inspections is sincerely valued and valuable.

For those of you who have perhaps not previously experienced an inspection, and also for those of you who have, I would offer a word of advice: take the time to read the whole report. Experience tells me that often, the tendency is to look at the 'scores on the doors' (the grades) and this leaves us with an emotional response that is often difficult to overcome and see past.

So when you see or hear that we have been graded as 'adequate' in five areas and 'good' in four others, please remember that the report also highlights lots of good things happening as well as the areas for continued improvement. Please also remember that at the time of the inspection report, we were beginning our integration journey as a formal Partnership and the whole point of integration is that it will allow us to deliver even better outcomes together than we have historically done as two separate organisations.

Please never lose sight of all the very positive outcomes that we already delver for the people of Glasgow every day. I want us to see this inspection as an opportunity to give us a benchmark on where we were before integration to compare to where we will strive to be in a year's time and beyond.

As anyone who follows the media will know, one of the biggest challenges we face across society today is how we best care for the increasing number of older people in our communities, and for the carers who support them. So Glasgow does not face this challenge alone.

Integration is a rapidly moving agenda in Glasgow and I believe we are already much further on than at the point of the inspection. I would be very confident that if the inspectors came back today, they would see the real progress being made in improving the experience of older people particularly in significantly reducing unnecessary delays coming out of hospitals and I firmly believe that some of our grades would have improved further. And that improvement has been down to your preparedness to embrace integration and work differently with each other in order to achieve change and get better results.

Well done and thank you for that and let us keep the continuous learning and improvement going.

Partnership Briefing

Joint Inspection of Health and Social Work Services for Older People in Glasgow City

Background on the joint inspection report

The joint inspection of health and social care services for older people in Glasgow City, is carried out between the Care Inspectorate and Health Care Improvement Scotland. It is intended to align with the Scottish Government's policies for the integration of health and social care, including re-shaping care for older people, the dementia strategy and adult protection arrangements.

The Care Inspectorate is the unified independent regulator and inspector of social care and social work services across Scotland, and Health Care Improvement Scotland is the scrutiny and improvement body for NHS Scotland and regulator for independent healthcare providers.

The joint inspection considered how well health and social work systems work together to deliver the best outcomes for older people to provide the support that allows them to live in the community at home or in a homely setting.

The inspection process in Glasgow City formally began in August 2014, and it took place over a six-month period. During this time, the inspectors undertook a number of different stages to gather information, which included:

- initial briefings
- local submissions of self-assessment and supporting evidence
- case file sampling and reading
- staff survey
- inspector-led meetings and focus groups and
- interviews with managers, staff, Elected and Health Board Members, carers and external organisations.

For the joint inspection, the Care Inspectorate and Healthcare Improvement Scotland used a scrutiny model for multi-agency inspections of services. The principles of this method include:

- targeted, proportionate and risk-based where the level of inspection meets the assessed need for scrutiny
- provides public assurance that services are delivering quality outcomes
- informed by assessed needs, rights and risks
- open and transparent
- focuses on continuous improvement and development
- evaluates the consistency of outcomes for people who are supported health and social services across Scotland and

- ensures the approach to inspection is efficient and avoids duplication of effort on the part of the scrutiny body.

The inspection of health and social work services for older people was based on the evaluation of 10 'quality areas', which included 27 'quality indicators'. The quality areas included:

- key performance outcomes
- getting help at the right time
- impact on staff
- impact on the community
- delivery of key processes
- policy development and plans to support improvement in services
- management and support of staff
- partnership working
- leadership and direction that promotes partnership and
- capacity for improvement.

On conclusion of the formal inspection, a final report of findings and recommendations was prepared and shared with Glasgow City Health and Social Care Partnership's Executive and Senior Management Team before being published on the Care Inspectorate website.

Evaluations and recommendations

Based on the findings of this joint inspection, the following grades were assigned to the Partnership.

Quality indicator	Evaluation	Evaluation criteria
Key performance outcomes	Adequate	**Excellent:** outstanding, sector leading **Very good:** major strengths **Good:** important strengths with some areas for improvement **Adequate:** strengths just outweigh the weaknesses **Weak:** important weaknesses **Unsatisfactory:** major weaknesses
Getting help at the right time	Adequate	
Impact on staff	Adequate	
Impact on the community	Good	
Delivery of key processes	Adequate	
Policy development and plans to support improvement in services	Good	
Management and support of staff	Adequate	
Partnership working	Good	
Leadership and direction	Good	

The joint inspection also highlighted 10 areas for improvement in relation to emergency admissions, anticipatory care planning, carer assessment, social work and OT waiting times and chronologies. Improvements are also required in respect of staff communication and engagement, workforce development and risk management.

The full report of findings and recommendations is available on the Care Inspectorate website.

An action plan is being prepared to set out how we are taking forward these areas for improvement, and we will all be working together as a team to play our parts in making these changes happen.

Next steps

Following publication of the joint inspection report, it is now important that we go through a period of **extensive engagement**. This will include the people who use our older people's services, the Older People Strategic Planning Group, the Shadow Integration Joint Board, Elected and Health Board Members, Glasgow City Council Committees, Chief Executives of Glasgow City Council and NHS Greater Glasgow and Clyde and our partner organisations.

It is also crucial that staff use this opportunity to recognise our strengths and build on them. In particular, we can use our **protected learning** time to consider how best we take forward the recommendations that have come from both the joint inspection and self-evaluation processes. A Powerpoint presentation on protected learning is available for managers to use.

Another opportunity that the inspection report and self-assessment presents us with is **reflection on our practice** within older people services. I would urge all of us to use our team meetings and peer group discussions, to discuss and apply what the recommendations in the report means for all of us so that we deliver real benefits for the service and the thousands of people who rely on it across Glasgow city.

Item No 9

6th October 2015

Glasgow City Council / NHS Greater Glasgow and Clyde
Shadow Integration Joint Board

Report By: Stephen Fitzpatrick, Head of Older People's Services

Contact: Stephen Fitzpatrick

Tel: 0141 276 5596

UPDATE ON THE INTEGRATED CARE FUND

Purpose of Report:	To update on the implementation of the Integrated Care Fund (ICF) Plan in Glasgow and describe the governance arrangements established to oversee its implementation.

Recommendations:	The Shadow Integration Joint Board is asked to note this report.

Implications for IJB	
Financial:	The attached paper provides details of the financial allocations made through the Integrated Care Fund for services which will be managed by the HSCP.
Personnel:	A number of health and social care staff have been recruited to deliver the projects supported by the Integrated Care Fund, some of whom were already in place in the case of projects previously supported by the Change Fund.
Legal:	None
Economic Impact:	None
Sustainability:	None
Sustainable Procurement and Article 19:	None
Equalities:	Individual projects are asked to report upon usage of their services by Protected Characteristic Groups.
Implications for Glasgow City Council	The partner organisations will provide staff to enable the H&SCP to fulfil its obligations.
Implications for NHS Greater Glasgow & Clyde	The partner organisations will provide staff to enable the H&SCP to fulfil its obligations.

1. Purpose

1.1 This paper provides an update on the implementation of the Integrated Care Fund Plan in Glasgow and describes the governance structures and the monitoring and evaluation arrangements which have been established to oversee the implementation of the Plan.

2. Background

2.1 The Scottish Government made £100m available over three years - from April 2015 - to new integrated Health and Social Care Partnerships (HSCPs), through the Integrated Care Fund (ICF).

2.2 The ICF is intended to support Partnerships to drive the shift towards prevention and early intervention in order to reduce future demands upon health and social care services; strengthen approaches to inequalities by focusing on areas of greatest need; and facilitate the development of integrated care services that can improve the way people are looked after in the community, prevent avoidable hospital admissions, and enable them to return home smoothly if they have to be admitted.

2.3 Partnerships were asked to submit an Integrated Care Fund Plan in respect to this funding by the 12 December 2014, outlining how they intended that this money would be spent in pursuit of these aims. Within Glasgow, a Plan was jointly prepared and agreed by a range of partners including the CHP, social work, acute, housing and the third and independent sectors. Glasgow's plan was subsequently approved, with £13.29 million being allocated to the city for 2015-16, with amounts for subsequent years to be confirmed.

2.4 This plan set out four priority programme areas; Early Intervention and Prevention; Anticipatory Care; Integrated Care Pathway; and Accommodation. Within these areas, a number of projects have been identified. These are listed in Appendix 1, which also includes details of the amounts allocated to each and the lead organisations delivering them. This highlights the key role of the third, independent and housing sectors in delivering the desired shifts in the balance of care, with approximately 75% of the proposed ICF budget allocated across these sectors.

3. ICF Governance Structures

3.1 Partnership arrangements are in place to oversee the implementation of the ICF Plan at a number of levels. Leads have been appointed for each of the programme areas as detailed below and have responsibility for overseeing their projects' delivery and ensuring that they are subject to detailed scrutiny through the respective multi-agency sub-groups which they have established and chair:

Programme Area	Lead
Early Intervention and Prevention	Fiona Moss
Anticipatory Care	Paul Adams
Integrated Care Pathway	Lorna Dunipace
Accommodation Based Strategy	Stephen Fitzpatrick

3.2 In addition, an ICF Monitoring Group has been established in order to provide an additional level of scrutiny in respect to the Integrated Care Fund and maintain an overview of performance across the ICF initiatives. This includes the above Leads, as well as representatives from the third, independent and housing sectors. This group was established in April 2015 and has been meeting quarterly. This group has now started to receive regular reports and assessments of progress from the Lead Officers for each programme area, with performance in quarter 1 of 2015/16 reviewed at its last meeting in August.

3.3 The ICF Monitoring Group reports to the Older People's Strategic Planning Group (SPG), which given its formal role within the Glasgow Health and Social Care Partnership (GHSCP), has responsibility for monitoring ICF spend; managing the budget; and formally reporting to the Integrated Joint Board on a six monthly basis and to the Scottish Government as required.

4. Monitoring and Evaluation Arrangements

4.1 All projects have now moved to implementation and individual project leads have produced a project plan which sets out their anticipated key milestones, outputs and associated targets. They have also been issued with a standard monitoring template which they have been asked to complete and return on a quarterly basis, which records their progress against their specified project plans.

4.2 In addition to the quarterly monitoring returns which focus on project delivery and activity, all projects have been issued with templates and asked to prepare evaluation plans by the end of October which will set out how they intend to demonstrate the impact of their projects. A researcher, who was appointed by NHSGGC's Public Health Department to evaluate the previous Change Fund programme, will support project leads in the development and implementation of these evaluation plans. Discussion is also ongoing with the Joint Improvement Team with regard to the potential for them to support the evaluation of the accommodation based strand of the ICF.

5. Implementation and Spend

5.1 Progress to date varies across the four programme areas depending upon the status and origins of the projects involved. Some projects are only now being established and require staff to be appointed before they can actually begin to deliver services. Others, which are an extension of previous Change Fund

initiatives, are at a more advanced stage given staff are already in place, and are moving ahead with their planned developments.

5.2 The first quarterly monitoring returns were received in July and a summary progress report produced for the ICF Monitoring Group's August meeting, which is attached in Appendix 2. At this meeting progress across the ICF programme was reviewed with no significant concerns noted by the Group at this stage.

5.3 Financial performance is being reviewed on an ongoing basis and will be reported through the ICF Monitoring Group. Any underspend against ICF will be kept under review over the year and reported to the Integration Joint Board.

6. Recommendations

6.1 The Shadow Integration Joint Board is asked to note this report.

APPENDIX 1 – ICF PROGRAMME SUMMARY

Early Intervention and Prevention

Ref. No.	Title	Full Year Cost (£)	Lead Organisation(s)
E1	Mental Health & Well-being - Stress Centres	669,305	Lifelink
E2	Mental Health & Well-being - Good Moves	110,000	Good Moves
E3	Poverty - Thriving Places Community Organisers Programme	160,000	Housing Assocs. (Various)
E4	Poverty - Bridging Service Employability Programme	114,000	Jobs & Business Glasgow
E5	Transformation Fund City Wide Development	831,000	Third Sector (Various)
E6	Carers - Early Identification	318,653	Social Work/ SE Carers Centre
E7	Power of Attorney	70,000	HSCP
	Total	**2,272,958**	

Anticipatory Care

Ref. No.	Title	Full Year Cost (£)	Lead Organisation(s)
A1	Anticipatory Care Glasgow Model	154,000	HSCP
A2	SPoA & Community Nursing Admin	160,000	HSCP
A3	Glasgow Falls Model	76,000	HSCP
A4	Community Respiratory Service	605,070	HSCP
A5	Dementia Post Diagnostic Support	276,000	HSCP
A6	Glasgow Dementia Strategy	90,000	HSCP
A7	Managed Medications - Pharmacy Acute	25,000	HSCP
A8	Fast Track Palliative Care	250,000	Marie Curie
	Total	**1,636,070**	

Integrated Care Pathway

Ref. No.	Title	Full Year Cost (£)	Lead Organisation(s)
P1	Integrated Care Pathway	4,599,915	Ind. Sector/HSCP/ Acute
P2	Rapid Response and Resettlement	162,077	HSCP
P3	Care Manager Role in Assessment/ Discharge	492,300	Acute
P4	Integrated AHP 7 day working	226,680	Acute
	Total	**5,480,972**	

Accommodation Based Strategy

Ref. No.	Title	Full Year Cost (£)	Lead Organisation(s)
H1	Community Connections	362,000	GCVS/Housing Assocs. (Various)
H2	Supported Living	2,200,000	Third & Ind. Sectors/Housing Assocs. (Various)
H3	Technology Enabled Care	763376	Richmond Fellowship/Carr Gomm/Cordia
H4	Home From Hospital	27,537	Southside HA
H5	Better at Home	36,349	GCIL
H6	Extra Care Housing	20,699	Trust HA
H7	Housing Options	175,000	Housing Assocs. (Various)
H8	415 Project	175,000	Wheatley Group
H9	Project Management	140,039	Social Work
	Total	**3,900,000**	

APPENDIX 2

GLASGOW CITY

INTEGRATED CARE FUND MONITORING SUMMARY

AUGUST 2015

SOURCE: JULY 2015 MONITORING RETURNS (Q1)

1. EARLY INTERVENTION AND PREVENTION

Ref	Title/Lead	Summary of Progress	Key Outputs
E1	Mental Health & Well-being - Stress Centres	Moved to new HQ in Brand Street took place in June. EQIA has been completed. Lifelink to review accessibility to services for individuals with sensory impairments and in particular those who use BSL.	Information on no. of 1:1 assessments; single session appointments; counselling appointments; and groups delivered to be included in the next report.
E2	Mental Health & Well-being - Good Moves	Service ongoing. Consultation with older men underway with 4 engagement events planned for July. This will inform future activities of the motivators who will be recruited and trained in September.	1200 people registered with Revitalise. 473 easy exercise sessions delivered, with 3965 attendances. 399 arts sessions delivered with 2031 attendances.
E3	Poverty - Thriving Places Community Organisers Programme	Ongoing delivery in existing areas with community organisers in post. Neighbourhoods for extension of Thriving Places programme agreed as Drumchapel; Easterhouse; and Priesthill and this will take place from December. GCHP equalities group are working with thriving places and each area are working through a range of actions and a workshop is planned for early 2016.	What Works Scotland working with each of the areas to track progress and establish agreed outcomes. Adult wellbeing survey will report soon and it boosted samples in each of the existing areas to track well-being, social connectedness and trust, and perceptions of the local areas.
E4	Poverty - Bridging Service Employability Programme	Referral rates from health and social care staff being maintained and aiming to increase ongoing engagement rates post referral. Bid for 3 year European funding submitted at the end of June 2015 which will enable OT input to the North East and South following positive evaluation in the North West.	488 clients being supported. 31 secured employment. 76 undertaking work related training and 102 non work related training. 24 achieved a qualification.

Ref	Title/Lead	Summary of Progress	Key Outputs
E5	Transformation Fund City Wide Development	See Appendix 1	See Appendix 1
E6	Carers - Early Identification	Links with 72 hour discharge and integrated care pathways processes being strengthened with discussions taken place with hospital and SW teams and locality meetings set up for August/September. Meeting also taken place to discuss partnership working with the accommodation based strategy co-ordinator. ICF workers now represented in the locality dementia strategy and 8 pillars groups. New worker commenced in June in the North East which meant numbers were slightly lower than anticipated due to an induction period.	147 carers assessments completed. 50 referrals for health reviews, 43 for training, 68 for emergency plans, 21 for telecare, and 46 for home safety checks. 2359 short break hours provided and 74 carers informed of POA.
E7	Power of Attorney	June campaign completed. Sign up being achieved from other areas with West Dunbartonshire, Lanarkshire and Tayside involved. East Dunbartonshire ready to join and discussions also held with Midlothian and Highland. Further funding to be sought and a Christmas campaign is planned. Leaflets produced and ongoing work on a publication.	93.18% increase in website visits during the campaign and a 122.44% increase in page views during the first week. Glasgow residents with a Power of Attorney registered with the Office of the Public Guardian.

2. ANTICIPATORY CARE

Ref	Title/Lead	Summary of Progress	Key Outputs
A1	Anticipatory Care Glasgow Model	Project manager has now been appointed on a 12 month secondment and started on the 3 August. Interviews scheduled in July for 3 seconded band 5 anticipatory care champions.	N/A
A2	SPoA & Community Nursing Admin	Project manager appointed and starts on the 20 July 2015. Project plan to follow in Q2 which will target outputs and milestones.	N/A
A3	Glasgow Falls Model	Project manager appointed and starts on the 20 July 2015. Project plan to follow in Q2 which will target outputs and milestones.	N/A
A4	Community Respiratory Service	Recruitment processes continuing with some appointments having been made and others ongoing. Promotion of service to stakeholders ongoing. Service commencing initially in the North West then extended to the other areas in September/October though recruitment delays may affect timescales. SCI referral pathway now agreed to support this extension. Work also underway on evaluation tools.	Averaging 23 referrals per month in the North West.35% receiving home pulmonary rehabilitation. 80% of urgent referrals not being admitted to hospital. 85% of patients reporting improved self management.
A5	Dementia Post Diagnostic Support (PDS)	Current models of service delivery being reviewed. Steering Group established. Plan is for tendering of new agreed model to take place in December for city wide service.	160 new people diagnosed with dementia in first quarter, though not fully inclusive of all June figures.100% of these people being referred to the PDS service.

Ref	Title/Lead	Summary of Progress	Key Outputs
A6	Glasgow Dementia Strategy	New dementia support post recruited to and the existing dementia support and development lead has had their contract extended. Draft work and evaluation plans completed and being considered by steering group on 30 July. Work on strategy document has commenced and planning underway for the consultation phase.	N/A
A7	Managed Medications - Pharmacy Acute	Interview for pharmacy technician completed and preferred candidate identified. Awaiting notification that they can be released.	N/A
A8	Fast Track Palliative Care Service	Recruitment underway. SN will start on the 3rd August. 5 HPCAs have been recruited and will be inducted on the 27 July. Agreed governance structures of meetings with the NHS.	102 patients this quarter with 1067 visits undertaken. 235 admission avoidance days achieved and 3294 bed days saved.

3. INTEGRATED CARE PATHWAY

Ref	Title/Lead	Summary of Progress	Key Outputs
P1	Integrated Care Pathway	Intermediate care briefings established and web area on Staffnet and Connect set up. Rehab service capacity has been expanded to provide dedicated services to intermediate care setting, budget is overcommitted but will be reduced in line with planned reduction in the number of sites. Geriatrician input to the model has commenced and GP cover is in place for all beds. Work has commenced to finalise the working model of intermediate care which will influence future working arrangements and linkages. Glasgow has been chosen as one of the four national frailty partnerships which will influence the development of future models.	As at 29 June, there were 23 delayed discharges, a significant reduction from 95 at the 30 March. Average length of stay in intermediate care beds 31 days, a fall from 33 in February. Percentage being discharged home at end of June was 21%, rising from 18% in February. 183 people accessing supported living, rising from 150 at the end of March. Since the introduction of the 72 hour discharge target on 1 December the number of breaches of the target has reduced from 117 to 25 on 7 September. In the same period the number of bed days lost to delays for the target population has reduced from 3,867 to 922, a reduction of 76.2%.
P2	Rapid Response and Resettlement	Steering group well established with all partners represented. Discussion on going with merging the intermediate care and rapid response service to ensure best use of red cross resource. Steering group will now be chaired by Christine Ashcroft ASM, NE sector due to previous lead leaving for new post.	N/A
P3	Care Manager Role in Assessment/Discharge	Service ongoing. Survey of medical consultants views of the service being planned. Weekend services being improved. ECAN cover being provided in IAU.	North - 809 patients seen. 128 discharges within 48 hours. South - 1746 patients seen. 236 discharges within 48 hours.
P4	Integrated AHP 7 day	Model being developed. Awaiting report.	N/A

Ref	Title/Lead	Summary of Progress	Key Outputs
	working		

4. ACCOMMODATION BASED STRATEGY

Ref	Title/Lead	Summary of Progress	Key Outputs
H1	Community Connections	Full staff team recruited and induction has been completed. Networking in localities underway and aim is for the service to commence within localities at end of 20 July. Priorities for thematic pilots being discussed. Sub-group set up to oversee and further develop comms activity.	Draft stakeholder and development plan produced and initial marketing materials and website created which will be further developed.
H4	Home From Hospital	Service fully established and operation and has been promoted. New leaflets being drafted detailing the services available 6 weeks post discharge. 1 promotional visit to target referrers completed.	162 home from hospital related tasks completed this year. 14% of tasks are non key safe, with the aim of increasing this to 22%.
H5	Better at Home Advocacy Service	Surgeries started for older and disabled people in partnership with local RSLs with aim of organising 6 this year.	1 surgery held so far which 12 people attended. Supporting 68 older and disabled people, 47 of which are carried over from the previous project... 25 housing applications completed and submitted on behalf of clients. Achieved 4 outcomes including 3 clients who have been rehoused
H6	Extra Care Housing	Initial meetings with tenants scheduled. Second area office to be remodelled. Senior staff still to be appointed. Service due t9o commence November 2015.	N/A
H7	Housing Options	Project management capacity identified. Work	N/A

		underway to develop team model and to populate multi-disciplinary team. Stakeholder event being planned for October.	
H8	415 Project	Telecare equipment for demonstrator apartments procured and aim is to have these completed by September. Fire and Rescue first through the door 6 week pilot commenced 13/7. Recruitment process underway for co-ordinator for the Activity and Engagement programme.	84 members of staff used the First Through the Door process so far.

APPENDIX 1 TRANSFORMATION FUND PROJECTS

Ref	Lead Organisation	Summary of Progress	Key Outputs
1	**Action on Hearing Loss Scotland**	We are on track, however the summer tends to be a quieter period for us as both service users and many of our volunteers are involved in childcare over the summer holiday period. We are on track with our budget and are not anticipating any slippage at this time.	The project started with 670 older people from clinics last year. 78 new service users have used the service in the 1st quarter therefore on track towards their target of 300. They also aim to recruit 6 older volunteers this year.
2	**Annexe Communities**	All positive activities are up and running with target numbers being reached for most of the classes, few spaces left in Circle dancing and Art class. And 80 beneficiaries over 65 years old are benefitting from one or more activities on a weekly basis. Hasam from Syria has timely turned up and is helping the knit and natter with their Hats for Syria project. He in return is getting English as a second language conversational support from one of the Connects2Project volunteers = Social capital Yes, on track to spend the grant as planned. Don't foresee any problems there and more likely to over spend than underspend but this can be covered by match Lottery funding.	Reaching 80 older people as planned. Although there was no target for older volunteers, the Annexe started with a baseline of 7 and have 10 at the end of Q1.
3	**Community Transport Glasgow**	We said we would make a minimum of 2000 patient journeys – we have made 938 journeys in our first quarter We said we would take a minimum of 150 new referrals – we have taken 86 in the first quarter We said we would support 15 older people to engage with other services. So far we have provided specific information on services to 25 people in the first quarter and supported 18 to engage with these services. We said at least 12 volunteers would be better connected to their community. In the first quarter we had a total of 12 volunteers driving for us. No underspend anticipated.	CTG started this year with a baseline of 196 older people and as can be seen from the progress summary, are well on track to exceed their targets for this year.

Ref	Lead Organisation	Summary of Progress	Key Outputs
4	**COPE Scotland**	A workbook for Carers with a focus on self-management in development; A workbook for Older adults on how to care for well-being in later life; in development; Offer individual support to 50 new people who are in a caring role for an older adult/s On target; Offer individual support to 50 new older adults to acquire skills for a healthier older age On target and set to exceed targets; Provide workshops attended by 50 new Carers plus any of those Carers being seen on an individual basis who wish to attend 43 people involved so far well on target; Provide workshops attended by 50 new Older adults plus any of those Older adults being seen on an individual basis who wish to attend 75 people exceeded targets already No underspend anticipated.	Starting from a baseline of 57, COPE aim to support a total of 200 older people and carers in the project this year. A combined total of 180 reached in the first quarter (47 carers) Provide volunteering opportunities and training for 5 people involved with the project, exceeded targets we have 6 older volunteers
5	**Cuthelton Social Club**	Yes, We started slowly, to accommodate the sourcing of therapists for our main venue. The two Sheltered complexes got going straight away. No underspend or slippage anticipated.	Activities on track as per summary and target of 60 older people already exceeded. Q1 reached 77 older people. Although there were no targets for carers, 8 of the older people are also carers and 4 also volunteer for the service.
6	**Diabetes UK Scotland**	The past three months have been taken up with a lot of desk research, networking and visits to organisations, as a result of which 3 new groups signed up for DEFT support. Delivery of diabetes information sessions has been completed for one group with the other two groups nearing completion. The groups consist of 30 individuals with the majority of participants being from a White European community in an area of multiple deprivation.	Aim to work with 100 older people over the year so are well on track at the end of the first quarter. 3 groups out of an annual target of 10 nearing completion.

Ref	Lead Organisation	Summary of Progress	Key Outputs
		No projected underspend.	
7	**The Dixon Community**	Yes, we have continued to deliver our activity programme and agreed new development opportunities through consultation with service users. This will be implemented from July 2015. No underspend or slippage is anticipated.	The baseline was 99 older people at the beginning of the funding and a target to reach 125 this year. 3 new users have joined and they anticipate reaching the target by the end of the funding period. There is no specific target for carers however 17 currently attend and likewise, they have 7 older volunteers.
8	**ENABLE Scotland**	The Cuppa Club restarted running fortnightly in June, so we have had 3 sessions. It is going very well with 2 new members and a lot of interest in the club. We are confident that the membership will continue to grow. The returning members are delighted that the club has restarted and have expressed how much they missed it. We have already had visitors to the club who provided a talk on the Carers Bill and facilitated a focus group about personalisation. Discussions like this are so important to the members as they feel like they are involved and can make a difference to carers lives, it also keeps them up to date with carers rights and helps them feel supported. All spending is in line with the budget.	40 older people engaged with the project last year and they are trying to gain new members this year. To date, 2 new members indicating progress here.
9	**Faith in Community Scotland**	We are on target for meeting our set objectives and targets. Expenditure is in line with budget	From a baseline of 277 older people, FICS local initiatives have reached 312 in Q1. As noted this is based on some who have left and some new service users. This is in line with their key targets this year. From a baseline of 55 older volunteers, FICS have reached 57 this quarter and are on target for 78 in the year. 5 carers also receive a service although no set target.
10	**Flourish House**	To date we appear to be on track with the key activities. Our steering group continues to meet on a weekly basis to plan and organise the activities that they group would like to be involved in. The weekly meeting also ensures a	Detailed stats to follow however they are starting from a baseline of 42 older people this year and aim to reach 50

Ref	Lead Organisation	Summary of Progress	Key Outputs
		level of commitment in working towards our specified outcomes. No underspend is anticipated.	
11	**Food Train**	I can confirm we are currently on track to meet all key objectives and targets. We currently support 306 of the most vulnerable older people living in Glasgow. This number is growing daily through a steady flow of referrals from partner agencies. In total we have provided volunteering opportunities to 150 volunteers and we currently have 58 active volunteers who work with us on a daily/weekly basis. In April we began a period of expansion and growth and now offer our services citywide across Glasgow. Food Train had already been established as a vital service for older people across the South and North East of the city therefore we have been focussing our development activities on the North West area developing referral partnerships with a wide range of agencies. I can confirm that we are on track to spend our full grant as planned.	From a baseline of 266, Food Train have added 40 new members this quarter and are on target to reach 400 this year. Whilst there is no specific target for older volunteers, they have 14 (I new this quarter).
12	**Glasgow Association for Mental Health**	The project is on track we have had 40 referrals as at the end of June. 17 people have been assessed. 14 older people and carers are in the process of being allocated therapies. 6 have been arranged with 4 people completing their therapies and 2 are ongoing. 8 are in the process of having their therapies arranged. The first mindfulness drop in started on the 18th of June and will finish on the 30th of July. The mindfulness course has been arranged to start on the 2nd of September for eight weeks. No underspend anticipated.	10 older people continued with the service from the previous year and 4 carers. Given the summary of progress for quarter 1, GAMH are on target to exceed their target of 45 new older people receiving a service this year.
13	**Glasgow Disability Alliance**	ODP CIRCLE project is well under way with all targets met or exceeded. In addition to the continued participation of existing beneficiaries, 59 new people have now engaged in activities through involvement with our two new STAR clubs, by joining one of the existing clubs, or through participation in our ongoing learning programme. Key targets achieved are as follows; • One newsletter distributed to over 2,800 people (1074 older people) • 18 courses/workshops/taster sessions delivered. • 1 discussion forum looking at wellbeing, barriers and solutions. • 29 older people supported to influence services through our Drivers for	Although GDA work with in excess of 500 disabled older people currently, it was agreed that for the purposes of this grant, the target should be 100. This is to try to show the added value of the Transformation funding and direct attribution as far as possible. They are well on track to achieve/exceed this target with 59 engaged in Q1.

Ref	Lead Organisation	Summary of Progress	Key Outputs
		Change Group • 2 new STAR clubs under development • Learning programme includes: Tai Chi for wellbeing; Happy Feet Day (talk about how to look after our feet plus 'foot MOT'); Pension Information Day; Line dancing/Ballroom; Fitness/Chair-based Yoga; Fly Fishing; Screen Printing; Creative writing; Singing; Confidence Booster Spend is on track.	
14	**Good Morning Service**	Report not submitted in time to be included in return : project on track – no concerns	Good Morning are starting with a baseline of 87 older people for whom the service is funded from the Transformation Fund. This year, they have the capacity to increase to 110.
15	**Lambhill Stables**	Our key objective is to promote and expand activities for older people. We are currently meeting with other like-minded projects with a view to offering our services and facilities to their service users, participants and carers. We have contacted Katherine Nicol from GCVS who is the Community Connector Practitioner (North West) and we hope to establish a working partnership with Queens Cross Housing Association. No underspend anticipated.	The project aim to reach up to 300 older people this year with an average weekly attendance of 100. The baseline is 88 (ave weekly 50). In the 1st quarter, there were 7 new users bringing the total to 95. 300 may be ambitious at this stage however they are working towards it as per the narrative.
16	**Marie Curie Cancer Care**	Report not submitted in time to be included in return : project on track – no concerns	Marie Curie have set a target to engage with 80 carers of palliative care patients this year.
17	**Muslim Elderly Day Care Centre**	Report not submitted in time to be included in return : project on track – no concerns	MEDCC have set a target to engage with 55 older people and 25 carers this year.

Ref	Lead Organisation	Summary of Progress	Key Outputs
18	**The Mount Befriending Service**	Report not submitted in time to be included in return : project on track – no concerns	The Mount have a static target to continue 28 befriending relationships this year.
19	**Nan McKay Community Hall**	We are on track to meet targets. Footcare exceeding targets. Therapies are about to begin at end of August in partnership with GAMH The footcare clinic has exceeded it's targets. Both in numbers and in the fact that our project has been used by several NHS staff and community groups as a teaching tool. Budget will be spent as planned.	66 older people have attended footcare clinic in Q1. Up to 100 NMH members can visit the fruit and veg stall over the course of a week. This is line with their target of 100 older people benefitting this year.
20	**Pollokshields Development Agency**	Report not submitted in time to be included in return : project on track – no concerns	PDA have a target to engage with 55 older people from a baseline of 35 this year.
21	**PRT, Greater Pollok Carers Centre**	We are on target to achieve the outcomes as agreed in the application. From April until June 2015 we have completed 80 new emergency plans for carers, detailing the arrangements that will be activated upon, should the main carer be unable to care due to an accident or period of incapacity. We have also provided on going support and a point of contact for the 760 carers who have already had a plan completed, including making some necessary changes to a few. We have: Helped carers to formulate an emergency plan Got a signed agreement from all parties who will assist in an emergency situation Ensured everyone is well aware of their role, and of the tasks required of them Sent a copy to Social work services to be recorded on their client information system Sent a copy to GP's Produced carer emergency cards Asked carers to complete a post evaluation	The target for this year is to complete 360 new emergency working with 360 older people and their carers. 80 plans have been completed in Q1 in spite of recruitment challenges, with 135 older people and 80 carers benefitting thus far. On track to reach targets over year.

Ref	Lead Organisation	Summary of Progress	Key Outputs
		Project spend is on track.	
22	**Scottish Opera**	The original activities we planned to deliver by June 2015 were • 8 weeks of weekly singing and movement workshops for 30 people affected by dementia in early summer • A public performance by people affected by dementia to friends and family in Scottish Opera's Production Studios We delivered these key activities and met our targets with the small exception of numbers: we had hoped to work with 30 people but ended up working only with 28.	The activities are on track and as noted in the summary, just one more older person and carer will bring them up to their target of 30 this year. There is a second series of workshops and a performance planned for the winter months.
23	**The Senior Centre Castlemilk**	Yes we are most definitely on track to meet both key activities and targets. Our membership continues to grow, increasing numbers requesting transport and participation in activities. Demand for transport has also increased therefore we have increased minibuses from 1 to 2 and both are now available to members Monday to Friday each week, enabling 40 + members with mobility difficulties to access our Centre daily. No underspend or slippage anticipated.	The Senior Centre already offer services to 522 older people. This year the grant is being used for a driver for the 2nd mini-bus and funding for activities is coming from another source. The target was to enable 30 older people with mobility issues to get transport and this has been exceeded. Additionally, there was a specific target to engage men and increase numbers by 20. 31 new men have joined in the 1st quarter.
24	**Southside Housing Association**	We are on track to meet our key activities and targets. Funding from the Transformation Fund forms part of a larger programme of work called Southside Connections. The first part of the year has focussed on further developing and building on this programme as a whole, with the Transformation Fund element of it planned for August – March 2016 as follows: • Survey developed and distributed to relevant Southside Housing Association tenants (August 2015).	SHA will work with 50 BME older people and 10 carers this year.

Ref	Lead Organisation	Summary of Progress	Key Outputs
		• Analyse survey results and develop action plan to overcome barriers identified (September 2015) • Provide practical support to encourage participation in Southside Connections (October – March 2016). We are on track to use the grant as planned.	
25	**South West Community Transport**	We are on track to meet our key targets for the coming year the Hoppa Shoppa continues to get our members out and about on their day trips and shopping twice a week. The afternoon teas are still a big part of the service and this will continue again starting in August through the rest of the year for our members. We are still working with groups utilising the Hoppa such as Linthouse Monday Club, Rainbow Care and Nan McKay Hall who have now set up a Pilot shopping Hoppa starting in August which will run for 10 weeks for their hall membership Spend on track with main service and the afternoon tea budget should catch up over the year.	108 older people as the baseline from last year. The target for new members this year is 40 and 22 have already taken up service in the 1st quarter.
26	**Springburn Alive and Kicking**	Report not submitted in time to be included in return : project on track – no concerns	The organisation have a static target to engage with 35 existing older members this year in three key activities.
27	**St George's & St Peter's Community Association**	Yes on track. We have found that having beautician and hairdresser being here is very influential in new starts joining. They are attending days they are in to begin with. Once they are here and enjoying it they are increasing their days. On track to spend budget as planned.	58 older people were benefiting from the services through the previous Transformation Fund. The target was static for this year but has actually been exceeded with 6 new members in the 1st Quarter. 3 existing older people have continued to volunteer

Ref	Lead Organisation	Summary of Progress	Key Outputs
			within the project.
28	**Sunny Govan Community Media Group**	We are on track with our targets and key activities. Currently working with older volunteers at SGCR towards a vintage day festival in late September 2015. This will include working with the Linthouse Senior Group following a visit by the group to the station. No underspend is anticipated.	Sunny Govan had a static target this year to work with 24 older people who had engaged with the Transformation funded activities last year. They have however exceeded this by engaging 2 new older people in Q1. Although there is no target for carers, 4 carers are also supported through the activities.
29	**Toryglen Community Hall**	• All our activities are on target we have seen an increase within the lunch club 17 people to **24** now attending. • 50 people will attend social activities; We also hold a social evening once a quarter and at the last one held in June 15 **80** people attended • 20 people will learn new skills through Art activities, this is on target and in addition **22** people took part in this project The Adult art group and our younger Art group have created a Mosaic that will be a lasting legacy for Toryglen Community Hall ,this was to commemorate the Commonwealth games and the halls 25th Anniversary, • 30 people will attend physical activities this has also increased the Line dancing now has **32** people attending (formerly sequence dancing) this therefore takes us above target. There is no underspend anticipated.	The target for this year was static to provide the activities to the 244 older people already accessing the hall. They have however increased the numbers by 24 in the 1st quarter to a total of 268.
30	**Visibility**	Annual targets and actual monthly achievements are as follows: • 150 people given advice, monthly target is 12/13 - actual monthly activity is 13. • 135 home assessments, monthly target is 11 - actual monthly activity is 13 • 90 onward referrals, monthly target is 7/8 - actual monthly activity is 9 • 45 carers supported, monthly target is 4 - actual monthly activity is 7	Visibility are targeting 150 older people and 45 carers this year. In Q1, 26 older people and 15 carers benefitted. As reported, they are a little behind where they would like to be in terms of numbers of older people supported however at this point in time, they still feel the target is achievable.

Ref	Lead Organisation	Summary of Progress	Key Outputs
		• 121 people given equipment, monthly target is 10 - actual monthly activity is 6/7 but actual number of pieces of equipment given out per month is 20. The late start means that we are currently carrying a one month underspend on salary. To date we have spent £987 on equipment and don't anticipate any underspend	
31	**West of Scotland Housing Association**	A combination of new and continued activities are well under way: Arts & crafts classes Lunch clubs Tea Dance Cultural Outings The 'BE' Programme - a training toolkit which encourages confidence and positivity of the participants. The Project Co-ordinator has received training and will begin delivering this soon. Activities still in the planning stages are health awareness sessions and singing group. These will be tasked to the Sessional Worker(s) to research and assist with implementation, once employed Our projected costs have been accurate to date. There are some activities and outings that are planned and booked but have not been paid for, as yet.	WOSHA are starting from a baseline of 484 older people who engaged with the Transformation funded activities last year. The target is an additional 200 this year and in this 1st quarter, 58 have taken up so well on track.
32	**West of Scotland Regional Equality Council**	It has been a great start to the project in April 2015. As the project previously had been delivered up until December 2014, there had been much interest on when classes and other training would commence again. It has been a smooth transition so far with the previous element of work carried out still fresh and much of the resources were developed using the guidelines and learning from the previous year. The Community Activities Officer has completed a lot of groundwork, tailoring the training that had been in place last year both from client feedback and also assessing needs of new service users. Marketing the project was not difficult as many had become aware of the service offered last year so recruitment for the training has been successful. Elements this year are:	The project has supported 24 new older people in Q1 from an annual target of 55 so well on track.

Ref	Lead Organisation	Summary of Progress	Key Outputs
		• Group Training Sessions Celebration Events • Drop in Service • Silver Surfers Clubs Budget spend is on track at the moment. We do not foresee any underspend in coming months or have reasons/request any changes at the moment.	

Item No 10

6th October 2015

Glasgow City Council / NHS Greater Glasgow and Clyde
Shadow Integration Joint Board

Report By:	Sharon Wearing, Chief Officer Finance & Resources
Contact:	Sharon Wearing
Tel:	0141 287 8838

FINANCE REPORT TO JULY 2015

Purpose of Report:	To provide a summary of the financial performance of the Glasgow City Health & Social Care Partnership for the period 1st April to 31st July 2015.

Recommendations:	The Shadow IJB is asked to; (i) note the contents of this report, (ii) note that the separate elements of this budget statement are being reported through the respective partner organisations, and that Social Work Services are working to an action plan to mitigate any overspend in the current financial year.

Implications for IJB	
Financial:	As detailed in the report
Personnel:	None
Legal:	None
Economic Impact:	None
Sustainability:	None
Sustainable Procurement and Article 19:	None
Equalities:	None
Implications for Glasgow City Council	Social Work spend remains currently the responsibility of Glasgow City Council.
Implications for NHS Greater Glasgow & Clyde	Health spend remains currently the responsibility of NHS Greater Glasgow & Clyde.

1. Introduction

1.1 This report provides a summary of the financial performance of Glasgow City Health and Social Care Partnership for the period 1 April 2015 to 31 July 2015.

1.2 For the purposes of this report, the NHS and Social Work elements are shown separately. Work is on-going to develop an integrated report, and this will be brought to the (Shadow) IJB in due course.

1.3 This statement is based on information contained within financial systems of the respective partner organisations and includes accruals and adjustments in line with agreed financial policies.

2. Summary Position

2.1 Within the NHS, gross expenditure is £33,000 (0.01%) less than budget and income is on budget, resulting in net expenditure of £33,000 (0.01%) less than budget.

2.2 Within Social Work, gross expenditure is £186,000 (0.12%) greater than budget and income is £611,000 (0.96%) less than budget, resulting in net expenditure of £797,000 (0.83%) more than budget.

2.3 A summary analysis of this position is shown at Appendix 1.

3. Reasons for Budget Variances

3.1 The main reasons for the budget variances are outlined below.

3.2 NHS Budget Variances

3.2.1 **Community Addictions** are underspent by £148,000. Funding has been provided at the top of scale within the Resource Allocation Model, resulting in non-recurring savings in-year.

3.2.2 **Adult Community Services** (excluding EquipU) are underspent by £287,000. This occurs largely within nursing services (District Nursing, Out of Hours Nursing and Other Nursing) as a result of staff turnover. As recruitment takes place, this rate of underspend is expected to reduce in the second half of the year.

3.2.3 **EquipU** charges are overspent by £161,000. This reflects the additional spend as a result of Integration Fund initiatives. The equivalent budget variance at month 4 last year was £65,000 and so, although it is early to be forecasting a full-year position with any degree of confidence, it is likely to be higher than last year (£242,000). Although costs are closely monitored and analysed, EquipU charges are expected to be a continued and increasing source of pressure for the Partnership given the need to move patients quickly from inpatient beds.

3.2.4 **Specialist Children's Services** are overspent by £307,000. This is a Board-wide service managed by the former CHP on behalf of the Board. The current overspend is a result of on-going service redesign, unachieved savings and the centralisation of overspent Medical budgets which had previously been held in individual CHP/CHCP service budgets. Provision to fund the recurrent medical pressure has been planned via the overall Partnership Children's Services Financial Plan 2016-2020. The non-recurring pressure is expected to diminish as retirements from demitted staffing grades are progressed. Achievement of savings aligned to Tier 4 services will be challenging.

3.2.5 **Children's Services – Community** are overspent by £102,000. Patient and Children's Teams ('PACT') services are overspent by £185,000. The savings taken from this service are beginning to be achieved as trained staff transfer to vacancies in mainstream Health Visiting services from June 2015. It is expected that this savings target will be achieved on a full year basis from 2016/17. This is offset by an underspend within School Nursing, resulting from staff turnover and vacancies.

3.2.6 **Hosted Services** are underspent by £146,000. Homelessness Services are underspent by £141,000. This service has traditionally underspent as a result of the high turnover of staff and frequent review of requirements. Recruitment is currently underway for the recently expanded Asylum Team and this is expected to reduce the level of underspend in the future.

3.2.7 **Mental Health Services** covering Adult and Elderly Community and Inpatient services, are underspent by £113,000. This is largely the result of BUPA partnership beds in South Glasgow, a position which is expected to continue. Pressures exist, however, in admission and assessment wards, particularly at Parkhead. This particular pressure is expected to continue until the site can be cleared.

3.2.8 **Other Services** are overspent by £163,000, partly as a result of double running costs for both old and new Possilpark locations. Sector management is actively looking at options for vacating the old building to remove the ongoing running costs of this building.

3.3 Social Work Services Budget Variances

3.3.1 There remains a pressure in employee costs of £1.1m within directly provided **Older People's Residential Care**, which includes overtime and agency costs incurred in order to maintain sufficient cover in staffing rotas within residential units.

3.3.2 **Homelessness** is currently underspent by £398,000. There is an underspend in employee costs (£638,000) as a result of the 17 week dispute in community casework teams and rent costs are underspent by (£350,000). This position is partially offset by an under recovery in housing benefit subsidy income (£349,000), and in temporary furnished flats rental income (£385,000). The under recovery in rental income and underspend in rent costs are directly related to the reduced number of flats available in comparison to the estimated budget requirements.

3.3.3 **Purchased Services** (excluding Homelessness, and OP and Children's Residential Care) are underspent by £766,000 in respect of the provision of care packages for service users. This position offsets pressures within new demand for services.

3.3.4 **Transport** continues to be an on-going pressure across the Service which, together with difficulties in achieving programmed savings, has led to an overspend of £242,000 at period 5.

3.3.5 **Children and Families** shows a net overspend of £667,000. This position reflects current placement levels, however there are plans in place to bring some of the additional placements back to the new directly provided establishments to mitigate the additional costs, where appropriate. The position does not reflect any potential growth in numbers.

The key areas are:

- **Residential Schools**
  Placement numbers have increased by 8 since period 4 and total 116 at P5. Subsequent movements and plans for further movements from high cost placements back to new directly provided Residential Units will negate this increase in placements, but still result in an increase in full year commitment of £0.3m. The full year projected overspend is £2.5m, which includes 11 placements within secure establishments, of which three are on remand. At period 5 the overspend is £966,000, taking account of the above assumptions.

- **Purchased**

  Purchased residential placements total 436, a decrease of 4 since period 4, with a net decrease in full year commitment of £372,000. The full year projected underspend is £1.1m, with period 5 showing an underspend of £458,000. Purchased fostering placements have decreased by 5 since period 4 and total 324. Young people in transition to adult services are reflecting an overspend of £422,000 at period 5.

  There are underspends in various areas including, provided foster care (£142,000), adoption allowances (£137,000), shared care and community respite (£166,000) and supplies and services (£117,000).

4. Action

4.1 In terms of the Social Work budget, the Chief Officer Designate GCHSCP continues to manage and review the budget across all areas of the Service in conjunction with the leadership team. A number of actions are in place to mitigate the budget pressures outlined in this report, including:

- Bring back high cost placements in Children's Residential Units outwith Glasgow to new provided Residential Units
- In-year savings within Addictions Services to cover any potential part year shortfall in the Service Reform Programme
- Further efficiencies within Adult Purchased Services to offset the impact of new demand
- Review of Purchased and Provided Day Care for Older People
- Consideration of all options to reduce spend within Homelessness
- Actions to reduce agency and overtime in Residential Units

4.2 In addition, we will look for further efficiencies within the overall IJB budget to assist recovery of the financial position.

5. Recommendations

5.1 The Shadow IJB is asked to;

(iii) note the contents of this report,

(iv) note that the separate elements of this budget statement are being reported through the respective partner organisations, and that Social Work Services are working to an action plan to mitigate any overspend in the current financial year.

Appendix 1 – Analysis of GCHSCP Integrated Budget, showing NHS and SWS care group details

	Annual Budget	YTD Budget	YTD Actual	YTD Variance	% Variance
	£000	**£000**	**£000**	**£000**	
NHS Services					
Gross Expenditure					
Addictions - Community	5,056	1,686	1,538	148	8.8%
Addictions - Hosted	26,653	9,857	9,899	(42)	0.4%
Adult Community Services	23,613	7,894	7,768	126	1.6%
Child Services - Community	13,196	4,395	4,496	(101)	2.3%
Child Services - Specialist	31,868	10,170	10,478	(308)	3.0%
Fhs - Gms	84,917	27,995	27,995	0	
Fhs - Other	88,569	30,886	30,886	0	
Fhs - Prescribing	122,135	40,074	40,074	0	
Hosted Services	19,665	5,968	5,823	145	2.4%
Integrated Care Fund	12,434	3,664	3,664	0	
Learn Dis - Community	2,196	738	681	57	7.7%
Learn Dis - Inpatient/Other	11,609	3,849	3,883	(34)	0.9%
Men Health - Adult Community	17,988	5,971	5,948	23	0.4%
Men Health - Adult Inpatient	64,509	21,528	21,612	(84)	0.4%
Men Health - Elderly Services	26,105	8,572	8,451	121	1.4%
Men Health - Other Services	38,564	12,522	12,468	54	0.4%
Other Services	26,830	7,962	8,124	(162)	2.0%
Planning & Health Improvement	8,111	2,663	2,627	36	1.3%
Resource Transfer - LA	65,496	21,831	21,831	0	
Sexual Health Services	11,289	3,759	3,705	54	1.4%
NHS Sub Total	**700,803**	**231,984**	**231,951**	**33**	**0.0%**
Social Work					
Expenditure					
Community Care	385,009	100,568	100,207	(361)	0.3%
Children & Families	130,903	46,492	47,171	679	1.5%
Criminal Justice	16,615	5,093	5,093	0	
Fieldwork	9,764	3,192	3,207	15	0.5%
Support Services	11,962	4,509	4,362	(147)	3.3%
Sub Total	**554,253**	**159,854**	**160,040**	**186**	**0.1%**
Income					
Community Care	135,063	56,325	55,699	(626)	1.1%
Children & Families	1,985	598	610	12	2.0%
Criminal Justice	18,584	6,045	6,045	0	
Fieldwork	1,863	729	731	2	0.3%
Support Services	268	191	192	1	0.5%
Sub Total	**157,763**	**63,888**	**63,277**	**(611)**	**0.9%**
Social Work Net Sub Total	**396,490**	**95,966**	**96,763**	**797**	**0.8%**
Grand Total	**1,097,293**	**327,950**	**328,714**	**764**	**0.2%**

Item No 11

6th October 2015

Glasgow City Council / NHS Greater Glasgow and Clyde
Shadow Integration Joint Board

Report By:	David Williams, Chief Officer Designate
Contact:	David Williams
Tel:	0141 287 8853

UNSCHEDULED CARE AND WINTER PLANNING

Purpose of Report:	To advise the Shadow Integration Joint Board on the unscheduled care and winter planning requirements for 2015/16, and current work in progress.

Recommendations:	That the Shadow Integration Joint Board note: • the Scottish Government's requirements for unscheduled care plans and winter • the work underway to contribute to the NHS Board's unscheduled care planning process; and, • that a further update report will be provided at the next (Shadow) Integration Joint Board meeting on the Glasgow City unscheduled care plan.

Implications for IJB	As outlined in the Integration Scheme the IJB will have strategic planning responsibility for specific acute hospital services most commonly associated with the unscheduled care pathway. 2015/16 is seen as an interim year with the IJB formally assuming these responsibilities in 2016/17. This report outlines the work to date to ensure the IJB is in a position to fulfil these responsibilities in 2016/17.
Financial:	The financial implications of the winter plan have yet to be assessed, including the resources required by the Partnership to support HSCP actions.
Personnel:	The winter plan once finalised might have personnel implications in that staff rotas and leave might be affected should additional capacity be needed. Appropriate consultation will be effected should this be the case.
Legal:	None
Economic Impact:	None
Sustainability:	None
Sustainable Procurement and Article 19:	None

Equalities:	In preparing the unscheduled care and winter plan the equalities implications will have to be assessed particularly to ensure adequate access is available to a range of services to support people over the festive period and the winter as a whole.
Implications for Glasgow City Council	Additional capacity within step up / step down beds might need to be purchased as part of the winter plan. This is yet to be confirmed.
Implications for NHS Greater Glasgow & Clyde	The winter planning guidance attached to this report sets out the implications for the NHS Board.

1. Purpose

1.1. The purpose of this report is to advise the Shadow Board of the Scottish Government's requirements for unscheduled care / winter planning in 2015/16, and the work underway within Glasgow City.

2. Background

2.1. The Cabinet Secretary wrote in July 2015 to Health Board chairs, copied to IJB chairs, on unscheduled care performance (annex A) highlighting the need for NHS Boards and IJBs to work together on plans for the forthcoming winter. Subsequently formal guidance was issued in August 2015 (annex B).

2.2. In previous years the focus of the Health Board's winter plans have been on ensuring there was adequate capacity within the acute hospital system to cope with the additional demands that arise over the winter period. From a Partnership perspective, work has focused on supporting the acute system by helping to avoid unnecessary admissions, managing reductions in delays, ensuring there is sufficient community staff available to respond to increased demand, and other measures.

2.3. While it is recognised that in future years IJBs will lead on the strategic planning for unscheduled care (as described within the Integration Scheme), and as part of this process, the preparation of winter plans, this year is seen as an interim year with NHS Boards leading the planning process working with Partnerships and acute services.

2.4. NHS Boards are required to publish final plans by the end of October 2015.

3. Progress to date

3.1. The Partnership has actively participated in the NHS Board's unscheduled care planning process, and is engaged with acute and NHS Board colleagues in preparing this year's winter plan. The Partnership is also separately setting up a planning group to specifically develop an unscheduled care plan for Glasgow City, progress on which will be reported to a future (Shadow) Integration Joint Board meeting.

3.2. The key areas that the Partnership will focus on as part of its emerging unscheduled care plan including preparation for the winter period, involve:

- maintaining previously reported improved performance on reducing delayed discharges;
- measures to reduce admissions to hospital, including GPs identifying patients at risk of admission through anticipatory care planning;
- assessing the need for additional intermediate care capacity to support any potential additional acute "surge" capacity that might be required;
- community rehabilitation teams providing rapid response for vulnerable older people at risk of hospital readmission over the winter period;
- ensuring community nursing and other services staffing levels are sufficient over periods of peak activity;
- planning with GPs over the festive bank holidays to prioritise emergency patients and manage and advice to patients with chronic conditions on sources of help; and,
- developing an agreed set of indicators to monitor performance, including an alert system.

3.3. The Partnership will continue to work with the NHS Board and acute services over the coming weeks to finalise the winter plan for 2015/16. A further update will be provided at the next Shadow Board meeting.

4. Recommendations

4.1. That the Shadow Integration Joint Board note:

- the Scottish Government's requirements for unscheduled care plans and winter
- the work underway to contribute to the NHS Board's unscheduled care planning process; and,
- that a further update report will be provided at the next (Shadow) Integration Joint Board meeting on the Glasgow City unscheduled care plan.

ANNEX A

Cabinet Secretary for Health, Wellbeing and Sport
Shona Robison MSP

T: 0300 244 4000
E: scottish.ministers@scotland.gsi.gov.uk

The Scottish Government
Riaghaltas na h-Alba

NHS Health Board Chairs

LEGACY 2014
XX COMMONWEALTH GAMES
SCOTLAND

14 July 2015

Dear Chairmen

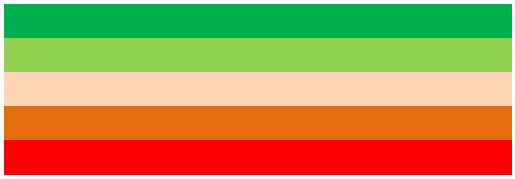
Unscheduled Care Performance over the last 4 weeks

Sustainability of unscheduled care performance is often compared in seasons with the summer months usually the least variable. With this in mind, I am writing to highlight the Health Board by Health Board Unscheduled Care Performance over the most recent 4 weeks. I am pleased that a number of Health Boards continue to deliver consistently at or above the 98% standard to the benefit of their populations, with increasing numbers performing above or around the 95% interim target. Well done and thanks to all staff who contributed to this improvement.

However, there are a few Health Boards/Sites whose performance remains too variable and still have patients waiting too long – see table below.

Core 4 Hour Performance, Most recent 4 weeks to 05-July 2015 (rounded)

	Most recent 4 weeks to 05-07-15	2014 Equivalent
NHS AYRSHIRE & ARRAN	93%	97%
NHS BORDERS	97%	96%
NHS DUMFRIES & GALLOWAY	97%	98%
NHS FIFE	96%	95%
NHS FORTH VALLEY**	91%	92%
NHS GRAMPIAN	94%	95%
NHS GREATER GLASGOW & CLYDE*	91%	91%
NHS HIGHLAND	96%	95%
NHS LANARKSHIRE	94%	91%
NHS LOTHIAN	95%	96%
NHS ORKNEY	99%	98%
NHS SHETLAND	96%	97%
NHS TAYSIDE	98%	99%
NHS WESTERN ISLES	99%	98%
NHS SCOTLAND	94%	94%



98% or above
Between 95% and 98%
Between 93% and 95%
Between 90% and 93%
90% or less

* Number of weeks less than 90%

It is also important to note that this is the current summer performance and it is imperative that Health Boards and IJBs put in the required “groundwork” now to ensure that performance is maintained and improved as we approach the autumn and through to winter.

Our draft winter guidance has just been circulated and I would ask that you ensure that the guidance, alongside your own Health Board/IJB review of last winter and your team’s initial plans for the coming winter are considered at each Health Board/IJB meeting. With this in mind, can you lead an early joint winter preparation meeting with your CE and IJB Chair(s) and CO(s).

As we approached the festive period in Dec 2014, there were significantly more delayed discharge patients in the system than at the same point in Dec 2013.

The table below highlights the HB specific position in Oct 13 compared to Oct 14. This highlights that there were 318 less beds available in the system in Oct last year compared to the previous year which more than negated the fact that HBs were reporting 148 more medical beds between quarter ending Sept 2014 and Dec 2014.

Total number of delayed discharges, any duration (inc. Code 9s)

	Oct-13	Oct-14	% Change
Scotland	**1,062**	**1,380**	**29.9%**
Ayrshire & Arran	58	78	34.5%
Borders	8	13	62.5%
Dumfries & Galloway	19	38	100.0%
Fife	86	106	23.3%
Forth Valley	62	64	3.2%
Grampian	153	237	54.9%
Greater Glasgow & Clyde	222	247	11.3%
Highland	68	117	72.1%
Lanarkshire	90	125	38.9%
Lothian	191	243	27.2%
Orkney	0	3	n/a
Shetland	2	10	400.0%
Tayside	84	72	-14.3%
Western Isles	19	27	42.1%

Source: ISD Scotland

Although the level of delayed discharge did not increase further over the winter period last year, as is the norm, it is essential that this year, your delayed discharge profile over the coming months, as a minimum, at least matches the Oct 13 position above. It is imperative that safe & effective admission/discharge continues in the lead-up to and over festive period continuing into January.

To facilitate, this health and social care workforce capacity plans & rotas for the winter/festive period need to be established now i.e. whole system activity plans for winter/post-festive surge activity levels. An essential linked requirement is to ensure elective pressures are minimised in advance of winter . The level of elective patient cancelations last

winter was more significant than in previous years. The anxiety and disruption this causes patients and the additional premium costs HBs have to incur to ensure any cancelled patients are rightly treated as soon as possible, means that your winter plans must ensure this does not occur again this winter.

We look forward to reviewing your draft winter plans in August, as previously communicated and seeing your board approved winter plans by October 2015.

SHONA ROBISON

CC: IJB Chairs

ANNEX B

The Scottish Government
Directorate for Health Performance

Dear Colleague

National Unscheduled Care Programme: Preparing for Winter 2015/16

Summary
This guidance supports Boards to ensure that they are fully prepared for this winter in order to minimise any potential disruption to NHS services, patients and carers. This guidance should be read in conjunction with the national report '*Health & Social Care: Winter in Scotland in 2014/15'.* Winter plans should provide safe and effective care for patients and have effective levels of capacity and funding to support service delivery and expected activity levels.

Background
Integrating health and social care and the £100m being invested to improve delayed discharge are priorities for the Scottish Government. The Scottish Government has also developed a fresh approach to improving unscheduled care across Scotland – in winter and all year round - which is based on six essential actions. This focus on integration, improving delayed discharge and the six essentials actions underpin the planning guidance for winter 2015/16 - with an additional focus on planning for the additional pressures and business continuity challenges that are faced in winter.

Action
NHS Boards are to lodge a draft winter plan and progress report on their local winter planning arrangements for this year by the end of August, and final plans by the end of October. These should be sent to winterplanningteam@scotland.gsi.gov.uk. Winter plans should also be signed of by the full board and published on the NHS Board's website by the end of October.

Yours sincerely

JOHN CONNAGHAN CBE
NHSScotland Chief Operating Officer

DL (2015) 20

6 August 2015

Addresses

For action

NHS Board:
1. Chief Executives
2. Unscheduled Care Leads
3. Business Continuity Mgrs
4. Emergency Plan Officers
5. Infection Control Managers
6. Medical Directors
7. Nursing Directors
8. Human Resource Directors
10. Consultants in Dental PH

Other
1. Directors of Social Work
2. IJB Chief Officers

For information
1. Public Health Directors
2. Non Executive Directors
3. NHS Board Chairs

Enquiries to:
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National Unscheduled Care Programme: Preparing for Winter 2015/16

1. Introduction

1.1 Winter planning continues to play an integral role in the Scottish Government's 6 Essential Actions Unscheduled Care Improvement Programme (Annex 1) and you should ensure that your NHS Board is fully prepared for this winter in order to minimise any potential disruption to NHS services, patients and carers. Boards must be satisfied that winter plans will provide safe and effective care for patients and that effective levels of capacity and funding are in place to support service delivery and expected activity levels.

1.2 This guidance should be read in conjunction with the national report '*Health & Social Care: Winter in Scotland in 2014/15'.* In winter 2014/15, the NHS in Scotland increased capacity and carried out more activity. There were increased and prolonged pressures from influenza and respiratory illness. Pressures from delayed discharge continued to increase through to the end of 2014 and eased in to 2015. These pressures will have contributed to the reduced key whole-system 4 hour A&E waiting times performance in December, January and February. Scotland saw significant A&E waiting times performance improvements in the spring and summer months. Integrating health and social care and the £100m being invested to improve delayed discharge are priorities for the Scottish Government. The Scottish Government has also developed a fresh approach to improving unscheduled care across Scotland – in winter and all year round - which is based on six essential actions. This focus on integration, improving delayed discharge and the six essential actions underpin the planning guidance for winter 2015/16 - with an additional focus on planning for the additional pressures and business continuity challenges that are faced in winter.

1.3 The continuing shift in patterns of disease to long term conditions, growing numbers of older people with multiple conditions and complex needs, and the financial environment present challenges to NHSScotland and its partners. That is why the Scottish Government is integrating health and social care. Joint working and resourcing will be crucial in putting outcomes for people at the centre of all our work, helping to avoid unnecessary admissions and ensuring that patients are discharged from acute settings as soon as they are ready.

1.4 Unscheduled and elective care performance in Scotland compares favourably with international comparators. Robust planning and analysis should facilitate NHS Boards to pursue further sustainable improvement through 95% performance towards the 98% 4 hour Emergency Access Standard. This should also help Boards to maintain the Treatment Time Guarantee (TTG) and to ensure delayed discharges are kept to an absolute minimum. New integration authorities are expected to increase the percentage of people who are discharged within 72 hours of being ready and reduce the bed days associated with delays.

1.5 Boards will need to take a balanced approach to the effective planning and scheduling of elective and unscheduled care, working closely with their Integration Joint Boards. This will be particularly important in light of predicted emergency activity over the festive period, when any surge in respiratory and circulatory admissions over the winter can increase pressures, particularly towards the end of December and into January. Support to understand the capacity and demand of each site is available through the unscheduled care 6 Essential Actions Improvement programme. Developing the Basic Buildings Blocks model (Essential Action 2) will provide a baseline of the whole system and enable robust planning. The focus of the whole system patient flow programme and Guided Patient Flow Assessment will also contribute to this overall picture.

1.6 NHS Boards should effectively forward plan to ensure that cancer patients who have a MDT, diagnostic or treatment target date occurring over the festive period are not delayed and that 31 day and 62 day cancer waiting times are not adversely impacted. In addition, NHS Boards should work through Regional Planning Groups to ensure that both local and regional cancer treatment dates are maintained through the winter period.

1.7 In preparing for this winter, NHS Boards are expected to consider the recommendations and actions from the '*National Primary Care Out of Hours Review'* being led by Sir Lewis Ritchie, which is due to report in the Autumn.

1.8 NHS Boards should monitor any changes in the cohorts of admitted patients and their care requirements (including respiratory, circulatory and ICU) over the festive period. Primary care and community services should be engaged in minimising transfers of care through use of anticipatory care planning. A directory of services and alternatives to admissions should be available, covering primary and community services and also third and independent sector social care provision. Any additional capacity in these areas should be highlighted.

1.9 Robust analysis should be undertaken to plan capacity and demand levels for this winter. Data now available from ISD, via the Health and Social Care Data Integration and Intelligence Project (HSCDIIP), can help with such analysis. Recent years activity levels and improvements in flow should be taken into account as part of this process. Trends over three to five years should be considered. We also expect NHS Boards' winter planning to address variation in demand.

1.10 This planning must be explicit on the additional capacity planned for winter, including capacity in staffed medical beds and intermediate care beds. Deliverable plans for workforce capacity over the winter period must be agreed by October and detailed in the winter plan – these are important milestones. Nursing rotas that are made up for the festive period should not include the use of agency staff and should conform to workload planning tool guidance. It is important that this capacity is in place before the risk of boarding medical patients in surgical wards increases and the appropriate indicators of potential surge are monitored on a daily basis. Analysis should include triggers for whole system escalation process to prevent access block.

1.11 Sustainably achieving safe and effective patient flow is critical to maintaining performance as a standard operating model across the winter period. Utilising the improved communication and leadership of the Capacity and Patient Flow Programme, Safety Huddles should focus on proactive discharge planning including, pre noon discharges, weekend discharges, utilisation of discharge lounge and criteria led discharge. Review of support services such as portering, cleaning, pharmacy and transport should be undertaken to ensure capacity is aligned to demand, not just within hours, but also across 7 days and out of hours periods.

1.12 The Chief Medical Officer would encourage NHS Boards to make sure all staff are vaccinated against seasonal flu, particularly front-line staff and those working in areas where patients might be at greater risk (paediatric, oncology, maternity, care of elderly, haematology, ICUs). Boards should aim for vaccinating 50% of front line staff and efforts should be made to make the vaccine available at times and places that are convenient for staff. Senior clinicians and NHS Managers should ensure staff understand the benefits of the vaccine to healthcare workers and to patients.

2. Critical Areas, Outcomes and Indicators

2.1 This guidance takes last winter's performance into account. It highlights the critical areas that should be covered in this year's local winter plans, as detailed below. It is expected that the local indicators, underpinning each critical area, are included in relevant local management processes to achieve the outcomes described. Indicators should also align with the unscheduled care 6 Essential Action Improvement Programme (summarised at annex 1). Winter plans should set out the geographies and frequency of the local indicators being monitored and provide further detail on how these indicators might be developed, where applicable.

<u>i) Safe & effective admission / discharge continues in the lead-up to and over the festive period and also in to January.</u>

Outcome: Emergency and elective patients are safely and effectively admitted and discharged over the Christmas - New Year holiday period. Over this period the numbers of patients receiving elective treatment reduces. NHS Boards should minimise the risk of boarding medical patients in surgical wards. This will help ensure that patients do not have unnecessary stays in hospital; and hospitals are in a good position to deal with the surge in patients normally admitted in the first week back in January.

Local indicator(s) : the daily and cumulative balance of admissions / discharges over the festive period; levels of boarding medical patients in surgical wards; delayed discharge; community hospital bed occupancy; number of Social Work assessments including variances from planned levels.

<u>ii) Workforce capacity plans & rotas for winter / festive period agreed by October.</u>

Outcome: NHS 24; GP OOH; Dental; SAS emergency / PTS; and Hospital (medical / nursing / diagnostics / pharmacy / phlebotomy / AHP/ IPCT / portering / cleaning / etc.) rotas as well as levels of community capacity (including community nursing / AHP / intermediate care / Social Work assessment / home care / care home) for the winter / festive period are agreed in October to underpin safe and effective admission and discharge of emergency and elective patients.

Local indicator(s): Workforce capacity plans & rotas for winter / festive period agreed by October; effective local escalation of any deviation from plan and actions to address these; extra capacity scheduled for the 'return to work' days after the four day festive break, factored into annual leave management arrangements.

<u>iii) Whole system activity plans for winter: post-festive surge / respiratory pathway.</u>

Outcome: The clinically focussed and empowered hospital management have a target operating model that sets out the expected range of daily emergency and elective admissions and discharges over the festive and winter period. The expected range takes account of the potential surge in emergency admissions in the first week of January and includes the potential surge in respiratory and circulatory admissions over the winter. The hospital models will include flows between front doors, receiving units, and downstream wards.

Local indicator(s): daily number of cancelled elective procedures; daily number of elective and emergency admissions and discharges; number of respiratory admissions and variation from plan.

iv) Strategies for additional winter beds and surge capacity.

Outcome: The risk of an increase in the levels of boarding medical patients in surgical wards in the first week of January is minimised. The staffing plans for additional staffed medical beds and additional intermediate bed capacity for winter is agreed in October. The planned dates for introduction of additional staffed medical beds and intermediate beds in the community are agreed and the capacity is operational before the expected surge in admissions. It is essential that Boards who plan additional beds should make appropriate arrangements to create a safe and person centred environment.

Local indicator(s): planned number of additional staffed medical beds for winter by site and the planned date of introduction of these beds; planned number of additional intermediate beds in the community and the planned date of introduction of these beds; levels of boarding.

v) The risk of patients being delayed on their pathway is minimised.

Outcome: Patients receive timely assessments in A&E, Acute Assessment Units, Acute Receiving Units and downstream specialty wards. Delays between decision to transfer/discharge and actual transfer/discharge are minimised. The capacity in these units reflect the arrival patterns and potential waiting times for assessment and/or transfer/discharge. Patients in downstream wards are discharged earlier in the day to avoid unnecessary stays in hospital and to improve flow through the hospital. There is early engagement with SAS for ambulance discharge and transfer.

Local indicator(s) : distributions of attendances / admissions; distribution of time to assessment; distribution of time between decision to transfer/discharge and actual time; % of discharges before noon; % of discharges through discharge lounge; % of discharges that are criteria led; levels of boarding medical patients in surgical wards.

vi) Discharges at weekend & bank holiday.

Outcome: Patients are discharged at weekend and bank holidays to avoid unnecessary stays in hospital and to improve flow through the hospital.

Local indicator(s): % of discharges that are criteria led on weekend and bank holidays; daily number of elective and emergency admissions and discharges.

vii) Escalation plans tested with partners.

Outcome: Access block is avoided at each ED where there is a target operating model managed effectively by an empowered site management team with clear parameters on whole system escalation processes.

Local indicator(s): attendance profile by day of week and time of day managed against available capacity; locally identified indicators of pressure i.e.% occupancy of ED, utilisation of trolley/cubicle; % patients waiting for admission over 2, 4 hours – all indicators should be locally agreed and monitored

viii) Business continuity plans tested with partners.

Outcome: The board has business continuity management arrangements in place to manage and mitigate all key disruptive risks including the impact of severe weather.

Local indicator(s): progress against any actions from the testing of business continuity plans.

ix) Preparing effectively for norovirus.

Outcome: The risk of norovirus outbreaks becoming widespread throughout a hospital is minimised. The HPS Norovirus Outbreak Guidance for 2015/16 is effectively implemented.

Local indicator(s): number of wards closed to norovirus; application of HPS norovirus guidance.

x) Delivering seasonal flu vaccination to public and staff.

Outcome: CMO uptake targets for seasonal flu vaccination for those aged 65 and above, at risk groups, and front line staff are delivered as early as possible in the season before flu viruses are circulating.

Local indicator(s) : % uptake for those aged 65+ and 'at risk' groups; % uptake of staff vaccine by site / speciality and variance from planned levels in line with CMO advice.

xi) Communication plans

Outcome: The public and patients are kept informed of winter pressures, their impact on services, and the actions being taken.

Local indicator(s) : daily record of communications activity; early and wide promotion of winter plan

xii) Effective analysis to plan for and monitor winter capacity, activity, pressures and performance

Outcome: NHS Boards have, and use, a range of analysis to effectively plan for and monitor winter capacity, activity, pressures and performance at board and site levels.

Local indicator(s) : Agreed and resourced analytical plans for winter analysis.

3. Self-Assessment Checklists and Winter Plan Review

3.1 The self-assessment checklists (Appendix A) have been reviewed and provide further detail to support the development of local winter plans. These checklists should be used by governance groups to assess the quality of your Board's winter preparations and to ascertain where further action might be required. There is no requirement for these checklists to be submitted to the Scottish Government, however, local Executive Leads for unscheduled care should regularly review progress.

3.2 NHS Boards are to submit a progress report on their local winter planning arrangements for this year to winterplanningteam@scotland.gsi.gov.uk, by the end of August at the latest. This should cover the actions being taken around the critical areas highlighted

to achieve the outcomes described above. At the same time NHS Boards should also lodge their draft local plan with Scottish Government, who will continue to engage with NHS Boards throughout the autumn and winter period. This is a shadow year for IJBs, which provides opportunities for building on the whole system planning approach of recent years. IJBs and Chief Officers should be fully involved in the winter planning process, including development of business continuity responses, and ensuring that effective joint communication processes are in place. Data sets and information around capacity planning should be aligned to support a common understanding of capacity requirements across an integrated system. The Scottish Government will share local plans with partners to help support this planning process.

3.3 A National Unscheduled Care Event will be held on 17th September, venue (tbc) and will include sessions on a range of initiatives designed to support NHS Boards to effectively prepare for winter.

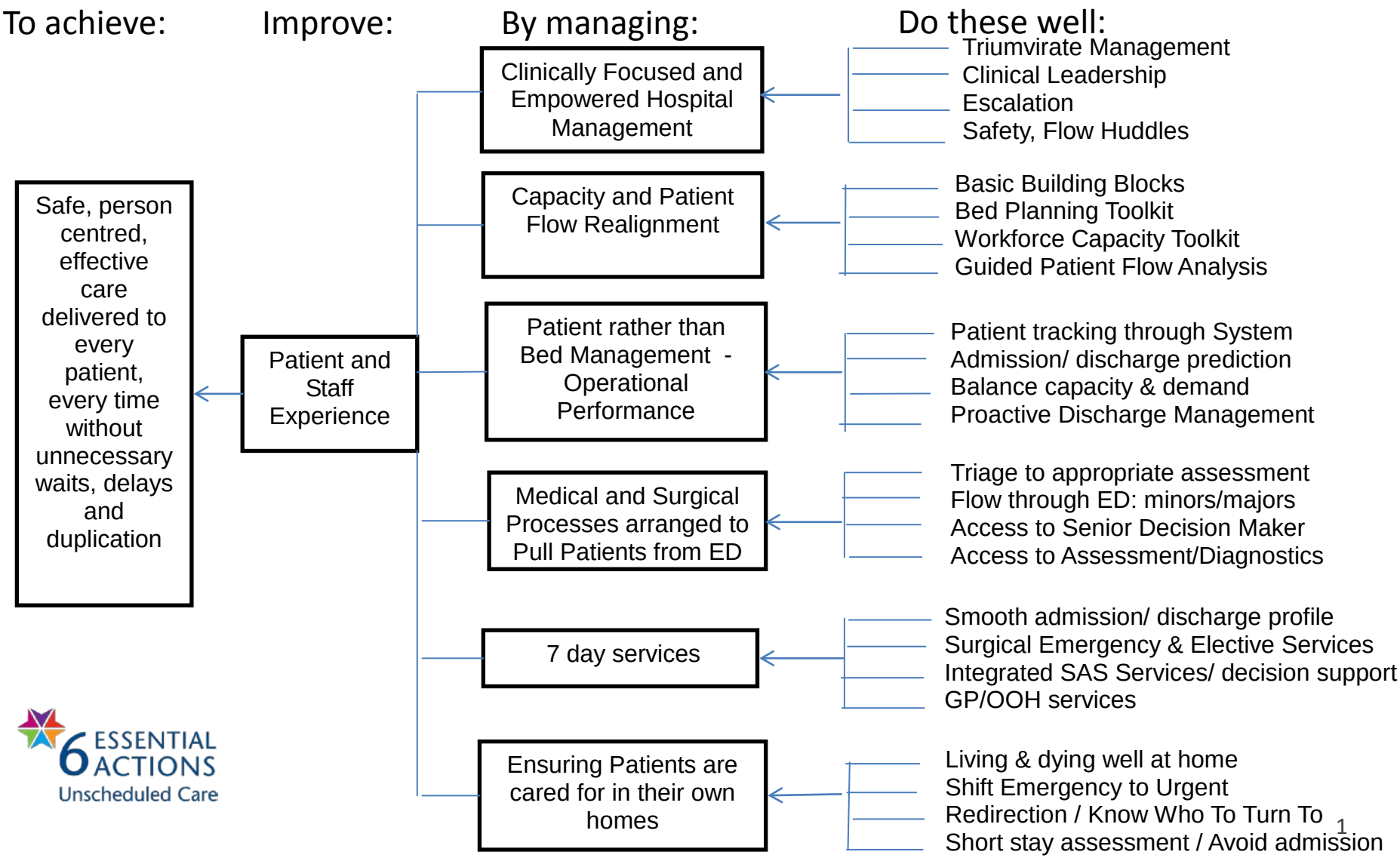
4. Winter Plan Sign-Off

4.1 Chief Executives must ensure that winter plans have been scrutinised by the full board, formally signed-off and published on their Board's website by the end of October 2015. At this point the plan should also be lodged with the Scottish Government. Planned actions should ensure safe and effective care for patients and support sustained performance, at the required standard, over the winter period.

4.2 I recognise the tremendous commitment made by the workforce in meeting the challenges of winter and I would be grateful if you could pass on my appreciation of their dedication and valued contribution.

Annex 1

6 Essential Actions to Improving Unscheduled Care Performance



Appendix A:

National Unscheduled Care Programme: Preparing for Winter 2015/16

Winter Preparedness: NHS Board Self-Assessment

Priorities

1. **Resilience**
2. **Unscheduled / Elective Care**
3. **Out of Hours**
4. **Norovirus**
5. **Seasonal Flu**
6. **Respiratory Pathway**
7. **Management Information**
8. **Sign-Off**
9. **Integration of Key Partners / Services**

These checklists should be read in conjunction with the:

- National Unscheduled Care Programme: Preparing for Winter 2015/16 Guidance.
- Health & Social Care: Winter in Scotland 2014/15 Report.

- NHS Territorial Boards, Integrated Joint Boards (IJBs) and other partners should consider all of these actions, in detail, as part of their winter planning preparations.
- NHS Special Boards, should review all of these actions to identify those most applicable to their own area of operations.
- Special Boards should also consider how they can best support Territorial Boards across the full complement of actions and initiate supportive partnership working where required.

ANNEX B

Winter Preparedness: Self-Assessment Guidance

- Local governance groups should use the attached checklists to self-assess the quality of their Boards overall winter preparations and to ascertain where further action is required to ensure that winter preparedness priorities are met.

- There is no requirement for these checklists to be submitted to the Scottish Government.

- Boards will be expected to lodge their draft winter plans and a progress report on local winter planning arrangements with the Scottish Government by the end of August 2015 and their final winter plans by the end of October 2015. Plans and reports should be sent to winterplanningteam@scotland.gsi.gov.uk.

- Winter Plans should consider the critical areas highlighted in the National Unscheduled Care Programme: Preparing for Winter 2015/16 Guidance and demonstrate effective integration of key partners and services.

- The following RAG status definition table is offered as a guide to help you evaluate the status of your Board's overall winter preparedness against each action.

RAG Status	Definition	Action Required
Green	Systems / Processes fully in place & tested where appropriate.	Routine Monitoring
Amber	Systems / Processes are in development and will be fully in place by the end of October.	Active Monitoring & Review
Red	Systems/Processes are not in place and there is no development plan.	Urgent Action Required

1	**Board Overview: Resilience Preparedness** *(Assessment of the Boards overall winter preparations and further actions required)*		**RAG**	**Further Action/Comments**
1	The Board has robust business continuity management arrangements in place to manage and mitigate all key disruptive risks including the impact of severe weather. These arrangements have built on the lessons learned from previous periods of severe weather, and are regularly tested to ensure they remain relevant and fit for purpose. Resilience officers are fully involved in all aspects of winter planning to ensure that business continuity management principles are embedded in winter plans. *The Preparing For Emergencies: Guidance For Health Boards in Scotland (2013) sets out the expectations in relation to BCM and the training and exercising of incident plans – see Sections 4 and 5, and Appendix 2 of Preparing for Emergencies for details.*	☐ ☐		
2	The Board's business continuity (BC) plans take into account the organisations critical activities, analysis of the effects of disruption and the actual risks of disruption and develop plans based on risk-assessed worst case scenarios. Risk assessments take into account staff absences and a business impact analysis so that essential staffing requirements are available to maintain key services. The critical activities and how they are being addressed are included on the corporate risk register and are regularly monitored by the risk owner. The Board has negotiated arrangements in place for mutual aid with local partners, which cover all potential requirements in respect of various risk scenarios.	☐ ☐ ☐		
3	The Board has HR policies in place that cover: • what staff should do in the event of severe weather hindering access to work, and • how the appropriate travel advice will be communicated to staff and patients *Resilience officers and HR departments will need to develop a staff travel advice and communications protocol to ensure that travel advice and messages to the public are consistent with those issued by Local /Regional Resilience Partnerships to avoid confusion. This should be communicated to all staff.*	☐		
4	The Board's website will be used to advise on travel to hospital appointments during severe weather and prospective cancellation of clinics.	☐		
5	The Board works with local authorities to create a capacity plan to manage any potential increase in demand for mortuary services over the winter period; this process involves funeral directors.	☐		

6	The Board will test the effectiveness of its winter plan by 30 Oct with stakeholders. The final version of the Board's plan has been jointly approved with the H&SC Partnership's Integrated Joint Board.	☐		

2	Board Overview: Unscheduled / Elective Care Preparedness *(Assessment of the Boards overall winter preparations and further actions required)*		RAG	Further Action/Comments
1	**Clinically Focussed and Empowered Hospital Management**			
1.1	Clear site management process is in place with operational overview of all emergency and elective activity. *Ideally this should be a triumvirate approach of operational, medical and nursing Directors/leads with autonomy to make decisions to manage the site*	☐		
1.2	Effective communication protocols are in place between clinical departments and senior managers to ensure that potential system pressures are identified as they emerge and as soon as they occur escalation procedures are invoked.	☐		
1.3	Effective communication protocols are in place between key partners, particularly across local authority housing, equipment and adaptation services, Mental Health Services, and the independent sector. *Shared information should include key contacts and levels of service cover over weekends and festive holiday periods, bed states and any decisions which have been taken outside of agreed arrangements.*	☐		
1.4	A Target Operating Model should be communicated to all staff. Escalation policies are well defined, clearly understood, and well tested. *Clear thresholds and authorities for triggering, and standing down, escalation plans should be established and clearly communicated.*	☐		
1.5	Escalation policies are in place and consider the likely impact of emergency admissions on elective work and vice versa, including respiratory, circulatory, orthopaedics, cancer patients, ICU/PICU. *This should be based on detailed modelling, pre-emptive scheduling of electives throughout the autumn, and early spring, and clear strategies regarding which lists may be subject to short-notice cancellation with a minimum impact.*	☐		
1.6	Escalation policies are focused around in-patient capacity across the whole system. *Pressures are often due to an inability to discharge patients timeously. Systems should be in place for the early identification of patients who no longer require acute care and discharged without further delay*	☐		

1.7	Escalation procedures are linked to a sustainable resourcing plan, which encompasses the full use of step-down community facilities, such as community hospitals and care homes. *All escalation plans should have clearly identified points of contact and should be comprehensively tested and adjusted to ensure their effectiveness.*	☐		
2	**Undertake detailed analysis and planning to effectively schedule elective activity (both short and medium-term) based on forecast emergency and elective demand, to optimise whole systems business continuity. This has specifically taken into account the surge in activity in the first week of January.**			
2.1	Demand, capacity, and activity plans across emergency and elective provision are fully integrated. *Weekly projections for scheduled and unscheduled demand and the capacity required to meet this demand should be in place.* *Plans for scheduled services should include a specific 'buffering range' for scheduled queue size, such that the scheduled queue size for any speciality/sub-speciality can fluctuate to take account of any increases in unscheduled demand without resulting in scheduled waiting times being exceeded. This requires scheduled queue size for specific specialities to be comparatively low at the beginning of the winter period.* *Boards should be able to evidence that for critical specialities scheduled queue size and shape are such that a winter surge in unscheduled demand can be managed without materially disadvantaging scheduled waiting times, whilst at all times ensuring patient safety and clinical effectiveness.*	☐		
2.2	NHS Boards should implement the range of analysis and management tools that are being promoted to enable effective and related planning and management of scheduled and unscheduled services *e.g. Statistical Process Control, Queuing Theory, Discreet Event Simulation, Variation Methodology, etc.*	☐		
2.2	Pre-planning has optimised the use of capacity for the delivery of emergency and elective treatment, including identification of winter surge beds for emergency admissions. *This will be best achieved through the use of structured analysis and tools to understand and manage all aspects of variation that impact on services, by developing metrics and escalation plans around flexing or cancelling electives, and by covering longer term contingencies around frontloading activity for autumn and spring.*	☐		

2.3	Pre-planning and modelling has been undertaken around elective activity to plan responses, escalation and recovery to minimise the impact of winter peaks in demand on the delivery of routine elective work. *A set of clear actions should be developed based on a firm understanding of demand and capacity, prediction and management of variation.* *In the event of severe weather impacting significantly on elective activity, NHS Boards, should contact SGHSCD Access Support Team to advise of any service disruption*	☐		
2.4	Planning and analysis will facilitate the Board to consistently deliver the 4 Hour Emergency Access target (95%) and work towards the (98% Standard), eliminate 12 hour breaches whilst avoiding 8 hour breaches, and maintain the delivery of all elective care. *Boards are expected to maintain performance against all LDP standards, while recognising that clinical decision making in the interests of all patients is paramount. This includes TTG (legal requirement), 18 weeks, Diagnostics, Outpatients and Cancer.* *Monitoring of these measure is required to support escalation policies and achieve sustainable flow through the system.*	☐		
2.5	NHS Boards should review and take stock of their performance against the British Association of Day Surgery (BADS) Directory version 4 to ensure that they have achieved optimum performance against the surgical procedures identified as being suitable for day case surgery" *Achieving optimal performance against BADS version 4 will support NHS Boards to manage bed occupancy, admission and discharge of elective patients.*	☐		
3	**Agree staff rotas in October for the fortnight in which the two festive holiday periods occur to match planned activities such as MDTs, and projected peaks in demand. These rotas should include services that support the management of inpatient pathways, (e.g.) diagnostics, pharmacy, phlebotomy, AHPs, IPCT, portering, cleaning etc.**			
3.1	Consultant (Medical and Surgical) cover along with multi-professional support teams, including IPCT cover, will be planned to effectively manage predicted activity and discharge over the festive holiday periods, by no later than the end of October. *This should take into account predicted peaks in demand, including impact of significant events (e.g.). Hogmanay Street parties on services, and match the available staff resource accordingly. Any plans to reduce the number of hospitals accepting emergency admissions for particular specialties over the festive period, due to low demand and elective activity, need to be clearly communicated to partner organisations*.	☐		
3.2	Extra capacity should be scheduled for the 'return to work' days after the four day festive break and this should be factored into annual leave management arrangements.	☐		

3.3	Additional festive services are planned in collaboration with partner organisations e.g. Police Scotland, SAS, Voluntary Sector etc. *Boards are aware of externally provided festive services such as minor injuries bus in city centre, paramedic outreach services and mitigate for any change in service provision from partner organisations*	☐		
3.4	Out of Hours services, GP, Dental and Pharmacy provision over festive period should be communicated to clinician/manager on call to ensure alternatives to attendance are considered.	☐		
4	**Optimise patient flow by proactively managing Discharge Process utilising Estimated Date of Discharge as soon as patients are admitted or scheduled for admission with supporting processes (e.g.) multi-disciplinary ward rounds. This will support the proactive management of discharge, ensuring there are no delays in patient pathways.**			
4.1	Discharge planning will commence at the point of admission or at pre-admission assessment using, where available, protocols and pathways for common conditions to avoid delays during the discharge process. *Patients, their families and carers should be involved in discharge planning as early as possible to allow them to prepare and put in place the necessary arrangements to support discharge.*	☐		
4.2	There will be on-going engagement with the SAS to effectively plan patient transport when it is known, or anticipated, that patients will require transport home or to another care setting. *Where transport service limited or higher demand Boards should consider alternative arrangements as part of the escalation process*	☐		
4.3	Multi-disciplinary Ward Rounds will be embedded to proactively manage the patient journey and prepare for discharge detailing the estimated date of discharge. *This should be displayed visually for the care team to see and should be the focus of all daily ward rounds and bed meetings and inform daily safety flow huddles*	☐		
4.4	Regular daily ward rounds and bed meetings will be conducted to ensure a proactive approach to discharge. Discharges should be made early in the day, including over weekends, and should involve key members of the multidisciplinary team, including social work. *Test scheduling and the availability of results, discharge medication, transport requirements and availability of medical and nursing staff to undertake discharge should all be considered during this process to optimise discharge pre-noon on the estimated date of discharge.*	☐		

4.5	Predictive data will be used to assess the hourly demand for beds allowing for discharges to be scheduled to optimise flow. *Boards should consider evaluating the accuracy of EDD to help improve the discharge process.*	☐		
4.6	Discharge lounges should be fully utilised to facilitate pre-noon capacity. *Processes should be in place to support morning discharge at all times. This should be monitored for uptake and discharge compliance*	☐		
5	**Ensure that senior clinical decision making capacity is available for assessment, care planning, MDTs and discharge and that AHP rotas are structured, to facilitate the discharging of patients throughout weekends and the fortnight in which the two festive holiday periods occur in order to maximise capacity.**			
5.1	There is adequate medical, nursing and AHP cover across both, the festive holiday period, and over weekends to conduct assessments, plan effective care programmes and perform dedicated discharge rounds. *Criteria-led discharges, should be put in place wherever possible to improve discharge process across 7 day.*	☐		
5.2	Key partners such as: pharmacy, transport and social care services will have determined capacity and demand for services and be able to provide adequate capacity to support the discharge process. These services should be aware of any initiatives that impact on increased provision being required and communication processes are in place to support this. *There should be a monitoring and communication process in place to avoid delays, remove bottlenecks and smooth patient discharge processes*	☐		
6	**Agree anticipated levels of homecare packages that are likely to be required over the winter (especially festive) period and utilise intermediate care options such as Rapid Response Teams, enhanced supported discharge or reablement and rehabilitation (at home and in care homes) to facilitate discharge.**			
6.1	There is close partnership working with local authorities and the third and independent sector to ensure that adequate care packages are in place in the community to meet predicted discharge levels. *This will be particularly important over the festive holiday periods.*	☐		

6.2	Ongoing and detailed engagement between local partners around the capacity of social care services to accommodate predicted discharge levels will start no later than October.	☐		
6.3	The Board and their respective local authorities have put in place a joint escalation plan resolve issues that might arise. *Consideration should be given to developing local agreements on the direct purchase of homecare by ward staff.*	☐		
6.4	Intermediate care options, such as enhanced supported discharge, reablement and rehabilitation will be utilised, where possible. *Rapid Response teams should have the ability to directly purchase appropriate homecare packages, following the period of Intermediate care.*	☐		
6.5	Host NHS Boards and local authorities are taking the discharge requirements of patients who are receiving treatment at the Golden Jubilee National Hospital into account.	☐		
6.6	Patients identified as being at high risk of admission from, both the SPARRA register and local intelligence, and who have a care manager allocated to them, will be identifiable on contact with OOH and acute services to help prevent admissions and facilitate appropriate early discharge.	☐		
6.7	All plans for Anticipatory Care Planning will be implemented, in advance of the winter period, to ensure continuity of care and avoid unnecessary emergency admissions / attendances. *If attendances or admissions occur Anticipatory Care Plans and key information summaries should be used as part of discharge hospital to inform home circumstances and fit for discharge*	☐		
7	**Ensure that communications between key partners, staff, patients and the public are effective and that key messages are consistent.**			
7.1	Effective communication protocols are in place between clinical departments and senior managers to ensure that potential system pressures are identified as soon as they occur, and that escalation procedures are invoked at the earliest opportunity.	☐		
7.2	Demand, capacity, and activity plans across emergency and elective provision are fully integrated. *Collaboration between partners, including NHS 24, Locality Partnerships, Scottish Ambulance Service, SNBTS through to A&E departments, OOH services, hospital wards and critical care, is vital in ensuring that winter plans are developed as part of a whole systems approach.*	☐		

7.3	Effective communication protocols are in place between key partners, particularly across local authority housing, equipment and adaptation services, Mental Health Services, and the independent sector. *Shared information should include key contacts and levels of service cover over weekends and festive holiday periods, bed states and any decisions which have been taken outside of agreed arrangements.*	☐		
7.4	Communications with the public, patients and staff will make use of all available mediums, including social media, and that key messages will be accurate and consistent. *NHS 24 are leading on the 2015/16 'Be Healthwise This Winter' media campaign, and SG Health Performance Directorate is working with partners and policy colleagues to ensure that key winter messages, around repeat prescriptions', respiratory hygiene, and norovirus are effectively communicated to the public.* *In late October the SG will launch its Resilience Campaign, in partnership with the British Red Cross, and other organisations to highlight the risks and consequences of all kinds of severe weather and the simple practical ways people can reduce these risks. Messages will continue to be targeted at more vulnerable and harder to reach people in our communities.* *The public facing website http://www.readyscotland.org/ will continue to provide a one stop shop for information and advice on how to prepare for and mitigate against the consequences from a range of risks and emergencies. This information can also be accessed via a smartphone app accessible through Google play or iTunes.* *The Met Office National Severe Weather Warning System provides information on the localised impact of severe weather events.*	☐		

3	**Board Overview: Out of Hours Preparedness** *(Assessment of the Boards overall winter preparations and further actions required)*		**RAG**	**Further Action/Comments**
1	The OOH plan covers the full winter period and pays particular attention to the festive period. *This should include an agreed escalation process.* *Have you considered/discussed local processes with NHS 24 on providing pre-prioritised calls during the OOH period?*	☐		
2	The plan clearly demonstrates how the Board will manage both predicted and unpredicted demand from NHS 24 and includes measures to ensure that pressures during weekends, public holidays are operating effectively. The plan demonstrates that resource planning and demand management are prioritised over the festive period.	☐		
3	There is evidence of attempts at enabling and effecting innovation around how the Board will predict and manage pressures on public holidays/Saturday mornings and over the festive period. The plan sets out options, mitigations and solutions considered and employed.	☐		
4	There is reference to direct referrals between services. *For example, are direct contact arrangements in place, for example between Primary Care Emergency Centres (PCECs)/Accident & Emergency (A&E) Departments/Minor Injuries Units (MIUs) and other relevant services? Are efforts being made to encourage greater use of special notes, where appropriate?*	☐		
5	The plan encourages good record management practices relevant to maintaining good management information including presentations, dispositions and referrals; as well as good patient records.	☐		
6	There is reference to provision of pharmacy services, including details of the professional line,	☐		

	where pharmacists can contact the out of hours centres directly with patient/prescription queries and vice versa			
7	Clear arrangements are in place to enable access to mental health crisis teams/services, particularly during the festive period.	☐		
8	There is reference to provision of dental services, to ensure that services are in place either via general dental practices or out of hours centres *This should include an agreed escalation process for emergency dental cases; i.e. trauma, uncontrolled bleeding and increasing swelling.*	☐		
9	The plan displays a confidence that staff will be available to work the planned rotas. *While it is unlikely that all shifts will be filled at the moment, the plan should reflect a confidence that shifts will be filled nearer the time. If Boards believe that there may be a problem for example, in relation to a particular profession, this should be highlighted.*	☐		
10	There is evidence of what the Board is doing to communicate to the public how their out of hours services will work over the winter period and how that complements the national communications being led by NHS 24. *This should include reference to a public communications strategy covering surgery hours, access arrangements, location and hours of PCECs, MIUs, pharmacy opening, etc.*	☐		
11	There is evidence of joint working between NHS Territorial Boards and the SAS in how this plan will be delivered through joint mechanisms, particularly in relation to discharge planning, along with examples of innovation involving the use of ambulance services.	☐		
12	There is evidence of joint working between NHS Territorial Boards and NHS 24 in preparing this plan. *This should confirm agreement about the call demand analysis being used.*	☐		
13	There is evidence of joint working with the acute sector and primary care Out-of-Hours planners in preparing this plan. *This should cover possible impact on A&E Departments, MIUs and any other acute receiving units (and vice versa), including covering the contact arrangements.*	☐		
14	There is evidence of working with social work services in preparing this plan. *This should be include referral systems, social work on-call availability, support for primary care health services in the community and support to social services to support patients / clients in their own homes etc.*	☐		

15	There is evidence of clear links to the pandemic plan including provision for an escalation plan. *The should reference plans to deal with a higher level of demand than is predicted and confirm that the trigger points for moving to the escalation arrangements have been agreed with NHS 24.*	☐		

4	Prepare for & Implement Norovirus Outbreak Control Measures		RAG	Further Action/Comments
1	Infection Prevention and Control Teams (IPCTs) should read the HPS Norovirus Outbreak Guidance 2015, due to be published around 17 Aug 2015, to ensure that the Board is optimally prepared.	☐		
2	IPCTs will be supported in the execution of a Norovirus Preparedness Plan before the season starts. *Boards should ensure that their Health Protection Teams (HPTs) support the advance planning which care homes are undertaking to help keep people out of hospital this winter and provide advice and guidance to ensure that norovirus patients are well looked after in care homes.*	☐		
3	HPS Norovirus Control Measures (or locally amended control measures) are easily accessible to all staff, e.g. available on ward computer desk tops, or in A4 folders on the wards. *Staff should be reminded of the need to remain absent for 48 hours post last symptom of Diarrhoea and vomiting. Where staff are prevented from returning to work NHS Boards should refer to the guidance note issued in 2010 relating to staff absence and infection control.*	☐		
4	Board communications regarding bed pressures and norovirus ward closures are optimal and everyone will be kept up to date in real time. *Boards should consider how their communications Directorate can help inform the public about any visiting restrictions which might be recommended as a result of a norovirus outbreak.*	☐		
5	Debriefs will be provided following individual outbreaks or end of season outbreaks to ensure	☐		

	system modifications to reduce the risk of future outbreaks. *Multiple ward outbreaks at one point in time at a single hospital might also merit an evaluation.*			
6	IPCTs will ensure that the Board is kept up to date regarding the national norovirus situation.	☐		
7	Before the norovirus season has begun, staff in emergency medical receiving areas will confirm with the IPCTs the appropriateness of procedures to prevent outbreaks when individual patients have norovirus symptoms, e.g. patient placement, patient admission and environmental decontamination post discharge. *The SG HAI team has contacted the HOAG to request that they liaise with the SMVN to reach consensus around testing procedures for patients that have been in the vicinity of norovirus outbreaks.*	☐		
8	Boards must ensure arrangements are in place to provide adequate IPCT cover across the whole of the festive holiday period. *While there is no national requirement to have 7 day IPCT cover, outwith the festive holiday period, Boards might wish to consider their local IPC arrangements.*	☐		
9	The Board is prepared for rapidly changing norovirus situations, e.g. the closure of multiple wards over a couple of days. *As part of their surge capacity plan, Boards should consider how wards will maintain capacity in the event that wards are closed due to norovirus.*	☐		
10	There will be effective liaison between the IPCTs and the HPTs to optimise resources and response to the rapidly changing norovirus situation. *This should include the notification of 'tweets' to help spread key message information.*	☐		
11	The Board is aware of norovirus publicity materials and is prepared to deploy information internally and locally as appropriate, to spread key messages around norovirus and support the 'Stay at Home Campaign' message. *This should include the notification of 'tweets' to help spread key message information.*	☐		

5	Seasonal Flu, Staff Protection & Outbreak Resourcing		RAG	Further Action/Comments
1	At least 50% of all staff working in areas with high risk patients such as paediatric, oncology, maternity, care of the elderly, haematology, ICUs, etc., have been vaccinated to prevent the potential spread of infection to patients, as recommended in the CMO(2015)12. *This will be evidenced through end of season vaccine uptake submitted to HPS by each NHS board. Local trajectories have been agreed and put in place to support and track progress. Uptake of vaccine in 2014/15 was still significantly below target, at 36.3%.*	☐		
2	All of our staff have easy and convenient access to the seasonal flu vaccine. In line with recommendations in CMO Letter (2014)12 clinics are available at the place of work and include clinics during early, late and night shifts, at convenient locations. Drop-in clinics are also available for staff unable to make their designated appointment and peer vaccination is facilitated to bring vaccine as close to the place of work for staff as possible. *It is the responsibility of health care staff to get vaccinated to protect themselves from seasonal flu and in turn protect their vulnerable patients, but NHS Boards have responsibility for ensuring vaccine is easily and conveniently available; that sufficient vaccine is available for staff vaccination programmes; and that senior management and clinical leaders with NHS Boards fully support vaccine delivery and uptake.*	☐		
3	The winter plan takes into account the predicted surge of flu activity that can happen between October and March and we have adequate resources in place to deal with potential flu outbreaks across this period.	☐		

	If there are reported flu outbreaks during the season, where evidence shows that vaccination uptake rates are not particularly high, Health Boards may undertake targeted immunisation. In addition, the centralised contingency stock of influenza vaccine, purchased by the Scottish Government can be utilised if required and an agreed protocol is in place with Health Boards on the use of the contingency stock. Antiviral prescribing for seasonal influenza may also be undertaken when influenza rates circulating in the community reach a trigger level (advice on this is generated by a CMO letter to health professionals)			
4	HPS weekly updates, showing the current epidemiological picture on influenza infections across Scotland, will be routinely monitored over the winter period to help us detect early warning of imminent surges in activity. *Health Protection Scotland and the Health Protection Team within the Scottish Government monitor influenza rates during the season and take action where necessary, The Health Protection Team brief Ministers of outbreak/peaks in influenza activity where necessary. HPS produce a weekly influenza bulletin and a distillate of this is included in the HPS Winter Pressures Bulletin.*	☐		
5	Adequate resources are in place to manage potential outbreaks of seasonal flu that might coincide with norovirus, severe weather and festive holiday periods. *NHS board contingency plans have a specific entry on plans to mitigate the potential impact of potential outbreaks of seasonal influenza to include infection control, staff vaccination and antiviral treatment and prophylaxis. Contingency planning to also address patient management, bed management, staff redeployment and use of reserve bank staff and include plans for deferral of elective admissions and plans for alternative use of existing estate or opening of reserve capacity to offset the pressures.*	☐		

6	Respiratory Pathway		RAG	Further Action/Comments
1	**There is an effective, co-ordinated respiratory service provided by the NHS board.**			
1.1	Clinicians (GP's, Out of Hours services, A/E departments and hospital units) are familiar with their local pathway for patients with different levels of severity of exacerbation in their area.	☐		
1.2	Plans are in place to extend and enhance home support respiratory services over a 7 day period where appropriate.	☐		
1.3	Anticipatory Care/ Palliative care plans for such patients are available to all staff at all times. *Consider use of an effective pre admission assessment/checklist i.e. appropriate medication prescribed, correct inhaler technique, appropriate O2 prescription, referred to the right hospital/right department, referred directly to acute respiratory assessment service where in place..* *Consider use of self-management tools including anticipatory care plans/asthma care plans and that patients have advice information on action to take/who to contact in the event of an exacerbation.* *Patients should have their regular and emergency medication to hand, their care needs are supported and additional care needs identified (should they have an exacerbation).*	☐		
1.4	Simple messages around keeping warm etc. are well displayed at points of contact, and are covered as part of any clinical review. This is an important part of 'preparing for winter for	☐		

	HCPs and patients. *Simple measures are important in winter for patients with chronic disease/COPD. For example, keeping warm during cold weather and avoiding where possible family and friends with current illness can reduce the risk of exacerbation and hospitalisation.*			
2	**There is effective discharge planning in place for people with chronic respiratory disease including COPD**			
2.1	Discharge planning includes medication review, ensuring correct usage/dosage (including O2), checking received appropriate immunisation, good inhaler technique, advice on support available from community pharmacy, general advice on keeping well e.g. keeping warm, eating well, smoking cessation. *Local arrangements should be made to ensure that the actions described are done in the case of all admissions, either in hospital, before discharge, or in Primary Care soon after discharge, by a clinician with sufficient knowledge and skills to perform the review and make necessary clinical decisions (specifically including teaching or correcting inhaler technique).*	☐		
2.2	All necessary medications and how to use them will be supplied on hospital discharge and patients will have their planned review arranged with the appropriate primary, secondary or intermediate care team.	☐		
3	**People with chronic respiratory disease including COPD are managed with anticipatory and palliative care approaches and have access to specialist palliative care if clinically indicated.**			
3.1	Anticipatory Care Plan's (ACPs) will be completed for people with significant COPD and Palliative Care plans for those with end stage disease. *Spread the use of ACPs and share with Out of Hours services.* *Consider use of SPARRA/Risk Prediction Models to identify those are risk of emergency admission over winter period.* *SPARRA Online: Monthly release of SPARRA data, http://www.bi.nhsnss.scot.nhs.uk/ . This release estimates an individual's risk of emergency admission in the period 1st August 2014 to 31st July 2015.* *Consider proactive case/care management approach targeting people with heart failure, COPD and frail older people.*	☐		
4	**There is an effective and co-ordinated domiciliary oxygen therapy service provided by the NHS board**			
4.1	Staff are aware of the procedures for obtaining/organising home oxygen services. Staff have reviewed and are satisfied that they have adequate local access to oxygen concentrators and that they know how to deploy these where required. If following review, it is	☐ ☐		

	deemed that additional equipment is needed to be held locally for immediate access, please contact Health Facilities Scotland for assistance (0131 275 6860) Appropriate emergency plans/contacts are in place to enable patients to receive timely referral to home oxygen service over winter/festive period. Contingency arrangements exist, particularly in remote and rural areas, and arrangements are in place to enable clinical staff in these communities to access short term oxygen for hypoxaemic patients in cases where hospital admission or long term oxygen therapy is not clinically indicated. *Take steps to remind primary care of the correct pathway for accessing oxygen, and its clinical indications.*	☐ ☐		
5	**People with an exacerbation of chronic respiratory disease/COPD have access to oxygen therapy and supportive ventilation where clinically indicated.**			
5.1	Emergency care contact points have access to pulse oximetry. *Take steps to ensure that all points of first contact with such patients can assess for hypoxaemia, and are aware of those patients in their area who are at risk of CO2 retention. Such patients should be known to Ambulance services, Out of Hours Emergency centres and A/E departments, either through electronic notifications such as eKIS, or by patient help cards, message in a bottle etc.*	☐		

7	**Management Information**		**RAG**	**Further Action/Comments**
1	Admissions data will be input to the System Watch predictive modelling system as close to real time as possible. Local quality assurance of the site and board level data is in place.	☐		
2	Effective reporting lines are in place to provide the Scottish Government with routine weekly management information and any additional information that might be required on an exception / daily basis. *Over the winter period we will be augmenting the weekly management information collected on an all-year-round basis and will share this information across NHSScotland to help Boards compare and benchmark performance.*	☐ ☐		
3	Effective reporting lines are in place to provide the SG Directorate for Health Workforce & Performance with immediate notification of significant service pressures that will disrupt services to patients as soon as they arise. *Any exception reporting should be set within the context of planned / actual capacity and demand activity.*	☐		

8	Sign Off		RAG	Further Action/Comments
1	The Chief Executive will discuss the winter plan at board meetings and personally sign off and publish the plan on the Boards website by the end of October at the latest.	☐		
2	A summary of the winter plan will be published on the Board website by the end of October.	☐		
3	Arrangements are in place to include governance of winter planning within local Unscheduled Care Management Groups or other relevant management groups as appropriate. *Membership of these groups should include national and local Unscheduled Care Teams where applicable.*	☐		

9	Key Roles / Services Integrated into Planning Process		RAG	Further Action/Comments
	Heads of Service	☐		
	Nursing / Medical Consultants	☐		
	Consultants in Dental Public Health	☐		
	AHP Leads	☐		
	Infection Control Managers	☐		
	Managers Responsible for Capacity & Flow	☐		
	Pharmacy Leads	☐		
	Mental Health Leads	☐		
	Business Continuity / Emergency Planning Managers	☐		
	OOH Service Managers	☐		
	GP's	☐		
	NHS 24	☐		
	SAS	☐		

	Territorial NHS Boards	☐		
	Independent Sector	☐		
	Local Authorities	☐		
	Integration Joint Board Chief Officers and Interim Chief Officers	☐		
	Strategic Co-ordination Group	☐		
	Third Sector	☐		
	SG Health & Social Care Directorate	☐		

Item No 12

6th October 2015

Glasgow City Council / NHS Greater Glasgow and Clyde
Shadow Integration Joint Board

Report By: David Williams, Chief Officer Designate

Contact: Allison Eccles, Head of Business Development

Tel: 0141 287 8751

PARTICIPATION AND ENGAGEMENT STRATEGY - UPDATE

Purpose of Report:	The purpose of this paper is to provide the Shadow Integration Joint Board with an update on development of the Participation and Engagement Strategy.

Recommendations:	The Shadow Integration Joint Board is asked to note this report.

Implications for IJB	
Financial:	All activity will be carried out within existing resources
Personnel:	None
Legal:	It is a statutory requirement that the Partnership produces a participation and engagement strategy for the Integration Joint Board. The Integration Scheme commits that this will be completed within one year of establishment of the Integration Joint Board
Economic Impact:	None
Sustainability:	None
Sustainable Procurement and Article 19:	None
Equalities:	An Equality Impact Assessment will be carried out on the Participation and Engagement Strategy before it is presented to the Integration Joint Board.
Implications for Glasgow City Council	Potential impact on wider participation and engagement structures within the Council
Implications for NHS Greater Glasgow & Clyde	Potential impact on wider participation and engagement structures within the Health Board

1. Purpose

1.1 The purpose of this paper is to provide the Shadow Integration Joint Board with an update on development of the Participation and Engagement Strategy.

2. Background

2.1 The Public Bodies (Joint Working) (Scotland) Act 2014 requires the Health and Social Care Partnership to produce a Participation and Engagement Strategy for the Integration Joint Board. This strategy must ensure that there is effective engagement with communities and partners which helps to ensure that local needs and expectations for health and social care are being met.

2.2 The draft Integration Scheme notes this requirement and commits that the Participation and Engagement Strategy will be produced within one year of the establishment of the Integration Joint Board.

3. Approach

3.1 This work is being led by Business Development, with significant input from colleagues in localities, Community Development, Community Engagement, and others as required.

3.2 The intention is to build on existing good practice in participation and engagement and align current engagement structures utilised by Social Work and NHS Greater Glasgow and Clyde into a clearly defined and understood structure linked to the Integration Joint Board.

3.3 Work to develop the strategy is taking the form of an ‘As Is’ review of current structures and development of a ‘To Be’ proposal for future engagement, and drafting of a strategy document which reflects the new arrangements and outlines the principles of engagement with the IJB.

3.4 A Project Initiation Document (PID) for this work has been drafted and is appended to this report.

4. Progress to Date

4.1 A Working Group has been established involving key officers responsible for taking forward individual pieces of work and a Steering Group has been established involving officers from the partnership and service user / patient and carer representatives from key stakeholders such as Voices for Change, Carers Reference Group, PPF and Strategic Planning Groups.

4.2 The Steering Group will be responsible for providing strategic direction to the Working Group and reviewing proposals ahead of presentation to the Executive Management Group and the Integration Joint Board.

4.3 Draft terms of reference and membership of both the Working Group and Steering Group are outlined within the PID.

4.4 An action plan has been produced and work is underway on the ‘As-Is’ exercise to map out existing participation and engagement structures, what works well within those and where there are opportunities for development.

4.5 Key stages in the process as outlined in the action plan are:

- Completion of the ‘As-Is’ and ‘To-Be’ exercises by the end of November 2015
- Production of a draft Participation and Engagement Strategy by the end of December
- A period of consultation and feedback in January 2016
- Proposals presented to the Integration Joint Board in February.

4.6 This timeline will allow the strategy to take effect on 1 April 2016 simultaneously with the Integration Joint Board’s Strategic Plan for integrated health and social care services.

5. Recommendations

5.1 The Shadow Integration Joint Board is asked to note this report.

Health and Social Care Integration

Participation and Engagement Strategy

Project Initiation Document

Date: August 2015
Version: 2.0

1. Background

The Public Bodies (Joint Working) (Scotland) Act 2014 ('the Act') received Royal Assent on 1st April 2014.

The Act requires the Health and Social Care Partnership to produce a participation and engagement strategy to ensure that there is effective engagement with all communities and partners to ensure that local needs and expectations for health and social care are being met, and this is reflected within the draft Integration Scheme.

The Community Empowerment Act sets a requirement that public bodies should engage with 'community bodies' to improve outcomes, and gives those community bodies a right to participate in processes to improve outcomes. The Act requires the Integration Partnership (and other Public Bodies) to put in place a participation process, and in due course report on the outcomes, including how engagement has shaped the result.

The Patient Rights (Scotland) Act 2011 aims to improve patient's experiences of using health services and to support people to become more involved in their health and health care.

Scottish Government Policy Circular 'CEL 4' Inform, Engage, Consult places a duty on Health Boards to involve the public in formal consultation in relation to major service redesign and change.

The Scottish Government's National Standards for Community Engagement (2005) set out best practice principles for the way that government agencies, councils, health boards, police and other public bodies engage with communities. Additionally the Scottish Health Council (part of Healthcare Improvement Scotland) has a role to audit the scope and quality of public involvement in healthcare planning and delivery; Health Boards must comply with their Participation Standard monitoring framework.

2. Objectives and Approach

The primary objective of this project is to develop a draft Participation and Engagement Strategy for the Glasgow City Integration Joint Board (IJB) and propose a structure for engagement with the Integration Joint Board which is clearly defined and understood by all stakeholders.

This will be by done via an initial review of current participation and engagement structures in place through Social Work Services and the former Glasgow Community Health Partnership (CHP), with a view to identifying what mechanisms work well and align with national and local policy and can be retained, and what mechanisms require to evolve or develop to ensure consistency of approach and alignment with the vision, values and objectives of the IJB and HSCP.

A review of current engagement structures is already underway. The review scope and methodology includes:

- Preparation of a definition for the Partnership on what their participation and engagement requirements are;
- Scoping and articulating the various statutory requirements, policy drivers, and quality standards, and their requirements/implications;
- Scoping out stakeholders and their existing processes, both city-wide and in localities for engaging within and beyond their stakeholder group, and consider how existing or revised arrangements will connect with the Partnership
- Engagement with stakeholders including Voices for Change, Public Partnership Forums, communities and equality groups will take place through a series of focus groups and workshops; stakeholder meetings and events; an online Survey Monkey Questionnaire for all stakeholders; the consultation on the Partnership Strategic Plan, anticipated from October to December 2015 will include consultation questions on participation and engagement mechanisms with the Partnership.

The above activity will inform and ensure a co-production approach to producing proposals for an engagement framework for the Glasgow City Health and Social Care Partnership and will ensure that 'to be' structures meet with legislative requirements and the Partnership's expectations for locality planning. These proposals will also outline the proportionate level of support for participation and engagement to be provided by the Health and Social Care Partnership (HSCP) in both officer and financial terms.

Following development of proposals for the engagement structure of the IJB, a strategy document which reflects the new arrangements and outlines the principles of engagement with the IJB will be drafted.

3. Scope and Deliverables

3.1 Scope

The review will look specifically at the current formal patient and service user engagement structures connected to the HSCP partner organisations such as:

- Voices for Change Groups – local and citywide
- Public Partnership Forums
- Carer's engagement structure
- Mental health service user engagement structure
- Kinship Carers Reference Group
- Addictions Recovery Networks
- Engagement processes within Strategic Planning Groups

The scope of the review will be limited to current patient and service user engagement structures. It is recognised that there are a huge range of other groups/fora/projects all working to improve services in communities but to scope and consider all of these would be a time consuming and labour intensive exercise without any immediate clear benefits.

<u>The review will focus on:</u>

- the systems in place to ensure that the structures reflect and represent who they are supposed to;
- the diversity of groups involved in the membership and the activity of the structure;
- the frequency/relevance of engagement with equality groups;
- the quality of training and learning opportunities;
- the process of selecting representatives from the structure to participate in working groups, re-design projects, other meetings etc.;
- the process of renewing and reviewing membership and representative roles;
- working agreement and /or policy frameworks e.g. Patients Rights Act;
- the relationship of the engagement structure to the formal governance and decision making mechanism (e.g. NHS CHP Committee, Strategic Planning Groups, IJB etc.);
- communication with the wider community, and promotion of the role of the structure, both internally and externally;
- opportunities for the public to feed in their views to the engagement structure e.g. visits to other groups/public events etc.;
- the effectiveness of the engagement structure in achieving its objectives and influencing change via action plans and evidence; and,
- identifying gaps in structures and representation; delivering proposals to resolve.

The draft Participation and Engagement Strategy will reflect learning from the review of existing structures, guidance from the Scottish Government and any other relevant input from key stakeholders including the IJB, community representatives and the Executive Management Team.

3.2 Deliverables

- A completed review identifying what works well and what may need to change
- A draft Strategy and proposed engagement structure presented to the Integration Joint Board for approval
- A completed Equality Impact Assessment / Screening on the draft Strategy

4. Benefits, Costs and Risks

4.1 Benefits / Business Case

- Development of a Participation and Engagement Strategy which aligns with the aims and objectives of the IJB and HSCP
- Identification of what works within existing structures and where development is required
- Community and representative groups clear on how to effectively interact with the IJB and HSCP
- Discharge of IJB's legislative duties to have a Participation and Engagement Strategy in place

4.2 Constraints and Costs

- Project must be carried out within existing workload requirements and staffing resources
- Participation and Engagement Strategy itself may not be cost neutral if it results in the implementation of new actions and requirements on the HSCP
- Potential costs related to carrying out the review (venue hire etc.)
- Timescale: strategy must be developed within one year of establishment of IJB (absolute deadline as per Integration Scheme)
- Other statutory provisions and requirements (e.g. Community Empowerment Act)

4.3 Preliminary Risk Assessment

Key risks may include:

- Workload pressures
- Negative response from existing representative groups to review findings and proposals
- Further directions / statutory provisions from Scottish Government, or emerging local policy priorities which affect validity or value in work already done

5. Governance, Organisation and Reporting

The review of existing structures and development of the strategy will be led by the Head of Business Development, Heads of Planning & Strategy, and supported by Business Development (including Community Development staff) and NHS Community Engagement staff, with involvement from other colleagues (e.g. Health Improvement) across the Partnership as appropriate.

A Steering Group (appendix 1), involving a number of key community reps will be established to support the strategic direction of the project, with key pieces of work managed through a Working Group (appendix 2) led by officers from the relevant sections listed above.

Progress will be reported via the HSCP Senior Management Team and the Integration Joint Board on an 'as required' basis.

6. Project Plan

A detailed project plan will be developed, however it is expected that this review and consultation will be concluded in winter 2015 with a report back to the Integration Joint Board in February 2016 with proposals to take effect from 1st April 2016. It is anticipated that more detailed locality engagement plans will follow within the first year of the implementation of the city-wide Participation and Engagement Strategy.

7. Sign Off

Project Sponsor:	_____	Project Manager:	_____	Customer:	_____
Signed	_____	Signed:	_____	Signed:	_____
Date:	_____	Date:	_____	Date:	_____

Appendix 1

Participation and Engagement Strategy Steering Group Terms of Reference

The role of the Steering Group is to oversee the review of existing engagement structures and development of the Participation and Engagement Strategy.

The Steering Group will provide a strategic direction to the Working Group throughout the process of developing and drafting the Participation and Engagement Strategy.

The Steering Group will meet periodically to discuss development of the draft strategy, and to consider any amendments that may be suggested by, or proposed to, the Working Group prior to submission to the Integrated Joint Board.

Steering Group Membership

*note: a number of members may act in more than one capacity

- Service User / Carer Members of Shadow Integration Joint Board
- Service User / Carer Members of Strategic Planning Groups
- Voices for Change rep
- PPF rep
- Carers Reference Group rep
- Mental Health Network rep
- Social Work Community Development rep
- NHS Community Engagement rep
- Business Development / Planning officers

Appendix 2

Participation and Engagement Strategy Working Group Terms of Reference

The role of the Working Group is to carry out pieces of work as directed by the Steering Group relating to the review of existing engagement structures and development of the Participation and Engagement Strategy.

The Working Group is responsible for maintenance of and adherence to the Project Plan, delivery of key pieces of work as outlined in the PID and Project Plan and reporting to the Steering Group.

The Working Group will meet monthly.

Working Group Membership

- Business Development / Planning Officers
- Social Work Community Development Officers
- NHS Community Engagement Officers

Greater Glasgow and Clyde NHS Board

Item No 13

Board Meeting
Tuesday 20th January 2015

Board Paper No. 2015/02

Medical Director

CLINICAL SERVICES FIT FOR THE FUTURE: APPROVING THE CLINICAL STRATEGY

Recommendation:

The Board is asked to:

- **approve the clinical strategy developed from the clinical services review process**

1. INTRODUCTION AND PURPOSE

1.1 In February 2012 NHS Greater Glasgow and Clyde agreed to establish the Clinical Services Fit for the Future Programme to review services to prepare a single clinical strategy for NHS GGC for 2015 onwards. The purpose of this paper is to bring the output of the clinical service review process to the Board to enable it to be approved as a clinical strategy which will provide the basis for future service planning.

1.2 The key aims of the strategy are to ensure:

- care is patient focused with clinical expertise focused on providing care in the most effective way at the earliest opportunity within the care pathway;
- services and facilities have the capacity and capability to deliver modern healthcare with the flexibility to adapt to future requirements;
- sustainable and affordable clinical services can be delivered across NHSGGC;
- the pressures on hospital, primary care and community services are addressed.

1.3 This strategy provides a framework to ensure that best clinical outcomes are achieved for patients and that services are:

- safe and sustainable;
- patient centred;
- integrated between primary and secondary care;
- efficient, making best use of resources;
- affordable, provided within the funding available;

- accessible, provided as locally as possible;
- adaptable, achieving change over time.

1.4 Board approval of this paper will enable:-

- the publication of the strategy providing a further opportunity to engage all stakeholders;
- engagement with the new Integration Joint Boards to adopt this as a shared clinical strategy and to work together on planning service changes;
- a platform for the development of implementation plans, including delivering changes to reflect the output of the Paisley development programme across the Board area;
- engagement with GPs, wider primary care contractors and with the new Health and Social Care Partnerships to refresh the Board's Primary Care Strategy and plan the further development of primary and community services.

2. SETTING THE SCENE: NHS SCOTLAND POLICY CONTEXT

2.1 In 2012 the Cabinet Secretary for Health, Wellbeing and Cities set out her strategic narrative and vision for achieving sustainable quality in the delivery of healthcare services across Scotland.

2.2 This vision for NHS Scotland is:

> **"By 2020 everyone is able to live longer healthier lives at home or in a homely setting with a healthcare system.**
>
> **There will be integrated health and social care, a focus on prevention, anticipation and supported self management. When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm. Whatever the setting, care will be provided to the highest standards of quality and safety, with the patient at the centre of all decisions. There will be a focus on ensuring that people get back into their home or community environment as soon as possible, with minimum risk of re-admission."**
>
> ***Achieving Sustainable Quality in Scotland's Healthcare: A 20:20 Vision***

2.3 This vision provides the context for taking forward the implementation of the Healthcare Quality Strategy for Scotland and the required actions to improve efficiency and achieve financial sustainability and for the development of our approach to planning clinical services fit for the future.

2.4 The actions outlined for NHS Scotland which drive the requirement to reshape our services are:

- We need a shared understanding with everyone involved in delivering healthcare services which set out what they should expect in terms of support, involvement and reward alongside their commitment to strong visible and effective engagement and leadership which ensures a real shared ownership of the challenges and solutions.

- We need to develop a shared understanding with the people of Scotland which sets out what they should expect in terms of high quality healthcare services alongside their shared responsibility for prevention, anticipation, self management and appropriate use of both planned and unscheduled/ emergency healthcare services, ensuring that they are able to stay healthy, at home, or in a community setting as long as possible and appropriate.

- We need to secure integrated working between health and social care, and more effective working with other agencies and with the Third and Independent Sectors.

- We need to prioritise anticipatory care and preventative spends, e.g. support for parenting and early years.

- We need to prioritise support for people to stay at home/in a homely setting as long as this is appropriate, and avoid the need for unplanned or emergency admission to hospital wherever possible.

- We need to make sure people are admitted to hospital only when it is not possible or appropriate to treat them in the community - and where someone does have to go to hospital, it should be as a day case where possible.

- Caring for more people in the community and doing more procedures as day cases where appropriate will result in a shift from acute to community-based care. This shift will be recognised as a positive improvement in the quality of our healthcare services, progress towards our vision and therefore the kind of service change we expect to see.

2.5 The direction underpinning this vision sees further focus on improving the quality of services, with expanded primary and community care, a focus on multi-morbidity and improving unscheduled and emergency care out with hospital where clinically appropriate. National work is currently underway between Boards and the Scottish Government to set out the steps which will need to be taken to deliver the 2020 Vision. This strategy provides our local basis to develop those changes.

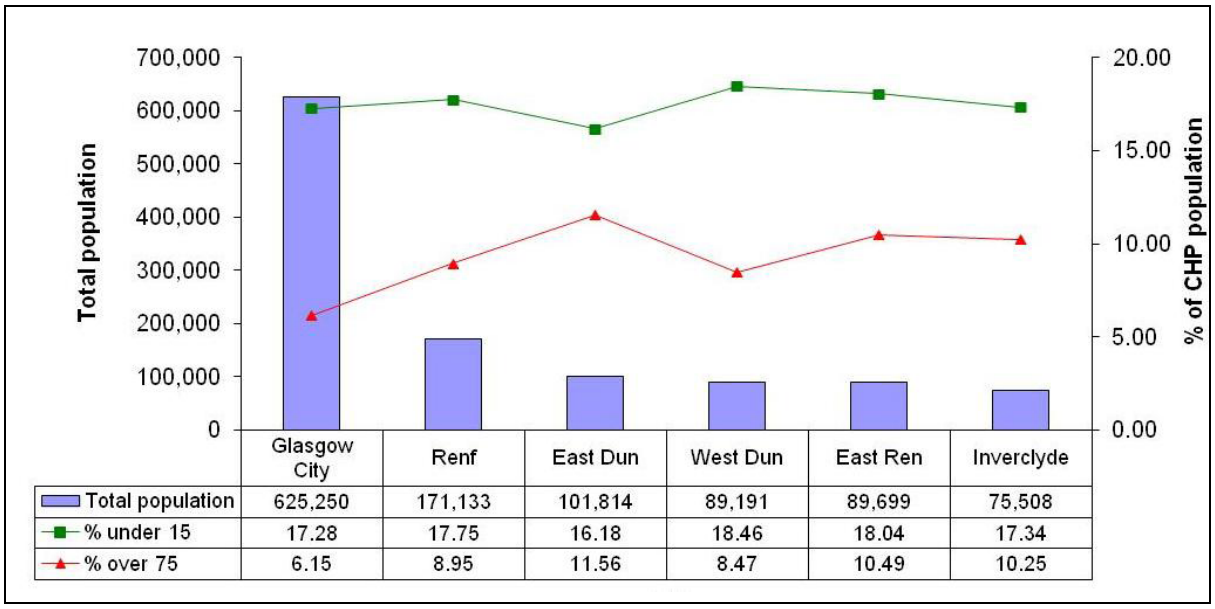
2.6 In addition to this context, a further important point of context for this clinical strategy is the establishment from April 201 of Integrated Health and Social Care Partnerships. Successful development of the new integrated partnerships will be key to the achievement of all of the strategic priorities and service models set out in this strategy which will frame our joint working with the Partnerships with shared responsibility for the strategic planning of acute services.

3. THE NHS GREATER GLASGOW AND CLYDE POPULATION HEALTH

3.1 In bringing forward this outcome of the CSR it is also important to restate the local context in which the CSR has been developed.

3.2 The Population of NHSGGC: Demographics

3.2.1 The current population and age profile is shown below. Our population is relatively young compared to other parts of Scotland, although this varies significantly between local authority areas. Women predominate in the older age groups.



	Glasgow City	Renf	East Dun	West Dun	East Ren	Inverclyde
Total population	625,250	171,133	101,814	89,191	89,699	75,508
% under 15	17.28	17.75	16.18	18.46	18.04	17.34
% over 75	6.15	8.95	11.56	8.47	10.49	10.25

3.2.2 The population of the NHS Greater Glasgow and Clyde area in 2010 was 1,203,870. This population is expected to increase overall by 2.4% by 2020. (See table below)

Age Group	Population 2010	Population 2015	% change by 2015	Population 2020	% change by 2020	Population 2025	% change by 2025
0-14	194,562	197,268	1.4	202,876	4.3	199,911	2.7
15-24	166,320	150,265	-9.7	137,743	-17.2	139,286	-16.3
25-34	176,434	193,672	9.8	184,614	4.6	166,623	-5.6
35-44	167,002	156,647	-6.2	172,422	3.2	187,458	12.2
45-54	177,130	177,566	0.2	159,827	-9.8	149,426	-15.6
55-64	136,201	147,198	8.1	164,852	21.0	165,878	21.8
65 & over	186,221	197,206	5.9	210,174	12.9	233,297	25.3
All Ages	1,203,870	1,219,822	1.3	1,232,508	2.4	1,241,879	3.2

3.2.3 During this time, the age profile of the population will continue to change. In common with much of Scotland, in most areas there will be a steep rise in the numbers and proportion of older people. The over 65 population will increase by 12.9% by 2020. This will impact differently across Greater Glasgow and Clyde with areas like East Dunbartonshire and East Renfrewshire already experiencing significant rises in numbers of older people, whilst Glasgow City is projected to see a short term decline in the numbers of older people, before following the same longer term trends. A small increase in the number of children together with a larger decrease in the number of people aged 15-29 will result in an overall reduction in the 0-19 age group.

3.2.4 It is a population with high levels of deprivation compared to the rest of Scotland. 30.4% of people in NHS Greater Glasgow and Clyde live in the 15% most deprived data zones (Scottish Index of Multiple Deprivation). This ranges from 3.1% in East Dunbartonshire, to over 50% North and East Glasgow.

3.2.5 Summary of key trends:

- The **top 10 causes of death** in Scotland account for 44% of all deaths. Each of the causes of death are amenable to prevention by not smoking; being a healthy weight; being physically active; drinking within recommended levels of alcohol and maintaining a healthy diet.

- **Population projections** estimate that Glasgow City is due to have a modest rise in population to 2033, whereas, all other local authorities in NHSGGC will have a decrease in population. This will be most marked in Inverclyde and East Dun.

- **Our population is ageing**. Between 1911 and 2008 there has been an increase in the number of people aged over 65 years in Scotland of 221%. However, NHSGGC is ageing at a markedly slower rate than the rest of Scotland.

- There are **wide variations within NHSGGC**. East Dumbarton experienced a 47% increase in people aged 65+ and Glasgow city a 25% decline between 1982-2007.

- **Forecasts predict the under 50's will shrink** from 70% in 2008 to 62% in 2033; whereas the over 50's will expand from 30% to 38%. The biggest increase is expected in the over 65's age group.

- **Dependency ratios are due to increase** to 2040 across NHSGGC. Within NHSGGC there are marked variations. Current dependency ratios vary from 44% in Glasgow City to 60% in East Renfrewshire by 2031 these are predicted to increase to 51% in Glasgow City to 91% in East Dunbartonshire and 89% in East Renfrewshire. A male born in East Glasgow can expect to live in a healthy state for 15 years less than a male born in East Dunbartonshire.

- **Older single person households are expected to increase**. It is anticipated these will account for 54% of households by 2031.

- Life expectancy and healthy life expectancy is lower in NHSGGC than the rest of Scotland. People living in NHSGGC can expect to have the **longest period of unhealthy life at 10.5 years.**

- Aging is associated with an increased burden on long term conditions and chronic disease.

- There will be a significant growth in the numbers of people with dementia as the population ages. There will be an estimated 18% increase in dementia in GGC by 2020. One in three people aged over 65 will die with a form of dementia and one in four hospital inpatients will have dementia (Alzheimer's Research Trust 2010)

3.2.6 In recent years across NHSGGC, there have been some significant improvements in health. Overall life expectancy has risen; rates of premature mortality have fallen, with particular improvements for Coronary Heart Disease. Cancer survival has improved significantly across a range of cancers. However, there remain many significant health challenges and marked inequality across NHS Greater Glasgow and Clyde. Overall,

average life expectancy in NHS Greater Glasgow and Clyde is well below the Scottish average (see below). Again, there is considerable variation between different parts of NHS Greater Glasgow and Clyde.

3.2.7 *Healthy* life expectancy in NHS Greater Glasgow and Clyde is even lower compared to the Scottish average. People in NHS Greater Glasgow and Clyde live for many years in ill health, with the consequent impact on quality of life, economic and societal contribution and need for services. Over the past 10 years, the gap in healthy life expectancy between the 20% most deprived and the 20% least deprived areas has increased from 8 to 13 years.

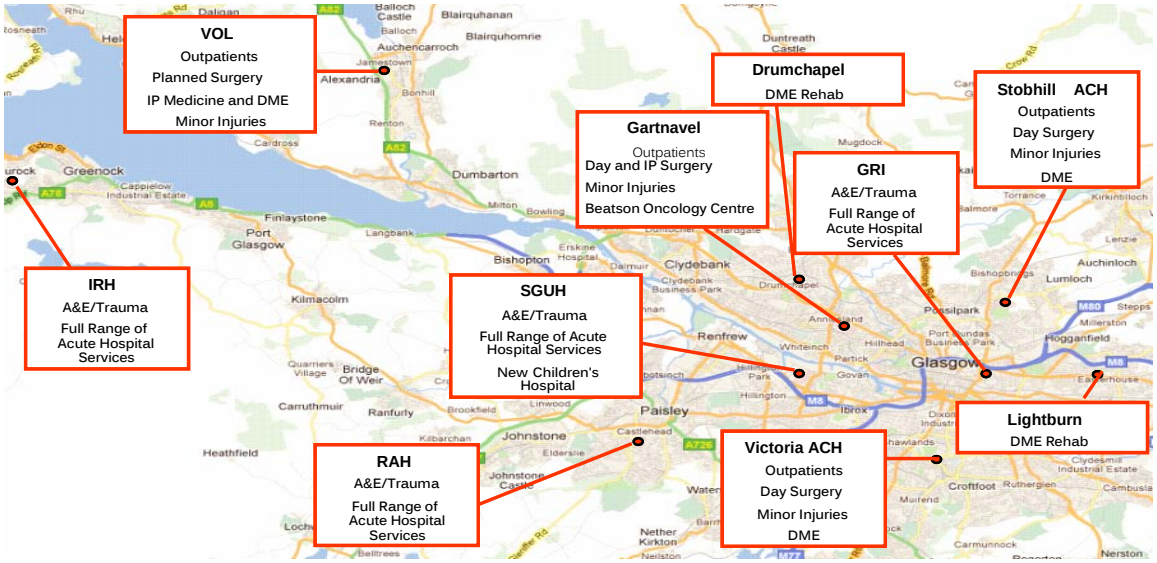
Life Expectancy at Birth by Gender 2007 - 2009 Source: NRS (formerly GRO(S))

CH(C)P	Male	Female
Glasgow City	71.1	77.5
East Dunbartonshire	78.3	83.1
East Renfrewshire	77.8	82
Renfrewshire	73.7	79.2
Inverclyde	73.1	79
West Dunbartonshire	72.5	78.4
NHSGGC	**73.1**	**78.9**
Scotland	**75.4**	**80.1**

4. THE CONTEXT OF ACUTE SERVICES PROVISION IN NHSGGC

4.1 Prior to the CSR NHSGGC had two separate approved acute strategies - one for Greater Glasgow, the Acute Services Review (ASR) agreed in 2002 and the other for Clyde (South Clyde in 2006/7 and North Clyde in 2009). The Clyde strategy has already been fully implemented and the Greater Glasgow ASR will be delivered during 2015. At that point the Acute Services Provision across NHS GGC will be as follows:

2015 GGC
Delivery of the Acute Services Review



4.2 In establishing the CSR the Board recognised the need to:

- integrate acute services across the whole Board area and ensure that there is equity of access to this level of care across NHSGGC;
- see acute services are part of a wider system of care including primary and community care that also requires to be considered to meet the challenges of the 2020 Vision and to deliver the integrated health and social care changes from 2015 onwards;
- recognise the changing landscape of health care with the developments in technology and treatments and the requirement to ensure care is provided in a patient centred way.

4.3 The following sections describe the approach we took to review the organisation of clinical services and to consider what would be required to achieve the best health outcomes for patients. The critical characteristics of the review work were clinical leadership, whole system clinical engagement and intensive patient and public engagement

5. THE CASE FOR CHANGE AND CHALLENGES THIS STRATEGY NEEDS TO ADDRESS

5.1 The first stage in the CSR was to establish the case for change. This part of the process was also based on the views of a wide range of clinicians on what is currently affecting the clinical services and what is likely to impact on services in the future, as well as the opinions of patients of what they value in the current service and what they would want of future services.

5.2 Following extensive engagement with stakeholders the Case for Change was published in December 2012. This identified 9 key themes:

1. The health needs of our population are significant and changing.
2. We need to do more to support people to manage their own health and prevent crisis.
3. Our services are not always organised in the best way for patients[i].
4. We need to do more to make sure that care is always provided in the most appropriate setting;
5. There is growing pressure on primary care and community services.
6. We need to provide the highest quality specialist care[ii].
7. Increasing specialisation needs to be balanced with the need for co-ordinated care which takes an overview of the patient.
8. Healthcare is changing and we need to keep pace with best practice and standards.
9. We need to support our workforce to meet future changes.

5.3 Together these issues paint a picture of health services which need to change to make sure that we can continue to deliver high quality services and improve outcomes. As outlined in the earlier sections the years ahead will see significant changes to the population and health needs of NHS Greater Glasgow and Clyde. It is clear that not enough focus on prevention and support for people at an early stage in their illness can lead to poorer health outcomes, and to people accessing services and support at crisis points or at later stages of illness. The growing complexity of need, including multi morbidity and a wide range of care and support needs, mean that users and carers can feel inadequately supported and services can feel complex and fragmented. This poses significant challenges to the way we deliver health services and work with partner agencies, to ensure that our services adapt to these changing needs.

5.4 The health service is facing a period of rising demand resultant from demographic pressures at the same time as facing a period of significant financial constraint. It is therefore important that in planning for future services the funding available is spent effectively to ensure the best outcomes for patients. A more consistent and joined up approach is required across all parts of the system, targeting interventions and support where they are most needed. The case for change tells us that we need to improve outcomes by organising and delivering services differently to prevent ill health in the first place, to support patients with multiple conditions more effectively and to enable older people to live more independently. We also need to change our hospitals to ensure that high quality care is consistently available, that there is timely access for all to specialist care and that we have 24 /7 access to specialised emergency care.

The full case for change is at http://www.nhsggc.org.uk/content/

5.5 The core of this clinical strategy is based on the case for change and the detailed work done in eight workstreams to consider how we can address these challenges. These workstreams, to determine the service strategy for 2015-2020 and identify the future clinical service provision, cover:

- Population Health
- Emergency Care and Trauma
- Planned Care
- Child and Maternal Health
- Older People's Services
- Chronic Disease Management
- Cancer
- Mental Health

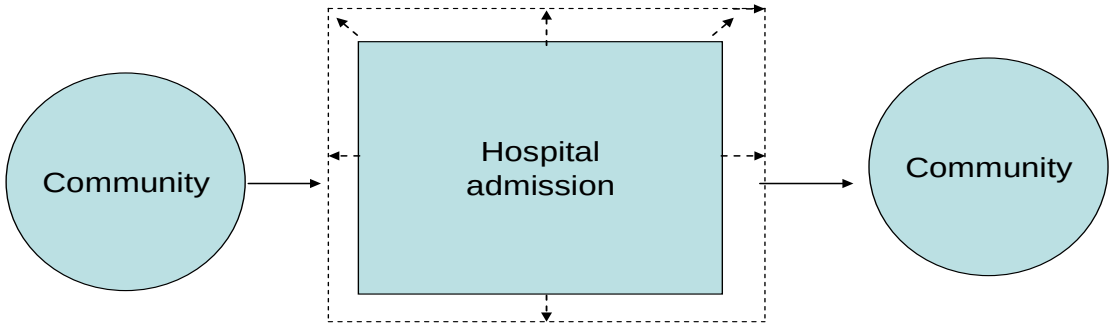
5.6 The detailed conclusions of this service models work are set out later in this paper

5.7 Meeting the challenge across the whole system

The diagrams below show the challenge we face across NHSGGC and the system we need to move towards in the future.

The current position is one where we face challenging demand pressures across a system in which 'hospital' and 'community' services are largely seen as separate, with often poor communication and joint planning across the system. While there are some good examples of joint working, these are not systematic and often on a small scale. The future demand pressures we face as a result of demographic and health changes mean that if we continue with the system as it is now, we would need an additional 500 acute beds by 2020. In an environment of constrained resources, the investment required for this would result in a vicious circle, with growing expenditure in acute hospital admissions and less money for investment in community services, which in turn reduces our ability to support people at home.

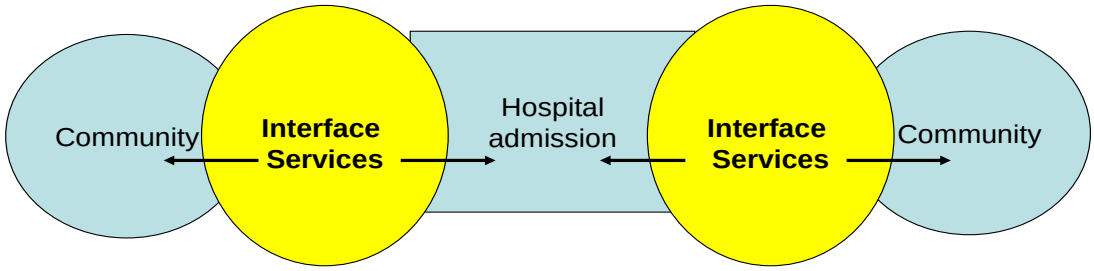
Figure 2



The system of care we want to move to sees a significant change focusing on providing care where it is most appropriate for the patient. This is based on strengthened 24/7 community services, acute services focused on assessment and management of acute episodes, and a range of services being developed at the interface including shared management of high risk patients and a range of alternatives to face to face hospital visits.

Working differently at the interface (represented by the yellow circles below) may involve new services, extending existing services, creating new ways of working through in-reach, outreach and shared care, as well as changes to the way we communicate and share information across the system.

Figure 3



It is recognised that to change the system will require strong clinical leadership and commitment as well as a significant cultural shift across the organization to undertake this size of system change. To achieve this we require to:

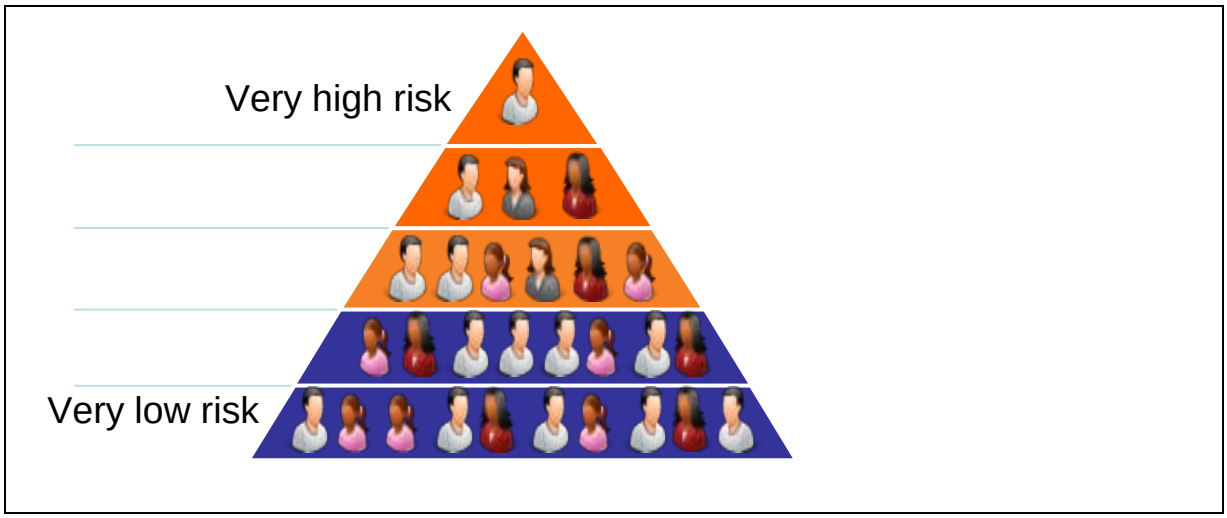
- think beyond artificial boundaries of 'hospital' and 'community';
- focus on patient pathway and needs at each stage;
- change the delivery of acute care: assess and direct to appropriate place of care;
- change the provision and accessibility of community services;
- create different ways of working at the interface.

5.8 This needs to build on the work of bringing clinical teams together to consider the problems and challenges facing the services, to jointly problem solve and plan services across the organisation for the future with shared responsibility for delivery of the new service models to maximise success.

5.9 <u>Core components of the future health system</u>

The overarching aim of this clinical strategy, based on the service models work, is to provide **a balanced system of care where people get care in the right place** from people with the right skills, working across the artificial boundary of 'hospital' and 'community' services.

At the heart of this approach is the requirement to understand our population and provide care at the most appropriate level. Getting this right will enable more intensive support for those most in need, and supported self management with rapid access into services when required for the majority of the population.



This approach relies on a strong emphasis on prevention. It is therefore important that as part of the strategy we continue to emphasise the importance of health improvement and disease prevention. We need to encourage the population to improve their health and prevent disease, recognising that lifestyle choices in modifiable behaviours are responsible for around 80% of our current LTC disease burden. This requires all health care professionals to promote healthier lifestyles and to support the population to take responsibility for improving their own health by adopting healthier lifestyles.

The key characteristics of the clinical services required to support this approach are:

1. A system underpinned by timely access to **high quality primary care** providing a comprehensive service that deals with the whole person in the context of their socio-economic environment:

   - Building on universal access to primary care.
   - Focal point for prevention, anticipatory care and early intervention.
   - Management where possible within a primary care setting.
   - Focus for continuity of care, and co-ordination of care for multiple conditions.

2. A comprehensive range of **community services,** integrated across health and social care and working with the third sector to provide increased support at home:

- Single point of access, accessible 24/7 from acute and community settings.
- Focused on preventing deterioration and supporting independence.
- Multi-disciplinary care plans in place to respond in a timely way to crisis.
- Working as part of a team with primary care providers for a defined patient population.

3. Co-Coordinated care at **crisis / transition** points, and for those **most at risk**:

   - Access to specialist advice by phone, in community settings or through rapid access to outpatients.
   - Jointly agreed care plans with input from GPs, community teams, specialist nurses and consultants, with shared responsibility for implementation.
   - Rapid escalation of support, on a 24 / 7 basis.

4. **Hospital assessment** which focuses on early comprehensive assessment driving care in the right setting:

   - Senior clinical decision makers at the front door.
   - Specialist care available 24/7 where required.
   - Rapid transfer to appropriate place of care, following assessment.
   - In-patient stay for the acute period of care only (see Fig 4).
   - Early supported discharge to home or step down care.
   - Early involvement of primary and community care team in planning for discharge.

5. **Planned care** which is locally accessible on an outpatient / ambulatory care basis where possible:

   - Wider range of specialist clinics in the community, working as part of a team with primary care and community services.
   - Appropriate follow-up.
   - Diagnostic services organised around patient needs.
   - Interventions provided as day case where possible.
   - Rapid access as an alternative to emergency admission or to facilitate discharge.

6. **Low volume and high complexity care** provided in defined units equipped to meet the care needs:

   - Driven by clear evidence of the relationship between volume and outcome.

The service models which follow at section 6 onwards consider what needs to be in place to deliver these core components of care for specific groups of patients.

5.10 Enablers

Changing the system on this scale will require a significant cultural shift and clinical commitment across the organisation. In order to achieve this, services will have to be underpinned by a series of enablers and improvements to supporting systems, including:

- Supported leadership and strong clinical engagement across the system to develop and implement the new models.
- Building on the clinical portal to enable shared IT systems and records which are accessible to different professionals across the care system.
- Jointly agreed protocols and care pathways, supported by IT tools.
- Stratification of the patient population to ensure that care is targeted at the appropriate level with supporting anticipatory care plans in place.
- Ensuring that access arrangements enable all patients to access and benefit from services
- Increasing the education and information shared with patients and the public to support people to take more responsibility for their own care.
- Involvement of patients and carers in care planning and self management.
- Shared learning and education across primary, community and acute services.
- Governance and performance systems which support new ways of working.
- Information systems which enable us to gather the information we need to monitor whether the changes are working, including disaggregated data on activity and outcomes for equality groups.
- Integrated planning of services and resources.
- Ensuring that contractual arrangements with independent contractors support the changes required.

5.11 Benefits

It is anticipated that a successful move towards this system of care would result in:

- Patients being in control of their care and empowered to share decisions about it;
- A system of care which is easier to navigate for patients and professionals.
- Clinicians and other staff at all stages having the necessary information about the patient, with care better tailored to the patient's needs.
- Better patient experience and patient safety, and improved health outcomes with a particular improvement for patients with multi-morbidity.
- A reduction in health inequalities as the most vulnerable patients receive better access to holistic person centred care.
- Care which is provided in the most appropriate setting, relative to the patients needs.
- More cost effective use of resources with care focused on early intervention, better management of complex multi morbidity and a reduction in duplication of care.

Figure 4

What is Acute Care? Who needs to be admitted for inpatient care?

The definition of Acute Inpatient Care we propose is:

"Acute care is where people receive specialised support in an emergency or following referral for surgery, complex tests or other things that cannot be done in the community. Acute care usually provides treatment for a short period, until the person is well enough to be supported in the community again."

The European Appropriateness Evaluation Protocol Approach has been developed and used in a number of countries to support this definition. This considers admission criteria in relation to both severity of illness and intensity of service required:

Admission criteria – intensity of service

- Surgery or other procedure in 24 hours requiring general/ regional anaesthesia or equipment or other facilities only for inpatients.
- Vital signs monitoring at least every 2 hours.
- Intravenous medications and or/ fluid replacement
- Continuous or intermittent (at least every 8 hours) respiratory assistance.

Admission criteria – severity of illness

- Severe electrolyte or blood gas abnormality.
- Acute loss of sight or hearing (within 48 hours of admission).
- Acute loss of ability to move any body part (within 48 hours of admission).
- Persistent fever >38 for more than 5 days.
- Active bleeding.
- Pulse rate <50 or >140 per minute.
- Blood pressure systolic <90 or >200, diastolic <60 or >120.
- Sudden onset of unconsciousness (except transient unconsciousness).
- ECG evidence of acute ischaemia, suspicion of new myocardial infarction.

Experience of applying this tool indicates:

- The most influential factor determining the appropriateness of bed utilisation is how the care system in place manages the patient, rather than the characteristics of the patient.
- Therefore it is important to consider the service configuration and care delivery to effect change.

Significant additional and different capacity is required if patients are to be treated more appropriately:

- A shift away from acute inpatient setting to provide a wide spectrum of home and community based care.
- Improved assessment and diagnosis.
- Non acute beds with therapy support.

Going forward we need to determine where the threshold for acute inpatient care is set

- ***Too high: difficult to implement, risk of readmission, significant impact.***
- ***Too low: won't be radical enough to address the problems we face.***

We need to develop a more comprehensive range of services in community settings based on the services we currently have. This will require us to determine what capacity is needed to ensure that core primary care and community services are accessible when required. It will require us to test the alternatives to ensure they are safe and cost effective.

5.12 The next section of this document sets out the high level service models to support the delivery of care in a more balanced system as we go towards 2020, indicating the areas where services should be further developed and the core components to underpin the health care provision.

6. SERVICE MODELS

6.1 The groups which developed the service models were clinically led and were formed with representatives of the hospital, primary care and academic clinicians. The clinical working groups included patient representatives and were supported by wider patient reference groups, involving patients, carers and voluntary organisations. The process was also supported by a series of cross-cutting events to consider specific issues across the groups, including primary care and the third sector. In addition work has been undertaken in relation to tertiary services which has been fed into the work of the different clinical groups where indicated.

6.2 The groups focused on:

- Reviewing current services, future changes and possible models of care;
- Looking at evidence from research, good practice and innovation;
- Thinking about what needs to change – and what doesn't;
- Reviewing feedback from the engagement sessions with the patient reference groups.

6.3 Underpinning each work stream was a core set of activities to consider current pathways, delivery models, workforce requirements and the relationship between primary and secondary care to ensure efficient and effective patient pathways.

6.4 The outputs from each of the groups were brought together into a discussion paper and summary document in June 2013, which set out how the models developed by all of the groups come together into a series of changes to the overall system of care in NHSGGC, as well as highlighting specific service models from individual groups.

6.5 The discussion paper was shared widely across NHSGGC, with partner organisations and with patients and third sector organisations. This included:

- Presentations and discussions with groups of clinicians, including Medical Staff Associations, Senior Nurses and AHPs
- Through each of our Directorates in the Acute Division, and all six of our Community Health (and Care) Partnerships
- Discussions with GPs through locality groups
- A session with all Patient Reference Groups
- A dedicated session for third sector organisations
- Discussions with West of Scotland Regional Boards and other partner organisations.
- Discussion at joint planning groups with Local Authorities
- Information in StaffNews and through papers available on the intranet
- Discussion with the Area Partnership Forum and Staff Partnership Forums across GGC
- Regular updates to the Area Clinical Forum and advisory committees

6.6 The general feedback was very supportive of the direction of travel set out in the service models paper and welcomed the approach being taken to involve the whole system. The approach described in the service models paper was considered an appropriate response to the issues raised in the case for change. Issues raised in the feedback included:

- Interface services require to be further defined: there was some concern about what it might mean for specific services and seeking details about how it will be taken forward
- The need for more emphasis on the role and implications for primary care.

- The need for explicit mention of health and social care integration, and effective working with social care.
- Request for inclusion of some patient stories to illustrate the proposed changes more clearly.
- Lots of examples of good practice, where services are already moving towards the sorts of models set out in the paper.
- Strong support for the emphasis on assessment and senior decision makers.
- Strong support for the focus on multi-morbidity
- The need to make sure that the service models recognise the different needs and approaches required for frail elderly patients, and younger patients with multiple chronic diseases.
- Respondents were keen to see the approach tried out before it is fully implemented, particularly to test out the affordability of the model.
- An appreciation of the level of engagement so far, and a request for reassurance that all parties will be involved in working through the details to understand the implications and the detailed models.
- An emphasis on the need for increased engagement and involvement of social care going forward, particularly to consider the interrelationship with the integrated health and social care agenda.
- Patients were keen to stay involved with and informed about the process

6.7 The comments received were incorporated into the final version of the Service Models paper which forms the basis of this clinical strategy. The detail of the outputs of the service models work is set out later in this paper but it is particular important to highlight a number of key consistent themes.

6.7.1 Equalities

- In addition to this, future service models will have to support NHSGGC to comply with its duties under the Equality Act 2010 to remove discrimination, close the health gap as a consequence of poverty and social class, and address the needs of marginalised groups.

6.7.2 Overarching principles

- Focus on what care the patient needs
  - care provided based on need and individual circumstance
  - care delivered in the best way
- Focus on improving clinical outcomes and delivering a good patient and carer experience.
- Locally accessible on an outpatient / ambulatory care basis where possible
- In-patient care only where necessary.
- Low volume and high complexity care provided in defined units equipped to meet specialist care needs.
- Consistently meeting core standards of care: patients should be able to access the same standard of care wherever they are in Greater Glasgow and Clyde.
- Continually evolving to ensure the most appropriate treatment / intervention is offered.
- Care should be focused on reducing inequalities by ensuring access for the most disadvantaged
- Services should be provided in a non-discriminatory manner
- Supporting patients to have the best health possible.
- Research should be strongly supported and fostered.
- Services should be sustainable, both clinically and financially.

6.7.3 Issues for patients

- Concern about lack of joined up care, particularly for those with multiple conditions receiving support from different teams across primary care, community services and hospital outpatients and / or inpatients.
- Lack of communication between teams and with patients
- A desire to be able to manage conditions better themselves, with appropriate support
- The need for patients and carers to be valued as partners in care
- The importance of access to services, in terms of both time and physical location
- A broad range of issues impacting on people's health and ability to benefit from services, including the impact of the recession and welfare reform
- The challenge of ensuring that changes to services add up to real benefits for
- individual patients

6.7.4 The following comments reflect a view of what success would look like from a patient perspective:

"I know who the main person in charge of my care is. I have one first point of contact. They understand both me and my condition."

"The professionals involved with me talk to each other. I can see that they work as a team."

"There are no big gaps between seeing the doctor, going for tests and getting the results."

"I am as involved in decision making as I wish to be."

"I understand my condition and am supported to manage my care."

"Having someone identified to help coordinate my care is important."

"Understanding who can help and support me, not just with my clinical care, is important."

"Receiving care in a specialist unit is fine as long as I can access local services for follow up and advice."

7. FRAIL ELDERLY AND CHRONIC DISEASE

7.1 Core Elements of Service Models

7.1.1 There is significant overlap in the models emerging for frail elderly patients, and for those with chronic diseases. However, there are also areas where a dedicated focus on frailty, distinct from single or multiple long term conditions, is essential. And there is a clear group of younger patients, particularly in deprived areas, who experience multiple long term conditions long before they would be defined as 'older'. The common approaches and specific requirements are set out below, followed by the areas where separate emphasis or approach is required.

7.1.2 The evidence suggests that getting the basics right – integrated, multifaceted and coordinated primary, secondary and social care are much more important than any single tool approach. The following interventions are supported by consistent evidence

(http://library.nhsgg.org.uk) and should be linked into a coherent whole as part of a future strategic approach to change in NHSGGC:

- Shared, high-quality protocols across care settings
- Collaborative relationships between specialists and generalists
- Planned systems of collaborative care involving case management, systematic follow-up
- Improved integration of primary and secondary care
- High quality primary care
- Effective coordination of care and use of IT to support communication
- Effective self management/supported self care
- Multi-professional teams
- Explicit care planning
- information sharing with patients and among care providers
- Reliable methodology and application of risk stratification
- Ensuring that all health professionals ask about diet, smoking and physical activity in their consultations with patients
- Ensuring that all health professionals can direct people towards appropriate computerised decision support tools to ensure coherent protocols available and used by clinical staff
- Use of a range of professional specialists nurses (e.g. Specialist nursing has demonstrable benefits for asthma, COPD and heart failure and may be replicable for analogous long term conditions).

7.1.3 The core elements of the service model to deliver this include:

- **Anticipatory care planning** enables patients and professionals to plan for a change in health or social status, particularly for those at high risk of crisis.

  Plans need to be developed by multi-disciplinary teams including primary care, community services and hospital specialists.

  Successful implementation of plans require the ability to mobilise a wide range of support in community, including home care, aids and adaptations, housing, befriending and carer support in a timely manner, based on a 7 day model that can also support care in the evening and overnight.

- **High Quality Primary Care** Age and chronic diseases represent a significant proportion of patient contacts in primary care, and the majority of care is managed in a primary care setting. General practice and the services it connects to are critical to a focus on prevention, management of risk factors and continuity of care for those with long term conditions.

- **Front door assessment model** will require early comprehensive assessment with senior decision makers at the front door, identifying specialist input and appropriate management plans guiding treatment and care packages in all settings, to support chronic disease management and / or frailty.

- **Non-acute beds may have a place as alternative to admission or to enable step down care** – this model requires a smaller ‘acute’ element of care with more non-acute and community infrastructure. The non acute beds would need to have rigorous standards for patient throughput and clear outcomes. Further work is required to define this approach.

- **Managing multi-morbidity** -better integration of services across specialties within hospital, between hospital and the community, and between health and social services are crucial to the management of multi morbidity.

- **Inpatient Care focused on acute episode of care, with planning for rehabilitation and return home** – ensuring rehabilitation is available dependent on need not age, focused on ensuring return home at the earliest opportunity by supporting rehab care in the community.

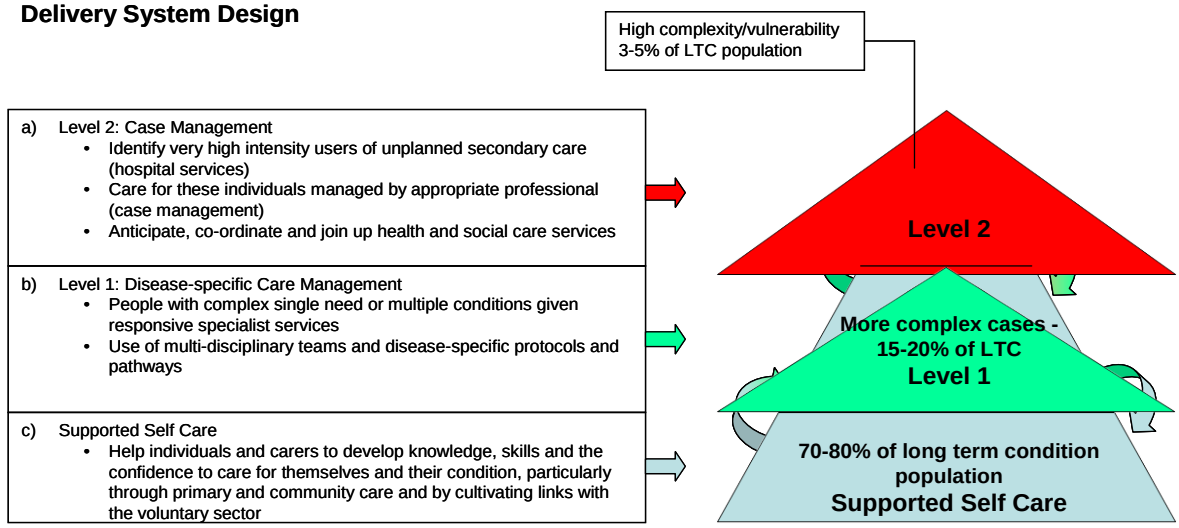
7.1.4 These are considered in more detail below in relation to both Chronic Disease and Frail Elderly pathways.

7.2 Chronic Disease

7.2.1 Overall approach

The proposed approach is based on risk stratifying the population by complexity and vulnerability, and providing care accordingly:

Figure 5



The key building blocks to support these models are listed below. A number of these are already in place, however the challenge is to ensure that they are consistently in place across the system, based on a 24/7 model, addressing the timing and volume issues currently facing many of these services.

Tailored Care - Care assistant - Physiotherapist/ OT - District Nurse - Community Pharmacy - Advanced Nurse Practitioner (generic) - Specialty Liaison Nurse - GP - Hospital Physician - Clinical Psychologist	**Advice** - Expert patient - GP - Nurse Specialist - Hospital Specialist - Acute Physician - Specialty Physician
	Access to Hospital facilities and outpatients
	Intermediate care
	Out of hours advice and assessment - Nurse provided - Expert Patient - 'Buddy system
Communication: Portal; e referral / direct referral	

These services need to work together effectively to provide both routine care, and to escalate support in response to a crisis or significant change in condition. These pathways are shown below at figures 6 and 7.

Fig 6: Chronic Disease Routine Care

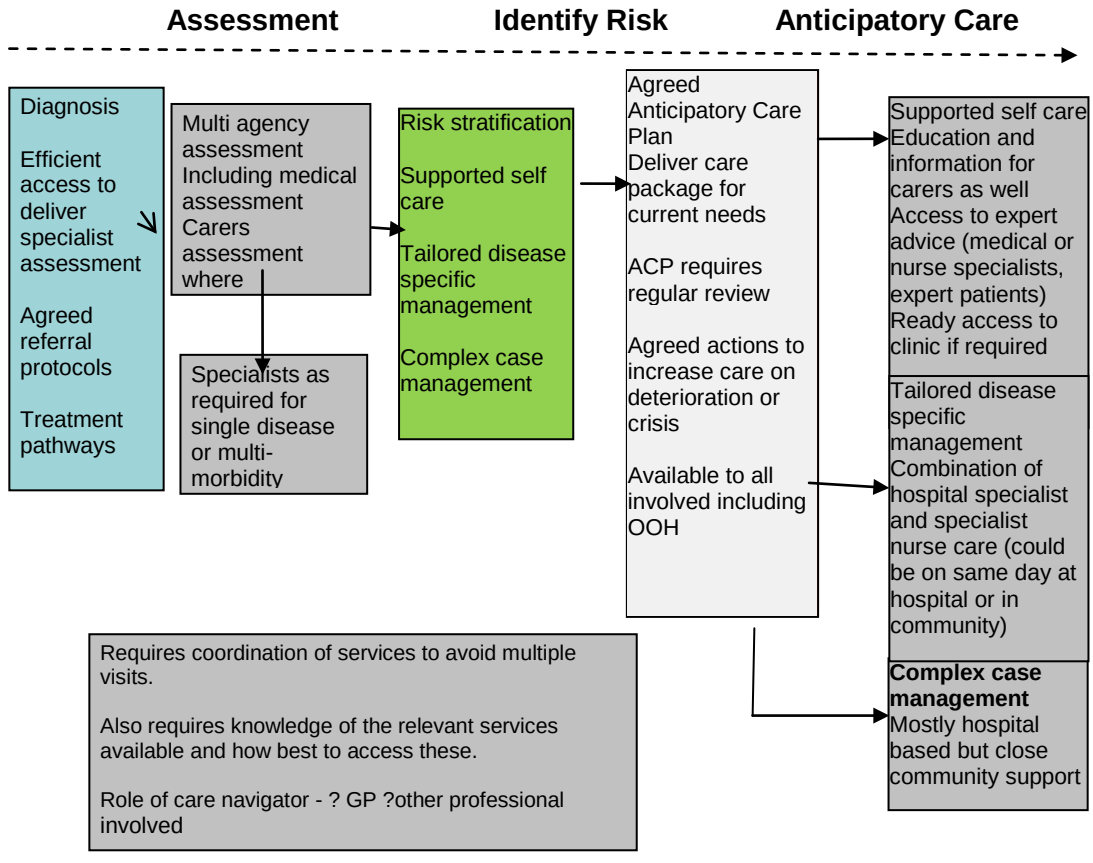
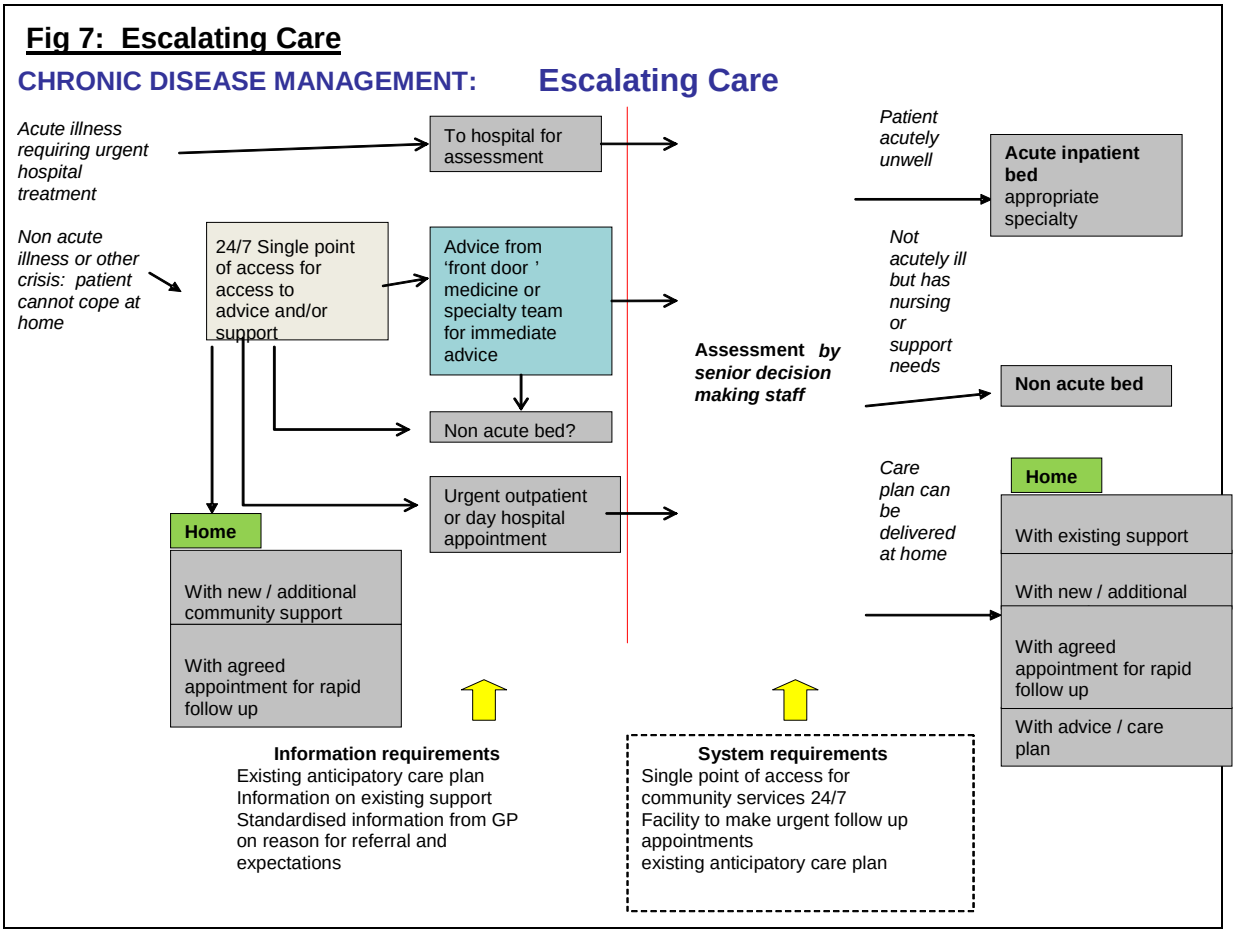


Fig 7: Escalating Care



7.2.2 Anticipatory care

A clear and responsive anticipatory care plan, which follows the patient and informs care in all settings, is a core part of this approach. While anticipatory care planning has been in development in NHSGGC in recent years, it is not yet a systematic multi-disciplinary approach focusing on those who would most benefit.

The agreed definition of anticipatory care in MHSGGC is "An integrated programme of defined preventive interventions delivered to individuals, operating across the continuum of primary, secondary and tertiary prevention. Its overall aim is to shift focus of service provision from reactive to preventive care, by adopting a whole population perspective across all aspects of service planning and delivery"

Anticipatory care planning is, by definition, planning of the above. It can be considered at an individual or population level. In both cases, it involves planning appropriate interventions that are i) evidence based; ii) connected to other interventions and services; and iii) applied across the entire continuum of disease, not just the latest stages.

Anticipatory care planning should be undertaken as early as possible – needs to start with diagnosis. Effective interventions relevant to that patient's needs should be delivered across the anticipatory care continuum, from primary prevention to end of life care. At each point along the continuum of primary, secondary and tertiary prevention, the objective is to control the underlying condition and prevent or delay progression of disease. Each stage of intervention in this process has a preventive component, a clinical management component and a self care component.

Health related behaviours, life circumstances and psychosocial factors all play an equally important role at each stage, not solely in primary prevention.

There are some good existing examples within NHSGGC of effective anticipatory care planning, including:

The Heart Failure Liaison Nurse Service cares for a well defined population of patients with chronic heart failure. These are referred from hospital and risk stratified to community or clinic care by the HFLNS. The HFL nurse will communicate with both the GP and the cardiologist about aspects of the care.

We would seek to roll out models such as this across GGC.

7.2.3 Multi morbidity

Developing better approaches to multi-morbidity has been a key theme of this Clinical Services Review. Within the pathways described above, the following elements will need to be developed further to establish a better approach to multi-morbidity:

- Continuing the work on QOF and Enhanced Services within primary care to bring together the management of different chronic diseases into a combined approach focusing on individual patient needs.

- Developing a better 'combined approach' to providing specialist input where patients are currently attending multiple outpatient clinics. This would focus on co-ordinating investigations, treatment and management so that any specialist input is managed in the context of the whole person and their environment not just narrow disease specific guidelines. This could be done through:

    - Shared clinics where there are common co-morbidities
    - Access to additional specialist input at chronic disease clinics (for example, specialist nurse input)
    - Improved access for GPs to specialist advice and opinion.

- Development of care navigator or case management roles to co-ordinate care and minimise visits and duplication, as well as improving co-ordination In some cases, this could be the GP, district nurse or specialist nurse as long as some form of designation occurs. There may be a need for another individual or care navigator in complicated cases. As with anticipatory care planning case management has been in development in NHSGGC in recent years, but is not as yet systematically in place focusing on those who would most benefit.

- Improving the identification and management of co-morbidities in emergency and inpatient settings. Co-morbidities are often a major reason for prolonged stays in hospital. Early generalist assessment to establish a comprehensive treatment and care plan for an individual will support better management of co-morbidities. Where a patient's care is transferred to a specific single condition specialist, we need to find better ways to enable input from generalist and / or other specialist, including the patient's general practitioner.

- Polypharmacy is often associated with multi-morbidity and carries with it a number of risks to patients. Medication reviews should be available on a regular basis to all

patients experiencing polypharmacy, and should be triggered by any acute or emergency episode of care.

- We know that multi-morbidity occurs is strongly linked to deprivation, occurring 10-15 years earlier in areas of high deprivation and encompassing both physical and mental health. Approaches to multi-morbidity therefore need to take account of a range of wider complex and challenging life circumstances which may act as barriers to patients' participation in new service models. Approaches to multi morbidity also need to focus on the changes in practice and behaviour required to take account of this.
- Multi-morbidity is a particular feature of patient contact in primary care, and we need to ensure that there is both sufficient capacity and support for effective approaches to managing multi-morbidity in a primary care setting, learning from current research activity in this area.

Illustration: for a patient, moving to the new model of care described might look like this:
Patient story

58 year old woman with diabetes, hypertension, chronic kidney disease and rheumatoid arthritis, is overweight and smokes and is unable to work.

Now: Has frequent appointments at hospital diabetic clinic, GP chronic disease reviews, podiatrist, renal clinic, hypertension clinic, rheumatology clinic. Frequent DNA because forgets appointments, doesn't see the point or doesn't have the bus fare to get there. This results in several acute admissions per year.

Future: Risk stratification flags up patient as high risk due to multi-morbidity; case review highlights multiple teams involved in care – case manager identified to develop a co-ordinated care plan involving the GP and appropriate specialists. Routine outpatient review minimized and clear triggers in place for return. Targeted support put in place and advice on diet and weight loss, smoking and benefits maximisation.

7.3 Frail Elderly

7.3.1 Overview

The older people group focused on 'frailty' as distinct from older people with other single conditions or multiple chronic diseases, with no additional functional problems. This reflects the fact that older people are cared for across all services, that amongst older people there is wide variety in terms of health and function, and that treatment should be needs based and not age based.

The main premise of the group is that specialist geriatric input should be focused on the frail elderly or those with 'frailty syndromes'. Stroke pathways are described in section 7.

What is frailty?

Frailty can be defined as a syndrome of multi-system reduction in physical capacity as t result of which an older person's function may be severely compromised by min environmental challenges, giving rise to the condition of 'unstable disability'.

Older people tend to present to clinicians with non-specific presentations or frailty syndrome

in contrast to the classical presentations seen in younger people. The reasons behind the nc specific presentations include the presence of multiple co-morbidities, disability a communication barriers. The ability to recognise and interpret non-specific syndromes is ke as they are markers of poor outcomes:

- ***Falls***
- ***Immobility***
- ***Delirium and dementia***
- ***Polypharmacy***
- ***Incontinence***
- ***End of life care***

These indicators should be the basis of simple assessment tools adapted to all settings – community, hospital 'front door' and inpatient.

The core pathways and components of care for frail elderly are set out in the diagrams below (figures 8-10):

Figure 8: Community support

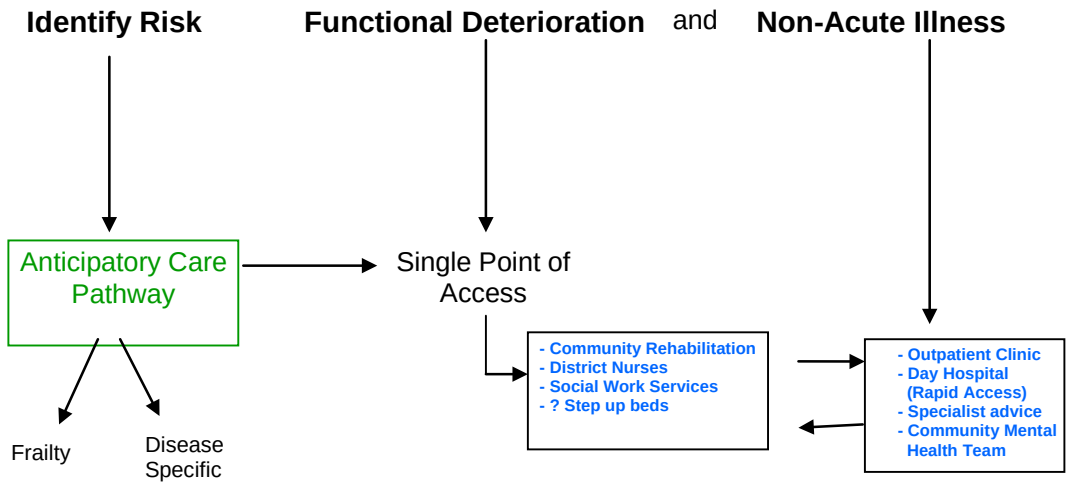


Illustration: For a patient, moving to the new model of care described might look like this:

Patient story

80 year old man with mild dementia and mobility problems, lives alone, has daily home care visits. Daughter lives 10 miles away, works full time and has small children but tries to visit several evenings a week.

Arrives one evening to find her father has an upset stomach and has been unable to get to the toilet quickly enough, and has fallen.

Now: Daughter unsure of where to get help, so phones NHS24. GP arrives, suggests admission to hospital. Patient admitted, investigated and treated for stomach bug. Confusion increases in strange environment, and mobility decreases as he stays in bed until his stomach is better. Stays in hospital for several weeks and now doubt about return home.

Future: Patient has been identified at risk due to mobility issues, dementia and living alone and has anticipatory care plan, informed by Comprehensive Geriatric Assessment, which sets out steps to take if he is ill or needs additional support. Daughter is able to see on the plan who to contact. Crisis team responds quickly, assesses father and helps to clean up and get him to bed. Arrangements made for GP to visit in the morning. Additional support put in place for a few days to ensure he is drinking enough and to support mobility until he is better. Care needs are reassessed and patient is given an alarm and increased support, with planned ongoing review.

Figure 9: Front door/hospital pathway

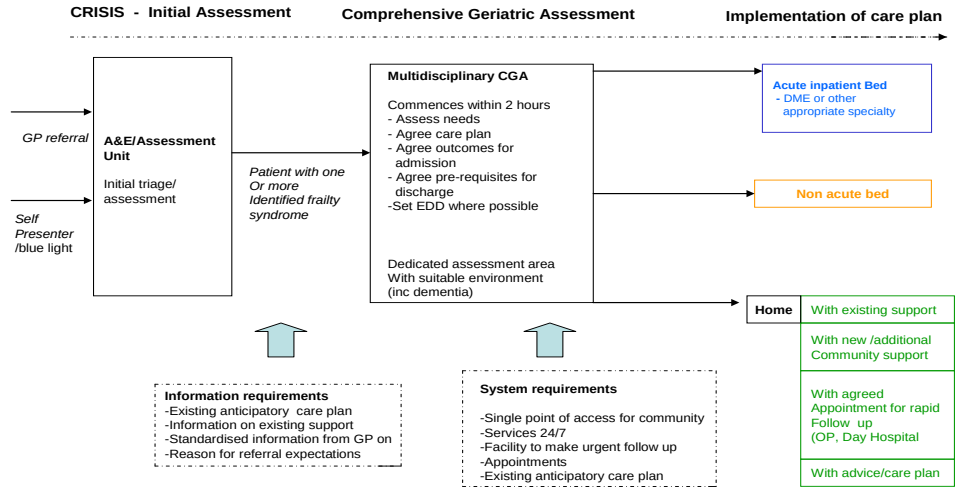
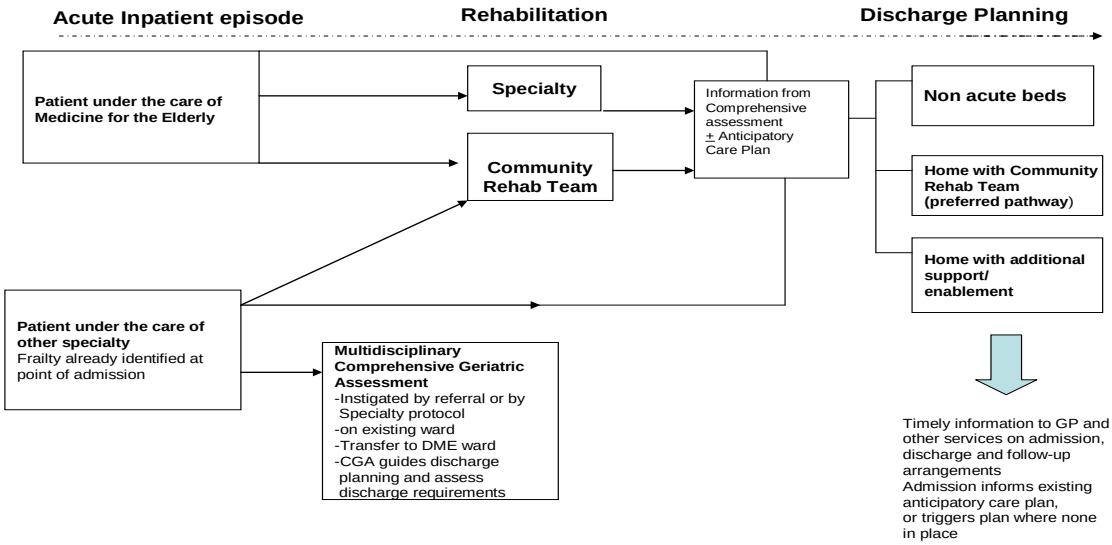


Figure 10: Inpatient Pathway (Frailty)



7.3.2 Anticipatory care

Anticipatory care plans must include frailty as well as chronic disease management. This includes consideration of social care needs, carer support, isolation, function and ability to manage the activities of daily living, supported by the multi agency single shared assessment process. It should explicitly include consideration of options for when carers are unwell or unable to provide support for any reason. The plans must enable rapid escalation of support from health, social care and third sector agencies supported by a 24/7 single point of access.

7.3.3 Comprehensive Geriatric Assessment (CGA)

CGA is strongly evidence based and drives the model for frail elderly. The pathways set out above enable CGA to be carried out in a community setting with specialist input through geriatric outpatients and day hospital services, and in acute settings with the presence of senior geriatric specialists at the front door.

Figure 11: The evidence base for comprehensive geriatric assessment

There is robust evidence to support multidimensional assessment and multi-agency management of older people leading to better outcomes, including reduced readmissions, reduced long term care, greater satisfaction and lower costs.

Comprehensive Geriatric Assessment (CGA) is defined as 'a multidimensional, interdisciplinary diagnostic process to determine the medical, psychological, and functional capabilities of a frail older person in order to develop a coordinated and integrated plan for treatment and long-term follow-up'.

While integrating standard medical diagnostic evaluation, CGA emphasises a quality of life and functional status, prognosis, and outcome that entails a workup of more depth and breadth. The hallmarks of CGA are the employment of interdisciplinary teams and the use of standardised instruments to evaluate function, impairment, and social support.

Comprehensive Geriatric Assessment should be available to patients with one or more identified frailty syndrome within 2 hours of A&E attendance (14 hours overnight) and should drive the treatment and care plan both within hospital and in the community. CGA needs to be available within the community, at the hospital front door and in inpatient settings. It is a key requirement that information which may inform CGA, and the outcome of the assessment, is passed through the system consistently and is easily accessible and useable in a fast paced environment.

Delivering CGA in an emergency environment is challenging, and will require access to a separate quieter area (such as a medical assessment unit) with an appropriate environment.

Patients who have been admitted as inpatients (either emergency or elective) to any specialty, may subsequently exhibit frailty syndromes and require access to Comprehensive Geriatric Assessment. This should be available in all settings and specialties, as an assessment which drives a care or discharge plan, or to consider the appropriateness of transfer to specialist Geriatrics.

Figure 12: Falls

Falls are a common trigger of an emergency episode, and a key indicator of frailty. Falls must be a core part of broader approaches to risk assessment and care planning. This approach should include the following components, with timescales in line with the National Falls Bundles:

- Primary prevention based on falls assessment as part of general frailty assessment and anticipatory care planning, including self assessment
- Secondary prevention based on rapid notification of falls in both community and inpatient settings, leading to:
  - Falls assessment as part of more comprehensive frailty assessment
  - Individualised plan agreed with patient and actioned within 6 weeks. The plan should cover a range of interventions to prevent future falls taking account of related clinical needs, mobility issues, home and social environment and medication.
- Inpatient treatment where required (e.g. fracture) with access to Comprehensive Geriatric Assessment 7 days a week for Orthopaedic patients.
- Rehabilitation. Transfer to Geriatric Orthopaedic Rehabilitation Unit where appropriate. Multi-disciplinary discharge planning and discharge to community rehab teams for ongoing falls assessment and intervention.

Review and follow up. Review of plan within 6 months of commencement to update or close the plan

7.4 Dementia

Dementia is a syndrome caused by a number of illnesses in which there is a progressive functional decline in memory, reasoning, communication skills and the ability to carry out daily activities. It is increasingly present in patients presenting for a range of other health needs. Alongside this decline, individuals may also develop behavioural and psychological symptoms such as depression, psychosis, aggression and wandering. These cause problems in themselves, complicate care, and can occur at any stage of the illness. Dementia was reviewed jointly by the Older People and Mental Health groups and is considered further in section 8, but assessment and response to dementia and associated symptoms must be a core part of assessment throughout the older people's pathways described above, in all settings of ca

7.5 Implementation challenges for this model

- Defining the alternative models to admission such as advice service to support patients in the community non-acute beds to enable step down care considering the how this might impact to create a smaller 'acute' element of care with more non-acute and community infrastructure. This will require further definition of categories of 'non-acute' patients and support required including the risk of change and deterioration in patients, level of nursing care required and any ongoing diagnostic requirements.

- Front door model – general assessment with quick access to specialist care for treatment where required and the staffing model to support.

- Sizing the different groups and input required, for example likely numbers with frailty syndromes will drive front door geriatric staffing model. This will be based on assessment of known demographic changes, assumptions re potential for avoiding admissions, and an assessment of the current proportion of admissions with frailty syndromes.

- Work to assess further potential for home based rehabilitation / re-ablement.

- Particular consideration needs to be given to end of life care and supporting alternatives to acute hospital admission, particularly where patients wish to die at home or supported in a community setting (see figure 13).

Figure.13: End of Life Care

A key group where acute admission may not be desirable is for end of life care. The approach to palliative and end of life care should be based on:

- Palliative care needs being identified as soon as possible with more effective use of the **Gold Standards Framework** (GSF) in primary care, the use of the **Support and Palliative Care Indicators Tool** (SPICT) in in/outpatient settings and the use of the **Support and Palliative Action Register** (SPAR) in care home/continuing care settings. This would allow appropriate, timely engagement in the process of **Anticipatory Care Planning** (ACP).
- Ongoing holistic assessment being undertaken by professionals with good communications skills and a knowledge and understanding of the disease process, likely symptomatic issues and an appreciation of where these needs could be met, in order that the ACP process can be engaged with in a realistic way by the patient and family. This may be the GP, District Nurse, Consultant, disease specific specialist nurse, ward staff, care home staff or any of this combination in partnership.
- Effective communication of priorities of care. Conversations could be initiated using the My Thinking Ahead and Making Plans (MTA&MP) communication tool and further details placed on **Key Information Summary** (KIS) or the **electronic Palliative Care Summary** (ePCS) which can be accessed by unscheduled care areas, the Out of Hours Services and the Scottish Ambulance Service.

The preferred place of care is influenced by many factors. Options should include:

- **Care at home**, with the facility for patients to be assessed at any time in a 24hour period with rapid access rehabilitation teams, increased home care provision or equipment. The need for an appropriately skilled, well coordinated multi agency service in the community with effective communication systems is essential to this.

- Patients, who need less acute interventions sometimes simply observed care, may be suitable for rapid admission to **non acute bed**.

- There will be an ongoing need for Acute Admission for patients with symptom issues that cannot be managed at home. There is also a need for a “wider team” (or “virtual team”) assessment of patients on admission

so that their palliative care needs are assessed promptly, their co-morbidities are taken into account and prioritised and a plan is made for that individual based on the above assessment. This could include referring patient immediately for Hospice admission or being able to get the patient home with enhanced community care.

- Rapid access to **hospice beds** for assessment, complex symptom control and end of life care may be appropriate for those with more complex care needs, not needing or wishing admission to an acute bed.

7.6 Mental Health

7.6.1 Introduction

The mental health clinical groups focused on the models of care required for:

- Adult Mental Health
- Dementia
- Drug and Alcohol Services

The overall approach which applies across these services is set out below, with condition specific examples given where appropriate.

7.6.2 Overview of the approach

The purpose of prevention, treatment and care activity in mental health is to deliver health outcomes, a positive user and carer experience from contact with services, and to contribute to user's progress towards recovery/living well with their illness.

Achievement of that purpose requires:

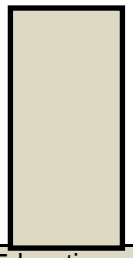
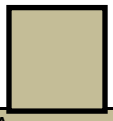
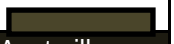
- A needs led structure of service delivery based on condition and frailty
- Interventions which are organised and delivered by condition
- Levels of intervention determined by the intensity and severity of the condition
- Interventions which are systematically delivered based on agreed condition specific care pathways consistent with evidence based/ best practice standards
- Users to be able to see their place on the care pathway
- Operational and team processes, practice, culture and pathways within and between teams which are organised and delivered to ensure:
    - Clinical interventions are systematically delivered based on the condition specific care pathways
    - Positive user experience in which carers and users are partners in care and feel well supported
    - Services are "easy in and easy out"
    - Interventions provide "everything you need and nothing more"
    - Patients with multiple morbidities receive coordinated rather than fragmented care
    - Care planning supports personal outcome based progress towards recovery/living well with the condition

7.6.3 Clinical framework for prevention, treatment and care

As with the approach described for physical chronic conditions, the overall approach is based on a stratified system of care, identifying need and responding at the most appropriate level of intensity.

The diagram (figure 17) below describes the overarching framework for mental health services. The Framework will be populated for each major clinical condition to set out the condition specific interventions and care pathway for that condition.

Figure 17

Numbers					
Need for help	Education and promotion of well being Targeted prevention for groups at risk	Anyone concerned about their own health or other peoples health	A prompt response for people who develop symptoms associated with a condition	Progress towards recovery whilst living with ongoing mental health problems	Acute illness
Type of Intervention	Information, screening, self-help	Education, self-help, peer support, group classes	"Low intensity" work: brief interventions, psychological therapies, guided self-help	Longer-term psychological therapies; community rehabilitation;	Risk management, physical health care
Access	Everyone	Open, self-referral	Self-referral and GP referral	GP or secondary care referral	GP or secondary care referral
Care level	Public	Open access /supported self care	ERBI: early response, brief intervention	Ongoing care and support	Intensive treatment

7.6.4 Personal outcomes for service users and carers

In their contact with services Service Users can expect:

- To define recovery goals together with the service
- Services support progress towards recovery /living well with their condition

People with mental health problems should be able to say that they have a positive experience of their contact with services and through this contact:

- I get the treatment and support I need when I need it
- Accessing services is straightforward
- I was diagnosed early
- I & those around me and looking after me feel well supported
- I am actively involved in decisions about my care
- I am treated with dignity and respect
- My care plan focuses on my recovery as I have defined it
- I have meaningful occupational interests and social involvement

7.6.5 Changes required to deliver the model

Moving towards this model will require the following changes:

1. Cease age based exclusions from access to service supports such as psychological interventions/crisis services and liaison psychiatry.

2. Shift from age based service configuration of adult and older people mental health services to needs based configuration of:

    - Mental Health 18+ (no upper age cut off, needs led transition based on physical frailty).
    - Dementia and Functional mental health combined with physical frailty service.

3. Consideration of service models for people with dementia given apparent commonality of health needs of people in acute wards and Older People Mental Health acute wards.

4. Address service gaps within the dementia care pathway:

    - Memory assessment service for early diagnosis of 2300 new patients per year in community setting.
    - Post diagnostic support services.

5. Review the functionality of services and teams to ensure their detailed operational processes are aligned to deliver the principles set out in sections 3, 4 & 5 above & in particular:

    - Systematic interventions of agreed condition specific care pathways.
    - Health outcomes.
    - Positive user and carer experience.
    - Recovery/living well with your condition.
    - “Easy in easy out”.
    - Coordinated management of multiple morbidities.

7.6.6 Implementation challenges for this model

Mental Health 18+

- Components of comprehensive service system are in place and no major service gaps per se
- Modest incremental further acute bed closures/balance of care shifts.

- Need to scope & size operational implications of shift to 18+ service for inpatient and community services.
- Review functionality of teams & operational processes to deliver the principles of the model, systematic delivery of clinical framework and condition specific care pathways, & personal outcomes for service users and carers.

Dementia services

Resolve service model and relationships between mainstream acute and specialist dementia services to determine:

- Configuration of dementia services as integrated mainstream acute service or specialist dementia service.
- Size the dementia cohort and the challenging behaviour cohort to model workload implications of the configuration options for both acute and community services.
- Rework the bed model and site alignments between acute and MH sites to reflect the eventual agreed model and configuration of dementia services.
- Develop detailed service model and configuration of community based memory assessment services & post diagnostic support services.
- Review functionality of teams & operational processes to deliver the principles of the model, systematic delivery of clinical framework and condition specific care pathways, & personal outcomes for service users and carers.

Drug and alcohol services

- Improve management of co morbidity between addictions and MH.
- Improve alignment between day services and community services.
- Improve access and support to substitute prescribing.
- Improve alignment of operational processes and recovery outcomes for service users.
- Review functionality of teams & operational processes to deliver the principles of the model, systematic delivery of clinical framework and condition specific care pathways, & personal outcomes for service users and carers.

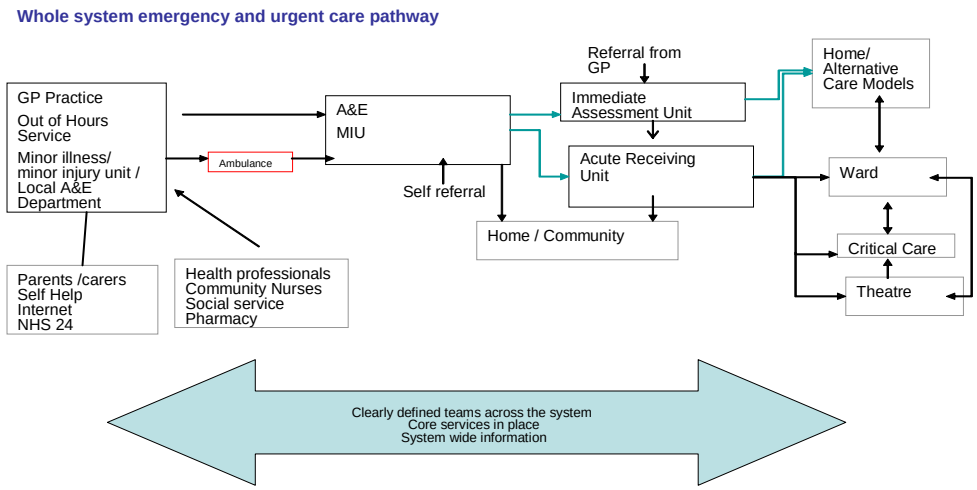
8. EMERGENCY CARE AND TRAUMA

8.1 Overview

Emergency services have to be able to respond appropriately to all patients who present. This section describes the proposed overall model for emergency services to meet standards and requirements for all patients and the changes to emergency services required to respond to the chronic disease and frailty pathways set out above (which form the majority of emergency admissions).

The overall pathway is summarised in the following diagram

Figure 14: Whole system emergency and urgent care pathway



8.2 Accessing emergency care

The key routes in to emergency care are set out below.

In-hours patients may:

- Call GP for an emergency appointment
- Call NHS 24 for advice and onward referral as appropriate
- Call other community service for an emergency appointment (e.g. Dental, Ophthalmology; Mental Health)
- Go to their pharmacy
- Call the Scottish Ambulance Service – who may treat on site, take to the Emergency Department or refer to another service (e.g. GP)
- Go directly to the Emergency Department/Minor Injury Units

Out of Hours patient may:

- Call NHS24 for advice with onward referral as appropriate and may be offered either GP OOH telephone advice, GP Out of Hours appointment; Minor Injury Unit or Emergency Department.
- Patients may choose to go directly to Minor Injury Unit, Emergency Department or walk-in to the GP Out of Hours service.
- Call the Scottish Ambulance Service – who may treat on site, take to the Emergency Department or refer to another service (e.g. GP)
- Call the Out of Hours District Nursing Service or other Community Services

8.3 Response to emergency assessment in all settings

When a patient is assessed in an emergency at any of the entry points above, a more flexible range of responses is required. A number of studies support the position that a much greater proportion of work could be undertaken as an outpatient or in an ambulatory setting including many acute medical emergencies. This requires our services to develop a

more “planned” urgent clinic approach to manage medical emergencies. Some examples are set out below:

Figure 15

Respiratory	Cardiology	Gastroenterology
- Community acquired pneumonia with a low CURB-65 score - Small pneumothorax - Asthma following British Thoracic Society guidance - Chronic obstructive pulmonary disease with supported home care - Asymptomatic pleural effusion	- Cardiac failure - Atrial fibrillation	- Upper gastro intestinal bleed with Rockall score of 0 - Lower gastro intestinal bleed with no haemodynamic compromise - Painless obstructive jaundice - Non-acute abdominal pain - Diarrhoea and vomiting
Endocrinology	**Infectious Diseases**	**General Medicine**
- Hyperglycaemia without ketosis - Hypoglycaemia with full recovery - Type 1 diabetes without ketosis - Electrolyte imbalances	- Cellulitis - Osteomyelitis	- DVT - Pulmonary embolism - Anaemia with no haemodynamic compromise - Syncope with low cardiac risk - Urinary tract infection

Based on the above position a number of services to support ambulatory emergency care are identified. These could be services that sit as part of the interface service model.

- Chronic obstructive pulmonary disease outreach
- Pleural disease clinics
- Rapid access chest pain clinics
- Transient ischaemic attack /stroke clinics
- Epilepsy clinic
- Pain management service
- Functional assessment teams and support teams
- Falls clinic
- Nurse specialists - diabetes, cancer, palliative care etc.
- Outpatient parenteral antibiotic teams
- Endoscopy services
- Heart failure team

A pre-requisite to changing how urgent and emergency care is provided is to ensure that there is quick and reliable access to GP appointments. This will allow patients to connect into the relevant services through their GP thus supporting patients accessing care in the right place at the earliest appropriate opportunity.

For most patients, the GP practice will be the first port of call for help or advice. Moving forward, we need to ensure that we have the right capacity in primary care to provide timely access to appointments for those who need to see a GP, and to build on the work of the access toolkit and productive general practice to provide a range of options for patients, including telephone advice where appropriate. This includes supporting GPs to free up

appointments by understanding and addressing the growing demand on primary care from multiple sources.

In addition to the disease specific approaches set out above, additional support to manage patients appropriately in the community could be provided through:

- Urgent access to specialist advice, for GPs to be able to discuss patients in an emergency situation.
- Urgent access to outpatient clinics (e.g. within 24 hours), directly bookable, where an immediate admission is not required.
- Single point of access to health and social care community services to provide immediate support at home where required.
- Access to step up beds where a patient requires additional support which cannot be provided at home, but does not require an acute admission.

It is also important that all services where people present as emergencies, work to the same common protocols with access to a consistent range of support services across GGC to ensure there is equity of access to care and that care is not escalated beyond the lowest level required.

To support this it will be important that all parts of the system can access the information about the patient, their ongoing care, e.g. their anticipatory care plan where applicable, to ensure the right intervention can occur.

8.4 Hospital Assessment and Admission

Once at hospital it is important to have clear patient pathways through each of the services. The major components of hospital emergency services are described below:

- Minor Injury Service
- Emergency Department
- Immediate Assessment Unit
- Acute Receiving Unit

8.4.1 Minor Injury Service

Nurse led Minor Injury Service led by Emergency Nurse Practitioners (ENPs) to provide treatment for a wide range of conditions including:

- Fractures of nose, shoulder, upper arm, elbow, forearm, wrist, hand (inc. fingers), knee, lower leg, ankle, foot and toes.
- Soft tissue injury including strains and sprains.
- Dislocations.
- Wounds.
- Burns.
- Minor head and neck injuries.
- Eye injuries and conditions.

This may be provided as part of a standalone Minor Injury Unit, or as an integral part of the Emergency Department, where the ENPs will work with medical staff as part of the wider emergency team.

8.4.2 Emergency Department

The Emergency Department provides care to patients with:

- Acute injury or illness associated with physiological derangement or threats to life or limb
- Acute undiagnosed illness or injury that requires time critical intervention to prevent long term impairment, disability or death
- Acute illness or injury resulting in acute severe pain until once made comfortable, they can have appropriate investigations or additional treatment before being directed to definitive care.

The Emergency Department does not provide services for:

- Minor non-urgent illnesses that can be better managed in a non time critical manner by other community or primary care services both in and out of hours
- Non acute exacerbations of chronic conditions that are under the management of specialist inpatient or outpatient services
- Non acute complications, enquiries or requests for advice following elective surgical procedures (including urology, orthopaedics, ENT, maxillofacial surgery, obstetrics and gynaecology etc).

The key role of the Emergency Department is to assess and treat quickly, and ensure that patients receive care in the most appropriate setting. Destinations from the Emergency Department will include home, home with community support which can be arranged directly from the Emergency Department, move to the Immediate Assessment Unit for a further assessment period, or admission to the Acute Receiving Unit.

8.4.3 Immediate Assessment Unit

GP referred patients will go directly to the Immediate Assessment Unit (IAU). The purpose of the unit is to provide rapid assessment of patients by senior decision makers.

The focus of the IAU will be to pursue appropriate alternatives to admission including: urgent out patient clinic appointments, rapid access to diagnostics, access to Comprehensive Geriatric Assessment by specialist multi disciplinary teams, initiating specialist care and opinion by the relevant specialty team and prioritising the timely admission of acute patients into the Acute Receiving Unit. Specific pathways will support patient management through this unit. Inter hospital transfers should not pass through Immediate Assessment Unit but should go directly to a specialty bed by agreement with the relevant specialty senior decision maker.

Care will be provided on a 24/7/365 basis. It is envisaged that the consultant input within the IAU for medicine will be predominantly from acute care physicians and the geriatric specialist team and will be supported by junior medical trainees and medical nurse practitioners.

The surgical model of care sees general surgery GP referrals, undiagnosed urology and undiagnosed vascular patients directed into the IAU.

The surgical receiving team under the control of the senior decision maker will provide opinion and admission or diagnostic decision making to the IAU 24 hours a day every day.

Orthopaedic, ENT and diagnosed vascular and urology patients should be directed from the Emergency Department for the relevant surgical specialist team to take the decision to discharge or admit to downstream wards or treatment facilities as appropriate.

It is proposed that all necessary imaging and diagnostic work is commenced in the IAU this should be available 24 hours a day 365 days a year; recognizing that these patients have the same diagnostic and imaging requirements as those within the ED.

8.4.4 Acute Receiving Unit

The Acute Receiving Unit (ARU) provides the initial period of acute management for patients assessed in the Emergency Department or Immediate Assessment Unit as requiring admission.

The ARU will enable senior decision makers to manage the patient's assessment with fast access to diagnostic tests and the ability to discharge home or for suitable patients for return to the emergency department outpatient department. The ability to care for patients in the ARU for periods over 24 hours will allow complex diagnostic investigations to be completed without the need to admit to a downstream ward. The aim is for all imaging of patients within the ARU to be completed whilst the patient is in ARU.

8.5 Principles and standards

8.5.1 For patients requiring attendance and or admission to hospital for emergency care the following principles and standards are proposed:

8.5.2 Principles

- Patients are managed in an area designated for their acuity of illness by a 'generalist' (this includes Emergency Department or Acute Care Physician, Care of the Elderly Physician, Intensive Care Medicine Physician or General Physician) with early input from a specialist where required to ensure the most effective treatment plans are put in place as quickly as possible
- Consistent standards of care are in place across the systems which maximise patient outcomes.
- Prompt commencement of time critical treatment.
- Prompt access to appropriate imaging (CT, U/S, plain radiography) to allow immediate diagnosis of life threatening conditions.
- Availability of appropriate critical care expertise and skills across the system.
- Early informed decision making regarding patient disposition.
- An extended presence of senior clinicians providing expert direct patient care, leadership and supervision.
- Timely, planned discharge to an appropriate setting and with appropriate support.

8.5.3 Process standards

- Emergency admissions should be seen promptly by someone who is appropriately trained to make an assessment of their care needs, and with prompt consultant input where required. The different needs of medical and surgical patients should be managed appropriately.
- The Assessment Unit approach is a core component of emergency care, providing protocolised periods of investigation, observation, and review for patients who would otherwise be admitted to scarce and expensive hospital beds or discharged potentially unsafely.

- Ambulatory care- care should be instigated in the Emergency Department / Immediate Assessment Unit / Acute Receiving Unit and continued in the community where clinically appropriate.
- A comprehensive 24-hour interventional radiology service should be available.
- To maximise patient outcomes, where specialist care is required, it should be provided by senior clinicians undertaking high volumes of cases/ operations in line with national guidelines.
- Emergency day case surgery should be available where clinically appropriate.
- Patients should be provided with any necessary care, treatment and support in the most appropriate setting and environment, compatible with the delivery of safe and effective care, including the community where appropriate.

8.5.4 Disease/condition specific standards

- Frail elderly patients should have early access to comprehensive geriatric assessment to support effective management.
- Appropriate and timeous access to mental health services should be in place for people with mental health needs.
- Patients suffering major trauma injuries should be taken directly to a major trauma centre.
- Patients suffering from chest pain should have timeous access to angiography services.
- Patients suffering from a stroke should be taken directly to a specialist centre (see figure 16)
- Acute hospitals providing care for patients with GI bleeding should meet the national recommendations and provide 7 days a week access to out-of-hours endoscopy services; within 1-2 hours of admission for severe bleeding and within 12 hours for moderate bleeding. Appropriate assessment systems should be in place in all sites, with appropriate care pathways in place to treat patients or to transfer patients to the appropriate site for definitive treatment.
- National guidelines should be met where available; for example in the care of patients with myocardial infarction, head injury, bleeding in early pregnancy, suicide prevention and child protection.

8.5.5 Diagnostics

- Underpinning the new models will be a heavy focus on access to diagnostics to support the assessment of patients. This will require changes to how the services are currently organised to support early investigation to support decision making without the need to admit patients to organise tests.

Illustration: for a patient, moving to the new model of care described might look like this:

Now: Present to A&E and is admitted to hospital

Future: assessed by a consultant, not acutely unwell requiring admission, sent home with an appointment for a diagnostic test the following day with an outpatient appointment. GP informed, community team informed where indicated. Patient has information on what to do if condition changes / warning signs to look for.

Figure 16: Example of future models: Stroke

- **Prevention:** Primary prevention and management of risk factors [Rapid assessment of high risk TIA patients within 1 day of referral. All GPs using rapid assessment service; cardiac and vascular services resourced to meet demand from stroke.

- **Hyper acute stroke service (HASS):** Scottish Ambulance Service take patients with FAST +ve suspected stroke directly to hospital with HASS beds; early specialist stroke team assessment; immediate imaging and investigations; treatment commenced (including thrombolysis where indicated); rehab commenced in HASS; 35% patients discharged home from HASS bed.

- **Integrated acute/rehab stroke unit:** transfer from HASS at average of 2.5 days post admission; 7 day stroke specialist Multi Disciplinary Team assessment and rehab (AHPs, nursing, medical); planning for discharge and support for carers; average length of stay in unit 21 days.

- **Early Supported Discharge within Community Stroke Team:** 6/7 day stroke specialist rehab; multiple visits per day to support early discharge from hospital; close links with re-ablement care services; time limited intervention with review/follow up.

- **Support in the Long Term:** local community and voluntary sector services with awareness of stroke; GP Enhanced Service for stroke.

8.6 Implementation challenges for this model

- How we can consistently support a model of the 'generalist' as first line approach supported by specialist rotas allowing timely intervention. It will also consider the implications of this model across Glasgow and Clyde in terms of:

    - Activity and patient flows
    - The staffing model of generalist and specialists required to support the model
    - Accommodation requirements to allow for the effective components of the models to manage patient flows as described.
    - Assessment / Decision Unit approach and availability of urgent outpatient service across GGC.
    - Contact system for GPs to discuss patients prior to referral to hospital.
    - Develop a more detailed position on key areas identified for a change in specialist approach:
        - Stroke
        - Angiography / angioplasty
        - GI bleeding
        - Vascular
    - Develop the major trauma centre in line with regional and national planning, considering the critical clinical adjacencies to support this.

9. PLANNED CARE

9.1 Key Components of the approach

9.1.1 Local provision of outpatient and ambulatory care facilities

It is proposed that wherever possible outpatients, investigations, day surgery and short stay surgery should be provided as locally as possible across NHS GGC. This would provide a full range of core clinical services locally to meet the majority of patient needs with patients travelling only where clinically required to other sites.

9.1.2 Outpatient model modernisation

Outpatient model of referral and attendance at outpatient clinic needs to be modernised to provide alternatives to clinic consultation. This should include telephone consultation, telephone advice services for GPs to manage patients without referral to hospital; direct to test approach where appropriate.

Return appointment models should be reviewed with the aim to reduce the return appointments where appropriate and to facilitate alternative follow-up arrangements where possible. This should include telephone follow up; discharge with patient driven return initiation. The recent cancer services group and the work on Quality Performance Indicators suggest that the follow up arrangements could be reduced. For chronic disease management, different approaches to ongoing management and follow-up are also being considered with both groups considering how community based follow –up and patient initiated follow up could be part of the future models.

9.1.3 Community based service provision

Care should be provided within the community wherever possible. This could include:

- Further development of local phlebotomy services and monitoring of patients in community.
- Nurse/AHP led clinical services in the community or in hospital where applicable. This would build on the currently available services such as the diabetes and respiratory services. Some of the areas currently proposed to be developed could include:
  - Lower urinary tract and incontinence service;
  - Raised PSA clinic – Nurse led triage clinic where TRUS biopsy is provided;
  - Chronic pain service.
- Specialist clinics in community settings, working with GPs and community teams to develop joint care plans for patients.

9.1.4 Consolidation of low volume/ high complexity care

The evidence suggests that there is a case for improving outcomes by providing complex investigations and treatments in only a few specialist centres. This applies in particular to cancer care, which is covered in the next section.

9.1.5 Maximisation of ambulatory care including day surgery and the development of short stay surgical models within Ambulatory Care Hospital type facilities

There is scope to improve the use of Greater Glasgow and Clyde's inpatient beds for planned care. This is in part by maximising day case surgery / day treatment but also by

managing the time patients spend in hospital after elective care, which can be quite variable across sites.
This variation is caused by a number of factors, including availability and the quality of home and community support as well as the surgical techniques used.

Programmes such as the Enhanced Recovery after Surgery (ERAS) should be in place to ensure that patients spend no longer than they need in hospital. These programmes also encourage active participation of patients in the care plan and recovery process. This type of approach should be encouraged across surgery. Similarly, less invasive techniques should be used where clinically appropriate to improve the patient experience and the speed of recovery.

Reducing length of stay, where clinically appropriate, will be important to improve the patient experience and to bring financial benefit to allow investment in other parts of the service.

9.1.6 Planned 'urgent' care clinics

Through the work of the Emergency Care work stream there are a number of areas being identified to develop a more planned approach to care to avoid emergency admissions. This was detailed in the earlier part of this report and requires the service to consider different approaches.

9.1.7 New service models

New service models to better support the management of patients are being considered such as the digestive diseases service combining gastroenterology and upper and lower GI surgery to provide a single coordinated service for GGC.

Illustration: for a patient, moving to the new model of care described might look like this:

Patient Story
70 year old woman lives in Argyll and Bute, 4 hour travel time to services in Glasgow, main carer for husband. She attends outpatient clinic once a year for specialist follow up.

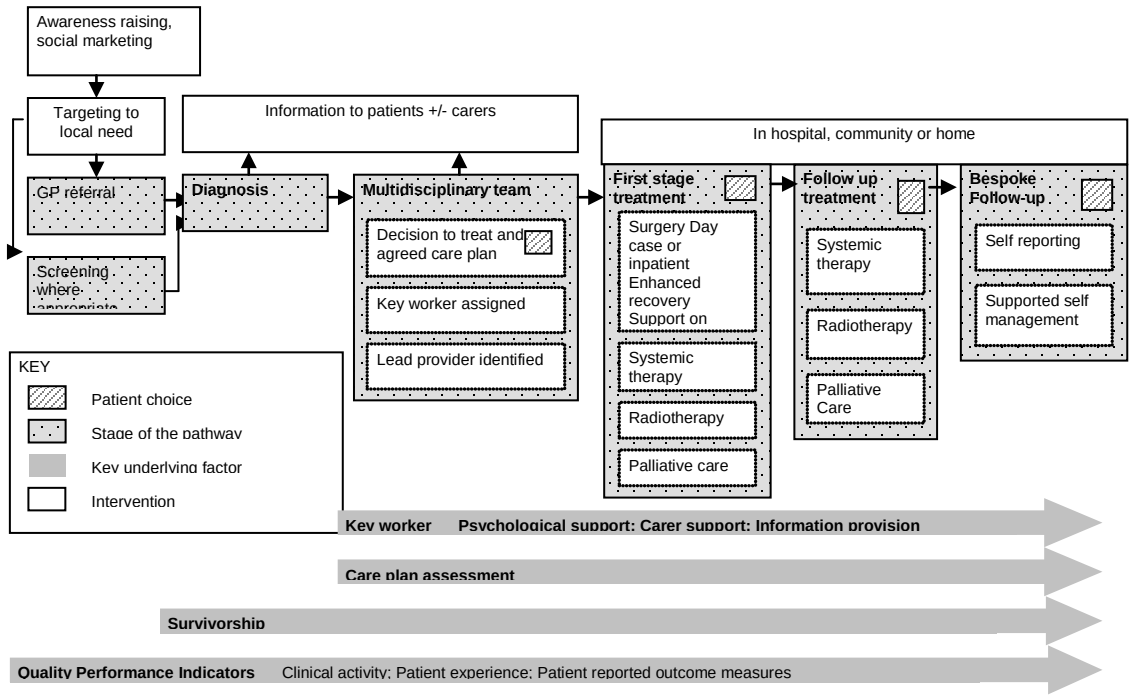
Now:
Sent an appointment for 9am, has to change to a time she can travel for
Makes arrangement for husband to be cared for
Travels all morning for rearranged early afternoon appointment
Has bloods taken and sees consultant for 5 minutes to be told everything is fine
Travels 4 hours home again – arriving late evening

Future:
Blood tests done locally, OP only arranged if indicated from results. Phone consultation or via telemedicine link for follow up where clinically appropriate.

10. CANCER

10.1 Key Components of Approach

Figure 18: Cancer Pathway



The key aspects of the care pathway identified to enhance survival and quality of life are shown on figure 18 above. In general the cancer pathways are considered to be well established and working well. Some areas were identified as areas where further consideration and development is required which are discussed below. Clinical evidence suggests that common cancer care such as systemic anti cancer therapy and patient follow-up should be provided as locally as possible and where possible outside the hospital setting. The evidence also makes the case for improving outcomes by providing complex investigations and treatments in only a few specialist centres.

10.2 Cancer surgery

The number of site(s) providing cancer surgery should be based on numbers of patients and outcomes achieved. The proposed model of care recommends some further consolidation of surgical services for both common and rarer cancers. This will ensure that clinical teams and environments are in place to provide high quality care and improved outcomes for patients across Greater Glasgow and Clyde.

10.2.1 Impact for Common Cancer Surgery

- **Breast cancer surgery**

  Breast cancer surgery can be delivered as a day case, with surgeons using less invasive techniques so that patients do not have to stay in hospital unnecessarily. Guidelines suggest that 60-70% of breast surgery should be day case.

To improve outcomes and experience, day case breast services should be available locally to all patients who require less complex surgery.

Patients undergoing more complex surgery should have the opportunity to discuss their breast reconstruction options and have immediate breast reconstruction if appropriate.

- **Colorectal surgery**

  The number of patients being seen and patient outcomes from cancer audit results should determine the number of sites. Where clinically appropriate this should be delivered locally. Complex colorectal surgery with plastic surgical involvement should be delivered in a specialist unit.

10.2.2 Impact for rarer cancers

Over recent years NHS Greater Glasgow and Clyde has consolidated services into single sites for some rarer cancers such as upper gastrointestinal cancer. For a number of cancers this has also resulted in supporting other boards within the region to provide a tertiary level service such as ovarian cancer. However there are still some areas where we are providing care on a number of sites for relatively small numbers of cases. Consolidating services into fewer hospitals would create and maintain complete clinical environments that can enable the delivery of best practice providing improvements and benefits for patients by focusing experience in limited areas within services.

There are a number of rarer cancers where volumes mean that the service can only be provided from a single site.

- **Rarer urological cancers**

  As with other small volume cancers urological cancers need to be provided from a specialist urology team. General urology services should be able to refer patients with complex needs to the specialist team. To ensure the best outcomes and experience, rarer urological services should have access to all of the requirements of a high quality service such as 24 hour access to interventional radiology, appropriate consultant cover and resident surgical juniors. NHS GGC needs to consider creating a centralised specialist team and unit to support the provision of complex urological cancer care. Currently there is ongoing work with other Boards within the region to realign small volume surgery into one service within NHS GGC.

10.3 Changes to Treatment

10.3.1 12.3.1 Systemic Anti-Cancer Therapy (SACT)

Guidelines recommend that to provide patient centred care the inpatient delivery of systemic anti-cancer therapy (SACT) should be minimised. Over recent year's local provision has developed in many areas linked to the central unit at the Beatson to provide more convenient treatment to patients where it is safe and clinically appropriate to do so. As therapies evolve with the development of oral preparations it will be important to develop the service to increase the care delivered locally and where possible and clinically appropriate out with the hospital setting.

10.3.2 Managing emergency care

For patients admitted as an emergency the guidelines indicate that arrangements should be in place to assess cancer patients immediately when they arrive at hospital to expedite care.

It is proposed to provide an acute oncology assessment unit (OAU) and 24 hour phone to provide a dedicated service for all adult oncology /haematology patients who are currently receiving /or have received treatment (chemotherapy /radiotherapy) in the past 6 weeks at the cancer centre, or are at risk from disease / treatment related immuno-suppression.

It will also support all patients attending the cancer centre who are identified to be at risk of developing malignant spinal cord compression (MSCC) as per the National Institute for Clinical Effectiveness (NICE) and the West of Scotland Cancer Network Guidelines.
It is expected that this will prevent unnecessary hospital admissions, and where hospital admission is required, ensure patients are seen /and or admitted to the right facility to support the care they require, improving patient outcomes and care.

10.3.3 Haematological cancers

The management of haematological (blood) cancers is increasingly dependent on the detection of particular genetic changes within the cancer cells. These require highly specialised molecular techniques and many new agents are being developed. These genetic changes are important for determining both prognosis and appropriateness of therapies, including the need for stem cell transplants. Molecular techniques can be used to monitor response to treatment.

Access to modern diagnostic techniques is critical to ensure appropriate use of therapies and to monitor effectiveness.

10.3.4 Follow up and Support

The follow-up of most cancer patients is done on a routine basis in hospital outpatient departments. Recent regional and national work through the Managed Clinical Networks (MCNs) indicates that there is a requirement to change the follow-up arrangements for many areas. This includes providing monitoring and follow–up within the community where possible including patient blood tests.

With changes to survivor rates it is recognised that the approach needs to be altered to offer more individualised aftercare services and more responsive to patient needs as some patients can become ill again between outpatient appointments and not feel able to see a specialist until their next scheduled visit. Changing the method of follow-up will improve outcomes and quality of life for patients and could free up specialists' time to continue to improve quality of care for all patients across GGC in other ways and could support a more person-centred interaction with the clinical team. To support this it will be important that patients are given the relevant information to make an informed choice on their preferred model of follow-up.

10.3.5 Supportive and palliative care

This is a key part of care, especially with the changes in survivor rates, and so needs to meet the needs of patients both living with cancer as well as to support advanced care planning for the end of life. Across NHS GGC the Gold Standard Framework has been

implemented as has the use of advanced care pathways. This has helped improve both palliative care and end of life care planning. See figure 13 on End of Life Care.

As future services are planned it is recognised that there is a need to ensure that holistic assessments are part of the patient pathway including assessment of psychological needs and the support requirements of carers with advanced care plans in place consistently across GGC to support patient care.

10.4 Implementation challenges for this model

- Modelling of the capacity required to meet the future predicted increase in cancer patient numbers.
- Consolidation of complex / low volume surgery / care – impact on patient activity changes / clinical team and infrastructure changes required.
- Front door model to support emergency care of patients with cancer.
- Provision of increased chemotherapy in the community – estimating the impact of chemotherapy changes and the community / local service capacity requirements or changes.
- Service requirements in primary care to support monitoring and follow up including links with the 3rd Sector to support patients and carers.
- Requirements to support palliative care and end of life care out with hospital with effective advanced care planning – this is linked to other work in relation to long term condition management and management of the frail elderly to consider alternatives to hospital care.

11. CHILDREN SERVICES

11.1 The emerging models from the Children's Services group in some respects mirror the developments in other work streams, such as emergency care and the management of patients with complex care needs, particularly in relation to the development of primary care, community services and better working at the interface. The specific drivers and proposed changes for children's services are set out in this section.

11.2 The Children's Group focused primarily on services provided to the NHSGGC population rather than on the wide range of regional and tertiary services provided by the Royal Hospital for Sick Children (RHSC). This acknowledges the national and regional planning fora which cover these more specialist areas, as well as the significant amount of work and redesign going into the planning for the new RHSC.

11.3 The work of the group focused on general paediatrics, long term conditions, links to the community and providing support in an emergency, as well as on effective transition between children's and adult services. These were the priority areas highlighted during the development of the Case for Change.

11.4 Core principles

- Care should be focused on the needs of children and families.
- Care should be provided in dedicated child friendly environments.
- The approach to care in settings should uphold the Rights of the Child
- There should be a focus on co-ordination of care and clear points of contact.
- There should be an appropriately trained, skilled and senior workforce: complying with relevant standards.
- Information should be shared and available across the system to inform care.

- There should be robust child protection systems in place.
- Emotional support has to be central.
- Clear transition arrangements should be in place when children move to adult services.
- Standards of care and access to range of children's services should apply equally across the whole of Greater Glasgow and Clyde.
- Care should be focused on reducing inequalities by ensuring access for the most disadvantaged and supporting children to have the best start in life.

11.5 Key components of approach

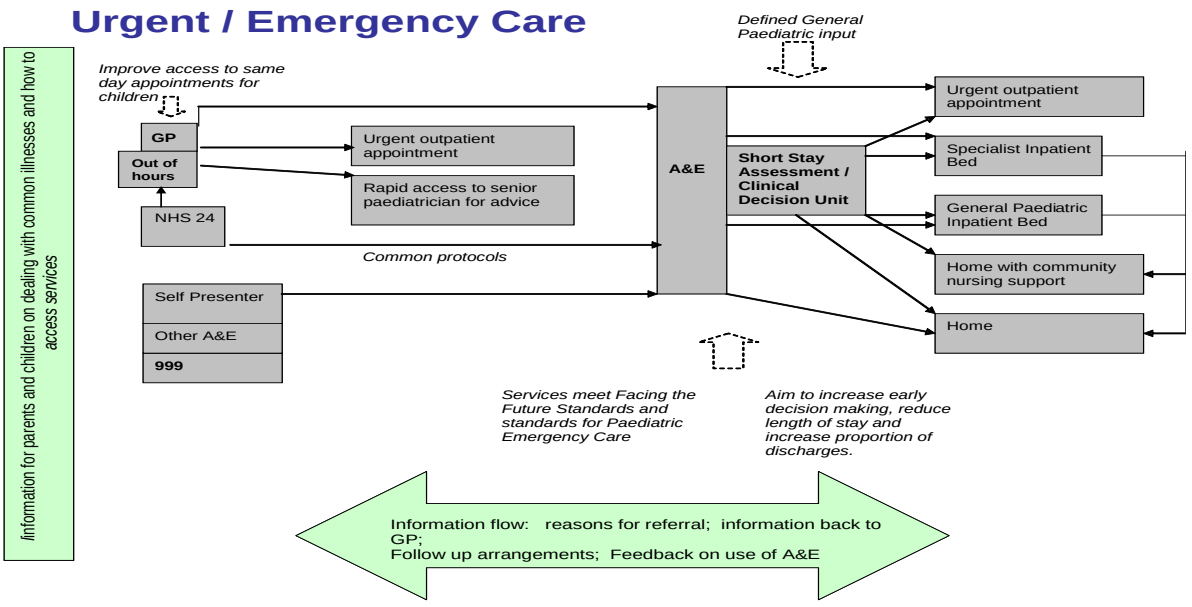
11.5.1 Emergency care

As with the model for adult emergency care there are a number of ideas being proposed to provide a range of alternatives to admission, which are accessible from the Emergency Department such as urgent outpatient appointment and community nursing support to enable earlier discharge.

This needs to be underpinned by the effective flow of information from the GP to the hospital and vice versa, supported by clear follow-up arrangements and feedback to practices on Emergency Department attendances and outcomes.

Where there are admissions for exacerbation of chronic disease this needs to prompt review of the care plan. The diagram below sets out the urgent / emergency care pathways.

Figure 19



This model requires a greater focus on the development of dedicated General Paediatric input as a focal point for the management of emergencies and alternatives to emergency admission. It also requires further development of nursing roles and closer working across acute and community services, facilitating earlier discharge and ensuring children can be supported at home were possible.

The 'Facing the Future' standard and Standards of Care for Paediatric Emergencies set out clear expectations for the skills, expertise and specialist opinion which should be available for children in all emergency settings. We need to ensure that we can provide this required range of specialist paediatric services to all children presenting as emergencies and those requiring inpatient care.

Key elements of this pathway will be implemented as part of the move to the new Royal Hospital for Sick Children on the South Glasgow Hospitals site. This move will enable all 'blue light' emergency cases for children in Glasgow to come to the dedicated paediatric unit which represents a gold standard in terms of access to the definitive place of care with specialist treatment, a dedicated child friendly environment and dedicated paediatric staff across a range of services and disciplines, including triple co-location between children's, adult and maternity services.

The changes described above will support that move and we need to consider further the pathways for 'blue light' emergencies and inpatient care, as well as minor injuries and self-presenters, across Greater Glasgow and Clyde to ensure that patients can access the right level of care as quickly as possible.

While this diagram focuses on access to urgent and emergency care from the community to hospital settings, we recognise that neonatal services also deal with a significant emergency workload with a pathway to urgent care from maternity units to neonatal units and that this is an additional route into emergency care. As such, it needs to be supported by clear criteria for identifying and transferring sick newborns both in maternity wards and in the early days following discharge home.

11.5.2 Planned care and long term conditions

The emerging service model seeks to establish local **Integrated Children's Centres.** This supports:

- Local provision of a range of services, enabling better joint management of patients across services and agencies, with locally accessible specialist care.
- Promote different way of working: not current hospital activity in a different place but rather a focus on effective joint care planning across primary care, community services and specialist paediatrics.
- Point of contact for families with long term conditions / complex disabilities, including being a focal point for transition.

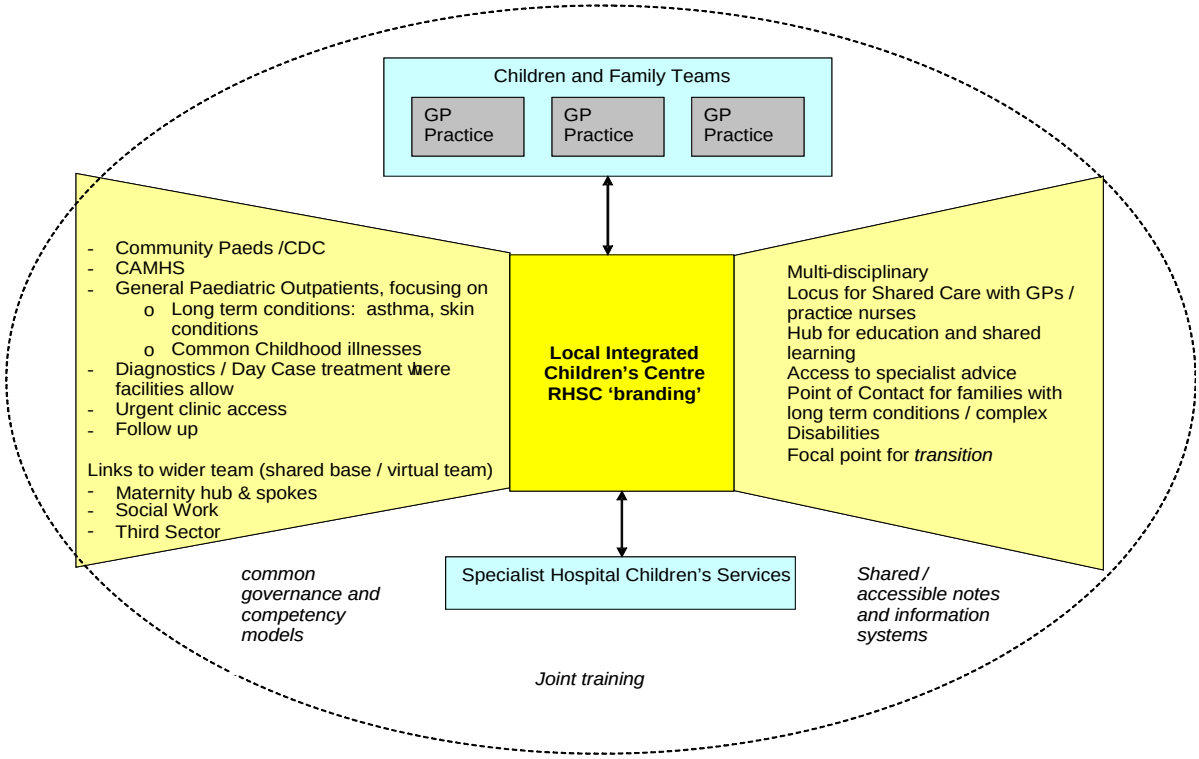
Core components of the **Integrated Children's Centres** would include:

- Community Paediatrics / Child Development Centres
- Child and Adolescent Mental Health Services
- General Paediatric Outpatients, focusing on
    - Long term conditions: asthma, skin conditions
    - Common childhood illnesses
- Diagnostics / Day case treatment where facilities allow
- Urgent clinic access
- Follow up
- Links to wider teams and services (shared base / virtual team)
    - Maternity hub and spokes
    - Social Work
    - Third Sector
- Link to localities / clusters of GP practices

- Locus for Shared Care with GPs / practice nurses
- Hub for education and shared learning
- Local point of access for specialist advice

This model will only work if it is seen as a very different way of doing things, rather than providing the same services in a different location. The real potential of integrated children's centres is to enable services and families to work together in a different way, across current service boundaries. The Royal College of Paediatrics and Child Health estimate that 50% of paediatric outpatients could be seen in a community setting, and that a greater community focus will lead to better long term conditions management and a more holistic social and behavioural approach. The centres also offer the opportunity to look at different ways of working to support children and families at home, and to set the foundations for effective chronic disease management for a lifetime. This includes using new technologies and making the most of opportunities for home monitoring and supported self care.

Figure 20: Integrated Children's Centres



11.5.3 Transition

Transition has been a recurring them of discussions with patients and professionals. The model described above will support effective transition through the integrated children's centres, enabling a clear point of contact and co-ordination for families, and by involving GPs at an earlier stage in the management of long term conditions and complex care packages for children which will give greater continuity into adulthood. In addition to this, good practice in the approach to transition has been identified as including the following components:

- Transition should be viewed as a process, not an event. Services need to view transition as a period of at least 2 years, which starts in early adolescence, and allows gradual, coordinated transfer of care to primary care and adult health services. The aim of the transition process is therefore to enable and empower young people and their families to confidently access adult services.

- A key worker should be identified to coordinate the transition from paediatric to adult health services.

- In order to develop workable transition care pathways, there should be good communication and cooperation between paediatric and adult services and GPs.

- Joint transition clinics for paediatric and adult health services would help support the transition of young people with more complex needs and/or those requiring ongoing active management. The future co-location of adult and paediatric hospital services at the South Glasgow Hospitals site might help to facilitate this joint working for some hospital-based teams.

- The collation and sharing of information between health professionals needs to be improved to ensure effective transfer of health information to adult services. This sharing of information may be facilitated by improved IT systems. The use of a patient-held health record should also be considered.

12. MATERNITY SERVICES

12.1 Principles

- Focus on providing safe, accessible and effective care which improves outcomes for women and babies and reduces inequalities.
- Care focused on the health and social needs of women and families.
- Promotion of normal childbirth and reduction of interventions.
- Appropriately trained, skilled and senior workforce: complying with national workforce recommendations.
- Strengthen communication and collaboration between services which include other key NHS services and local authorities.
- Women are able to make informed decisions about their care.
- Use women's experience of care to drive service improvements.

12.2 Key components of approach

The key components of the approach of the service model for maternity care are set out below:

- Pre-pregnancy advice and health promotion.
- Early booking.
- Comprehensive assessment as early as possible, informed by shared information.
- Early identification of red / green pathway: midwife led care where possible, with regular review and ability to move between pathways when required. Identification of risk and appropriate support is critical to successful outcomes, and to defining future service and workforce needs both for maternity and neonatal services.
- Early pregnancy assessment service available 7 days a week.

- Increased support for vulnerable women and families in pregnancy: identification of vulnerability based on broad assessment of individual family and social circumstances.
- Supporting access to wider services including financial inclusion, welfare advice, and family support.
- Health visitor involvement as early as required, especially for vulnerable families: co-ordination of care and handover between midwife and health visitor.
- Team based approach with a central role of midwives as autonomous practitioners of normal pregnancies, working as a team with obstetricians, anaesthetists and paediatricians, in the care of women with complex and complicated pregnancies.
- Delivery suites meet required staffing standards: Midwife, Obstetrician and Anaesthetic cover. Move to 24 hour consultant obstetrician presence. Increasingly this will require to be covered by dedicated Obstetricians, with the increasing specialisation of gynaecology.
- 'Timely' discharge from hospital: reducing length of stay.
- Neonatal units which comply with Neonatal Quality Framework standards, with clearly defined pathways to ensure that babies are identified in post-natal settings and transferred in a safe and timely manner.

13. UNDERPINNING SYSTEM CHANGE

13.1 As we move to develop implementation plans for this strategy there are a number of areas of work which need to underpin system change. These include:

- Diagnostics and diagnostic Systems
- Information and Information Systems
- Communications
- New Ways of Working - appointment systems / technology
- Ways we deliver care – person centred care. Equalities sensitive practice

13.2 There are also implications for Other NHS Organisations including the SAS, NHS 24 and other territorial health Boards.

14. PUBLIC AND PATIENT ENGAGEMENT

14.1 There has been extensive engagement through the development of this clinical services review which has been referenced throughout this document. Formal approval of the Clinical Strategy is a further opportunity for that wide engagement. As we develop specific change proposals engagement will continue to be fundamental.

14.2 The Scottish Health Council (SHC) have been involved in this process from the start, attending the ongoing engagement events with the patient reference groups and the third sector as well as attending the event at Hampden in April when the emerging service models work was shared with the wider clinical group. In addition they have met with Board Officers to discuss the programme and to share thinking on the approach being taken, feedback on their observations and to support planning for the ongoing engagement. As the planning to develop service change proposals follow this strategy this close engagement will be continued to ensure the approach taken is in line with SHC guidance in relation to engagement, pre consultation and consultation, where this is indicated. The fill SHC commentary on the review is attachment one to this paper.

15. CONCLUSION

15.1 The clinical service review has enable us to develop this clinical strategy to provide a basis for the development of detailed service change proposals working with Integration Joint Boards and with the emerging national approach to clinical strategy and delivering the 2020 Vision. We need to work together to deliver:

- Improving health and prevention of ill health; empowering patients and carers through the development of supported self care.
- Developing primary care and community service models; simplification of community models; focus on anticipatory care and risk stratification to prevent crisis.
- Improving the interface between the community and hospital to ensure care is provided at the right time in the right place; Community and primary care services inward facing and hospital services outward facing; focused on patient and carers needs.
- Developing the ambulatory approach to hospital care, with inpatient hospital care focused on those with greatest need ensuring equitable access to specialist care.
- Redesign of specialist pathways to establish a consistent service model delivering the agreed clinical standards and good practice guidelines.
- Developing the rehabilitation model based on need not age; working across the service within primary and secondary care and with partner organisations to provide rehabilitation in the home setting where clinically appropriate.
- Changing how care is delivered - patient centred care; shifting the paradigm to deliver care differently for patients particularly for patients who have multiple conditions; helping patients and the public to develop and understand the new approaches to care

[i] London Health Programmes: A framework for action, 2011.

[ii] Better cancer care: an action plan (2008). Edinburgh: Scottish Government.

Attachment 1

Board consideration of clinical services review

Clinical Services Review

21 February 2012	Board Meeting	Clinical Services Fit for the Future paper to the Board for agreement for agreement to progress
02 October 2012	Board Seminar	Briefing on Clinical Services Review
18 December 2012	Board Meeting	Case for Change to Board for Approval
07 May 2013	Board Seminar	Emerging Service Models (presentation)
07 August 2013	Board Seminar	Service Models (presentation)
20 August 2013	Board Meeting	Service Models Paper to Board for approval
6 December 2013	Board Away Day	Clinical Services Review Update (presentation)
17 December 2013	Board Meeting	Clinical Services Review Update - Development of the Renfrewshire Development Programme for approval
14 February 2014	Board Away Day	Clinical Services Review Update (presentation)
21 October 2014	Board Meeting	Clinical Services Review Renfrewshire Development Programme update paper to Board
09 December 2014	Board Away Day	Clinical Services Review Update (presentation)

9th

Attachment 2

scottish health council

making sure your voice counts

Ms Catriona Renfrew
Director of Corporate Planning & Policy
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Gartnavel Royal Hospital
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Date: August 2013

Our Ref: J B Russell House

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Dear Catriona

Clinical Services Review Fit for the Future

The Scottish Health Council has welcomed the exchange of information that's taken place between ourselves and board officers over the past 18 months. We consider that this has been helpful in enabling us to have a dialogue to ensure that the process, as it develops, observes the principles of openness and transparency, contained within national guidance.

As well as providing comment on the board's early process of engagement and information, we have also used these meetings to provide feedback on our observations from the meetings hosted by the board and share the findings of our recent survey on participants' experience of involvement.

Scottish Health Council staff attended most of the Patient Reference Group sessions held during the period March 2012 to April 2013; Third Sector events held in January and June 2013; the Combined Clinical Group workshop in April 2013; and the Combined Patient Reference Group meeting held in June 2013.

We also note that there was patient and public representation on each Clinical Steering Group and that an Overarching Patient Reference Group met several times throughout the process. In addition we are aware that NHS Greater Glasgow and Clyde officers took the opportunity to discuss this review process with Public Partnership Forums and some community groups across the Board area.

For each meeting between the Scottish Health Council and board officers we prepared a "feedback paper" to inform our discussions. Our most recent meeting was held on 25th July 2013. The feedback on the board's review process for June and an extract from the May feedback is provided as an appendix to this letter.

Some of the key themes from the engagement so far have included:

- Participants appear to support the general direction of travel (anticipatory care and early intervention) and some acknowledge that difficult decisions may be needed in order to deliver new models of care.
- Some people have expressed concerns around the interface between acute services and primary care (including access to and capacity of GPs), discharge planning and community support.
- Some participants at the Patient Reference Group sessions have whether there are sufficient links with local authorities, other public agencies and the Third Sector to support multi-agency pathways of care.
- Challenges have been identified around how some of the aspirations can be implemented eg staff training, finance and resources.
- Some participants at the Combined Patient Reference Group session in June 2013 noted that it was difficult, at this stage to see anything coherent within the draft service model discussion paper and referred to the challenge of articulating the emerging models of care, with the inclusion of the proposed 'interface services'.
- Consideration should be given to continued discussion and engagement with neighbouring Boards

and their patients/public involvement structures in any proposed service development and change. As part of the Scottish Health Council's survey to capture participants' experience of involvement to date, we issued130 questionnaires (70 by hand, 47 by post and 13 by email) and received 36 completed questionnaires giving a response rate of 28%. Responses included:

- 29 people (81% of respondents) felt they'd been able to contribute to the emerging models and 24 people (73%) felt that the models reflected previous group discussions.
- 25 people (69% of respondents) felt they'd been able to influence the process
- 32 people (89%) indicated that they intend to continue their involvement in the process

In response to some of the issues raised, the Scottish Health Council would encourage NHS Greater Glasgow and Clyde to:

- Consider how patients, carers, the public and voluntary sector may continue to be meaningfully involved in further engagement.
- Ensure that information is accessible for a wide range of people and that acronyms and technical language is kept to a minimum. Information and communications should be developed with patients, carers and public representatives to ensure that the language and content supports peoples' understanding of any proposals.
- Seek to address the issues and concerns that have been raised by patient and public representatives and staff during this early phase of engagement to inform the next steps.
- As the detail of the review emerges, demonstrate the 'contrasts' between existing and proposed new services. The paper makes reference to "support to maintain people at home, when clinically appropriate", "need to do more to stop people being admitted to hospital" and "help people leave hospital more quickly". However it may not be clear to people whether this drive is to maintain existing structures and services or may result in disinvestment or changes to service configurations. The use of case studies may also help people to appreciate the impact of change.
- Work in partnership with special and neighbouring NHS boards, public agencies, the Third Sector and others as more detail around service models emerges.
- Continue to develop the equality impact assessment, with additional elements from health inequalities.
- Evaluate its process and structure of engagement (March 2012 – June 2013) to identify any learning and areas for improvement.

At our meeting on 25th July, representatives from the board acknowledged that the service models developed do not currently contain the necessary detail required for public consultation. We agreed that the timescales in the draft discussion paper did not reflect the further work required to develop specific models/proposals in order for or a wider group of people to then be engaged. T This should include option development and appraisal which should assist in identifying any preferred options. Where the proposal, or elements of th his, may be considered 'major' the guidance "Informing, Engaging and Consulting People in D Developing Health and Community Care Service" (CEL 4 (2010)) indicates that the board should not move to consultation until they have confirmation from the Scottish Health Council on the public c involvement process to date. Finally, we would like to acknowledge t e the scope of involvement work conducted to d date and encourage this to be carried forward as the process develops. We would be happy too continue our dialogue with NHS Greater Glasgow and Clyde as planning is progressed and look f forward to hearing from you in due course.

Yours sincerely

Louise Wheeler
Service Change Adviser

Appendix

Extract from Feedback on process for Clinical Services 'Fit for the Future'
May 2013

Emerging themes from PRGs from discussions

- Numbers have remained consistent at each of the workshop sessions (suggesting that people have stayed involved in the process)
- Participants at the PRGs have questioned the 'links' with local authorities, public agencies and the Third Sector to support multi-agency pathways of care
- Participants have had the opportunity to respond to the issues/themes raised from earlier PRG sessions. Clarity was sought on shared understanding at the start of each session.
- At several of the workshops, participants have questioned buy-in to the review from GPs and the primary sector
- Concerns around how some of the aspirations can be implemented eg staff training, finance/resource (Unplanned care/Chronic Disease)

Information

- Note that information from the first two PRGs is available on the Board's website.
- Information and presentations do not appear to be shared consistently with participants in advance of meetings
- The presence of a clinician has enabled participants to ask, and get immediate response, to some probing and specific questions.
- To date, lay participants appear to be content with the review process and their involvement with some representatives speaking supportively of it at sessions.
- Some people noted that there were too many acronyms in some of the presentations (Planned care, Cancer). Where possible the use of these should be eliminated or reduced.
- In Mental Health, some participants found the papers difficult to understand. The content, detail and format of these should be considered for future participation.
- Participants raised an impression that there may be reluctance by NHS staff to refer to third sector services. This point was agreed upon as something requiring further investigation by the Board officer present.

Next steps

- Participants have suggested that it would be helpful to bring all the public representatives together for the next round of discussions, given the cross-over/ entire patient pathways
- With patient flows between services across neighbouring Boards – have discussions taken place to engage these Boards and their patients/public involvement structures?
- The Scottish Health Council welcomes the development of the EQIA for the review process – we would encourage the Board to consider how people with protected characteristics may be involved in considering service models and engagement and consultation processes.

- Gauge impact re specialist tertiary care – have other Boards and patients been involved in this work? Board officer stated that the Tertiary Care Clinical Group has been informed from discussions of other PRGs and the service models will be shared at event in June – will relevant Boards/ patients/ public representatives be invited to this session?
- Discussion around the Scottish Health Council's survey questionnaire (June 2013).

Feedback on process for Clinical Services 'Fit for the Future' July 2013

The comments below come from the Scottish Health Council's attendance at the Third Sector event on 24th June, the Combined Patient Reference Group session on 26th June, the Scottish Health Council's feedback survey and consideration of the Clinical Services Review discussion paper. It is also informed by reviewing footage of interviews conducted by NHS Greater Glasgow and Clyde with six members of the Overarching Patient Reference Group.

Information

- The Scottish Health Council welcomes the ongoing exchange of information and communication that's taken place with board staff and the Scottish Health Council and their response to feedback.
- Three people in NHS Greater Glasgow and Clyde's interviews advocated the use of plain language, without acronyms, to support understanding.
- From the Scottish Health Council's survey, 29 people (85% of respondents) said they'd received enough information and 32 (91% of respondents) said that information had been shared in a timely manner.
- The events in June were planned to share the emerging service models with patient and public representatives and the Third Sector. Although Board officers presented an overview there was little detailed discussion or interrogation of the discussion paper that was sent in advance of the meeting
- At the Combined PRG session, some people felt that there was too much information to take in and that it was difficult to see how this had evolved from PRG involvement.
- Some participants highlighted that they felt the presentations were comprehensive and provided a good overview.
- Some participants noted that it was difficult to see anything coherent within the discussion paper and that it was difficult to articulate the emerging models of care, with the inclusion of the proposed 'interface services'.
- One group at the Combined PRG session noted that there was not enough information for people to understand what the models mean. The Scottish Health Council notes that public representatives sit on the Clinical Groups as well as the Patient Reference Groups.
- Two respondents to the Scottish Health Council survey suggested that more detail would be needed to engage with the public.

Implementation and themes

- It was suggested that there may be challenges to collaboration within the Third Sector as each organisation seeks to:
- o Preserve their own identity and empowered budget
- o Successfully compete for the same pot of money
- Most participants at both events appeared to support the general direction of travel (anticipatory care and early intervention) and recognised that some difficult decisions would be needed around disinvestment in acute care.
- Some people are concerned around GP interface, discharge planning and community support.
- Three people (through the Overarching PRG interviews and Scottish Health Council survey) commented that work to date appears to have been mainly led by medical professionals – participants suggested that the Board extend involvement to other staff groups
- Participants suggested that further engagement is needed with social work, education etc.

Process

- Some participants at the Combined PRG session noted that they had welcomed the Board's openness and opportunities for discussion
- The Scottish Health Council notes that there were fewer people at the Third Sector event in June (around 35) compared with that held in January (around 100).
- • Responses to the Scottish Health Council survey indicated:
- o 32 people (89%) intend to continue their involvement in the process (note that Board advised that the PRG work has now drawn to a close).
- o 29 people (81% of respondents) felt they'd been able to contribute to the emerging model and 24 people (73%) felt that the models reflected previous group discussions.
- o 25 people (69% of respondents) felt they'd been able to influence the process
- • Some additional comments from the Scottish Health Council survey (not covered elsewhere):
- o Exciting and ambitious project
- o Continue to engage with service users and the public
- o Aim to recruit more young people/identify gaps in representation

Scottish Health Council's Survey Responses

The Scottish Health Council issued 130 questionnaires (70 by hand, 47 by post and 13 by email) and received 36 completed questionnaires giving a response rate of 28%.

Half of the respondents indicated which workstream they were involved in – but all workstreams had a response from at least one representative (highest was Older People with six responses).

Most people indicated that they were representing a group or structure eg Public Partnership Forum (12), community/voluntary group (12), Third Sector (11). Note that the Third Sector is also involved through a separate process.

Clinical Services Review Discussion Paper

- The Scottish Health Council is unaware of any discussions with lay representatives around the detail and content of the board's discussion paper though there has been lay representation in the development of service models through the Clinical Groups. We acknowledge that people have indicated general support for the direction of travel for the process to date. However, some people have commented on the lack of detail about what is being proposed.
- We acknowledge the scale of the Clinical Services Review project and the board's attempts to provide a comprehensive overview – and this is reflected in the length of the discussion paper. However, this may be to the detriment of making the paper accessible to lay participants. Consideration should be given to some of the terms used such as polypharmacy and co-morbidity and whether a glossary would assist with this.
- We welcome the Board's production and distribution of a more succinct four page summary. It may be helpful if this format is used as the process progresses and the details emerge.
- As the detail of this review work emerges it would be helpful to demonstrate the 'contrasts' between existing and proposed new services. The paper makes references to "support to maintain people at home, when clinically appropriate", "need to do more to stop people being admitted to hospital" and "help people leave hospital more quickly" however it may not be clear to people whether this drive is to maintain the existing structures or may result in disinvestment or changes to service configurations.

Next steps

- The Scottish Health Council notes that the service change models are still at a high level and give a general direction of travel. The paper and Board officers have acknowledged that more work involving stakeholders is needed to develop these further.
- The Scottish Health Council would suggest that in future information should aim to communicate the impact of change perhaps through the use of case studies or 'contrasts' (comparing existing service with the new service). Information and communication should be developed with patients, service users and carers to ensure that the language and content supports people's understanding.
- Consider how existing patient representatives may be further involved in the engagement process.
- It will be helpful to clarify what stage NHS Greater Glasgow and Clyde has reached in their review process in terms of the Informing, Engaging and Consulting guidance, CEL 4 (2010)and discuss expectations and next steps.

In particular we note the timescale outlined in section 13 of the board's discussion paper. The timescales do not appear to indicate further work may be required to develop more robust models/proposals that a wider group of people can then be engaged. This engagement should include option development and appraisal in order to identify any preferred options. This review process, or elements of this may be considered 'major' change. In such cases, the guidance indicates that the board should not move to consultation until they have confirmation from the Scottish Health Council on the public involvement process to date.