Shadow Integration Board

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

AGENDA

		Enclosure
1.	**Membership** To note that Trisha McAuley has been appointed as lead Non-Executive member from the Health Board and that in that capacity will be Vice Chair of the Shadow Board following the retirement of Andrew Robertson effective from 1st December 2015. To note that Councillor Matt Kerr has replaced Councillor Malcolm Cunning as a representative of the City Council on the Shadow Board.	
2.	**Apologies for Absence** None received	
3.	**Minutes** To approve as a correct record the Minutes of the meeting of the Shadow Board held on 6th October 2015.	Minutes
4.	**Matters Arising** (not otherwise on the Agenda)	
5.	**Integration Scheme** David Williams, Chief Officer Designate	Oral
6.	**Finance**	
	(a) GCH&CP Joint Finance Monitoring Report Sharon Wearing, Chief Officer Finance & Resources	Paper
	(b) Budget 2016/17 Sharon Wearing, Chief Officer Finance & Resources	Oral

7.	**Performance Report**	
	David Williams, Chief Officer Designate	Paper
8.	**Work Plan for IJB Governance Documentation**	
	David Williams, Chief Officer Designate	Paper
9.	**Draft Standing Orders for the IJB**	
	Sharon Wearing, Chief Officer Finance & Resources	Paper
10.	**IJB Future Membership**	
	Sharon Wearing, Chief Officer Finance & Resources	Paper
11.	**Autism Strategy**	
	David Williams, Chief Officer Designate	Paper
12.	**Unscheduled Care and Winter Planning**	
	Alex MacKenzie, Chief Officer Operations	Paper
13.	**Future Meetings**	
	To note dates of future meetings:	
	Tuesday, 19th January 2016 – 9.30 am/ 11.30 am	
	Monday, 8th February 2016 – 10.00am /1.00pm	
	Monday, 21st March 2016 – 10.00am /1.00pm	
	Monday, 11th April 2016 – 10.00am/1.00pm (provisional)	

NOT YET APPROVED AS A CORRECT RECORD

GLASGOW CITY SHADOW HEALTH & SOCIAL CARE INTEGRATION BOARD

Item No. 3

Minutes of meeting held in the Sir Peter Heatly Boardroom, Glasgow City HSCP, Commonwealth House, 32 Albion Street, Glasgow, G1 1LH at 2pm on Tuesday, 6th October 2015

PRESENT:	John Brown	NHSGG&C Board Member
	Cllr Malcolm Cunning	Councillor, Glasgow City Council
	Cllr Emma Gillan	Councillor, Glasgow City Council
	Trisha McAuley	NHSGG&C Board Member
	Robin Reid	NHSGG&C Board Member
	Andrew O Robertson	Chairman of NHSGGC (Joint Chair) (Chair)
	Cllr Russell Robertson	Councillor, Glasgow City Council
	Rev. Norman Shanks	NHSGG&C Board Member
	Donald Sime	NHSGG&C Board Member
	Mari Brannigan	Nurse Director - Partnerships
	Annie Craig	Carers Representative
	Richard Groden	Clinical Director, Glasgow City
	Ian Leech	Glasgow City Staff Side
	Alex MacKenzie	Chief Officer Operations
	Dorothy McErlean	NHSGG&C Staff Representative
	Peter Millar	Independent Sector Housing Provider Representative
	Anne Scott	Social Care Users Representative
	Dr Michael Smith	Lead Associate Director Mental Health
	Robert Smith	Substitute PPF Representative
	Shona Stephen	Third Sector Housing Provider Representative
	Sharon Wearing	Chief Officer Finance and Resources
	David Williams	Chief Officer Designate
IN ATTENDANCE:	Jennifer Armstrong	Medical Director, NHSGG&C
	Jonathan Bryden	Head of Finance (NHS)
	Sybil Canavan	Head of HR (NHS)
	Kay Carmichael	Administration Manager
	Janette Cowan	Business Development Manager
	John Dearden	Head of Business Administration
	Allison Eccles	Head of Business Development
	Jo MacLennan	Head of Partnerships – Development – Integration, Scottish Government
	Fiona Moss	Head of Health Improvement and Inequalities
APOLOGIES:	Cllr James Adams	Councillor, Glasgow City Council
	Simon Carr	NHSGG&C Board Member
	Ian Fraser	NHSGG&C Board Member
	Cllr Marie Garrity	Councillor, Glasgow City Council
	Cllr Archie Graham	Councillor Glasgow City Council (Joint Chair)
	Bailie Mohammed Razaq	Councillor, Glasgow City Council
	Susanne Millar	Chief Officer Planning, Strategy & Commissioning/ CSWO
	Ann Souter	PPF Representative

1. MEMBERSHIP

It was noted 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. Unfortunately Simon was unable to attend the meeting.

Annie Craig had been appointed as the Carers representative on the Shadow Board, with John McVicar as her substitute. Andrew welcomed Annie to the meeting.

2. MINUTES

The minutes of the meeting held on 11th August 2015 were approved as a correct record.

3. CHIEF SOCIAL WORKER'S (CSWO)ANNUAL REPORT

David Williams spoke to the paper on the Chief Social Worker's Annual Report 2014/15 on behalf of Susanne Millar. Such a report is provided by all Chief Social Workers annually to their local authority in relation to statutory functions.

David highlighted that the reporting period covers 1st April 2014 to 31st March 2015. It provided an overview of the City and the issues related to the delivery of social work services. It included the social work annual service plan and improvement report which assessed service targets and achieved performance during the year around Council strategic theme of vulnerable people.

The Chief Social Work Advisor of the Scottish Government compiles the Annual Report for Scotland from the key points from each of the Local Authority's CSWO Annual Reports to compile the annual report for Scotland.

A member commented that the report doesn't convey the sense of challenge. David Williams indicated that he will reflect to Susanne Millar that future reports are positive whilst, also including details of challenges.

The Board noted the report.

4. INTEGRATION SCHEME

David Williams advised that the revised draft Integration Scheme was not yet available as discussions continued.

Members indicated deep concern and disappointment over the delay in the Integration Scheme being agreed and the impact of this on the timetable for the formation of the Integration Joint Board.

Members asked that they be kept informed between meetings of how matters are progressing.

It was suggested that the IJB ask the co-chairs of the Shadow IJB that they seek appropriate explanations and background to the on-going discussions from the two Chief Executives. Andrew Robertson stated that he was happy to do this.

ACTION

The Board

a) noted the update.

Chief Officer Designate

b) asked to receive regular updates between meetings.

c) remitted the Chair and Vice Chair to seek appropriate explanation and background about the cause of the delay from the Chief Executives of the Council and Health Board.

5. STRATEGIC PLAN – UPDATE

David Williams spoke to a report on the draft Strategic Plan and indicated that at the last IJB meeting it was anticipated that the Strategic Plan would be published early September. Due to continuing difficulties in relation to conclusion of the Integration Scheme he had sought the approval of the Chair and Vice-Chair of the IJB to proceed with consultation.

Allison Eccles updated the meeting on the changes made to the Strategic Plan following comments received at the last Shadow IJB and the event held on 29th July 2015. The final draft of the plan will be submitted to the Plain English Society with a view to achieving a 'Crystal Mark' – being the recognised seal of approval of the Plain English Society. An Equalities Impact Assessment (EQIA) is also being carried out through the Council and Health Board processes.

Members made a number of comments in relation to the revised plan, including:

- there were some typographical, grammar and punctuation errors in the document
- some acronyms were not explained
- Page 34 – Public Protection, would benefit from more detail
- Comparative data provided may benefit from inclusion of Scottish averages rather than Glasgow only comparison.

The meeting was advised that whilst still a draft, the document had now been typeset and within the short timescale within which it was hoped to circulate it may not be possible to incorporate all comments made.

The Board

a) noted the report.

b) endorsed the draft Strategic Plan for publication.

Chief Officer Designate

6. JOINT INSPECTION OF OLDER PEOPLE'S SERVICES

David Williams spoke to the paper on the Joint Inspection of Older People's Services carried out by the Care Inspectorate and Healthcare Improvement Scotland between October and December 2014.

The paper contains the report "Services for older people in Glasgow – Report of a joint inspection of health and social work services for older people" which was formally published by the Care Inspectorate and Health Improvement Scotland on 14th August 2015.

The Joint Inspection assessed services against nine quality indicators and the paper highlights the grading's achieved against these. An Improvement Plan was developed based on the nine recommendations for improvement outlined in the report.

Members agreed that this was setting the agenda for the way forward and the report was not an unhelpful assessment of areas for improvement. Members were reassured by the action plan and indicated they wished to receive a review of the report in the context of the Strategic Plan at a future IJB meeting.

The Board

a) noted the report.

b) asked for a progress report to the IJB in 6 months commenting on performance in the context of the Strategic Plan aspirations..

Chief Officer Designate

7. INTEGRATED CARE FUND – UPDATE

Stephen Fitzpatrick spoke to the paper providing an update on the implementation of the Integrated Care Fund (ICF) Plan in Glasgow and described the governance arrangements established to oversee its implementation.

The Scottish Government have made £100m available to Health and Social Care Partnerships over three years from April 2015 through the Integrated Care Fund.

Within Glasgow City there are four programme areas:

1. Early Intervention and Prevention
2. Anticipatory Care
3. Integrated Care Pathway
4. Accommodation Based Strategy

A query was raised as to how the IJB would know what was best value and whether an integrated performance report would be provided to the IJB. David Williams responded that high level performance reporting would be part of future meetings.

Chief officer Designate/ Head of Older People's Services

The Board noted the report.

8. FINANCE REPORT TO JULY 2015

Sharon Wearing spoke to the paper (and amended Appendix 1) providing a summary of the financial performance of the Glasgow City Health and Social Care Partnership for the period 1st April to 31st July 2015.

Sharon highlighted that currently the NHS and SWS use different accounting conventions, however, the local authority conventions will be adopted for reporting.

In response to comments:-

(a) Sharon advised that a predicted outturn for the year would be compiled at period 7.

(b) the pressures within Children and Families reflected in a significant net overspend was noted.

(c) the under recovery of rental income on homelessness accommodation was identified as arising from a reduced number of flats available.

The Board noted the report.

9. UNSCHEDULED CARE AND WINTER PLANNING

Stephen Fitzpatrick spoke to the submitted paper advising the Shadow Integration Joint Board of the Scottish Government's requirement for unscheduled care and winter planning in 2015/16 and the work underway within Glasgow City.

The key areas which Glasgow City is focusing on as part of the emerging unscheduled care plan (including preparation for the winter period) are:

- Maintaining previously reported improved performance on reducing delayed discharges;
- Measures to reduce admissions to hospitals, including GPs identifying patients at risk of admission through anticipatory care planning;
- Assessing the need for additional intermediate care capacity to support potential 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 periods;
- 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.

A questioned was asked whether we are being smarter in relation to anticipatory care and in working with housing providers. Stephen Fitzpatrick confirmed that this was the case and work with the housing sector included accommodation based support.

Shona Stephens indicated a number of Registered Social Landlords (RSL's) are gathering information on tenants who are more vulnerable.

The Board

a) noted the report.

b) Requested an update report on the Glasgow City Unscheduled Care Plan to a future meeting.

Chief Officer Designate

10. PARTICIPATION AND ENGAGEMENT STRATEGY

Allison Eccles spoke to the paper on the development of the Participation and Engagement Strategy providing an update on the progress which has been made, including the establishment of a Working Group and Steering Group. The role of the Steering Group is to provide strategic direction to the Working Group and review proposals ahead of presentation to the Glasgow City HSCP Executive Group and the Integration Joint Board. The paper included the terms of reference for both Groups.

An Action Plan had been produced identifying the following key stages:

- 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 2015;
- A period of consultation and feedback in January 2016;
- Proposals presented to the Integration Joint Board in February 2016.

The Board

a) noted the report.

b) Agreed that following the consultation and feedback on the draft Participation and Engagement Strategy the Strategy be submitted for approval in February 2016.

Head of Business Development

11. HEALTH BOARD CLINICAL SERVICES STRATEGY

Jennifer Armstrong, Medical Director for NHSGG&C gave a presentation on 'Clinical Services Fit for the Future: Approving the Clinical Strategy', relating to a paper approved by the NHSGGC Board on 19th January 2015.

Jennifer described the approach adopted in the review and gave practical examples of how change was being implemented. She made particular reference to a number of pilots which had been undertaking within the Royal Alexandra Hospital in Renfrewshire.
The presentation raised a high level of interest and questions. Discussion ranged over:-

(a) the role of the IJB with Acute Services.

(b) development of common client/patient identification e.g. through the use of CHI (Community Health Index) to be used within CareFirst to allow for information to be shared between services more effectively.

(c) making best use of GP services through redirection of "worried well" to more appropriate sources of advice.

(d) the importance of identification of vulnerable persons and implementing measures to allow them to live in the community with appropriate support.

(e) the importance of public education.

(f) continuing the shift of the balance of care.

(g) utilising non-health professionals to identify health issues.

(h) the need for effective interaction with Acute Services, including representation from Acute on the IJB.

The Board

a) noted the report.

b) agreed that the Clinical Services Strategy be discussed further once the IJB is constituted.

Chief Officer Designate

12. ANDREW O ROBERTSON

In referring to Andrew Robertson's retirement as Chairman of NHSGG&C in November 2015, Councillor Malcolm Cunning paid tribute to the considerable contribution that Andrew had made over many years association with the Health Board. Malcolm expressed particular thanks for his support to the development of integrated working and his contribution to the Glasgow City Shadow IJB. Malcolm and all present wished Andrew well for the future.

13. NEXT MEETING

It was agreed that the next meeting scheduled for 2.00 pm on Monday 2nd November 2015 be cancelled.

Therefore the next Shadow IJB meeting would take place at 2.00 pm on Tuesday 1st December 2015 in the Sir Peter Heatly Boardroom, Glasgow City HSCP, Commonwealth House, 32 Albion Street, Glasgow, G1 1LH.

The meeting ended at 4.10pm

Item No. 6(a)

Meeting Date 1st December 2015

Shadow Integration Joint Board

Report By: Chief Officer, Finance and Resources

Contact: Jonathan Bryden, Head of Finance

Tel: 0141 287 0486

Subject :	**GCH&SCP Joint Finance Monitoring Report**

Purpose of Report:	To provide a summary of the financial performance of Glasgow City Health and Social Care Partnership for the period 1 April 2015 to end September (Health) and 24 September 2015 (SWS).

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

Implications for IJB:

Financial:	As outlined within this report
Personnel:	None
Legal:	None
IT Implications:	None
Economic Impact:	None
Sustainability:	None
Sustainable Procurement and Article 19:	None

Equalities:	None

Implications for Glasgow City Council	Contributes to net overspend position at Period 7 2015/16
Implications for NHS GG&C	None

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 end September (Health) and 24 September (SWS).

1.2 For the purposes of this report, the NHS and Social Work elements are shown separately. Work is ongoing to develop an integrated report, and will be reported 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 £121,000 (0.04%) less than budget and income is on budget, resulting in net expenditure of £121,000 (0.04%) less than budget.

2.2 Within Social Work, gross expenditure is £754,000 (0.3%) greater than budget and income is £694,000 (0.93%) less than budget, resulting in net expenditure of £1,448,000 (0.82%) 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 £153,000 (M04, £148,000). Funding has been provided at the top of scale within the Resource Allocation Model, resulting in non-recurring savings in-year. Provision was made in month 6, across Community and Hosted Addictions services for the year-to-date shortfall in the HSCP Addictions savings programme.

3.2.2 **Adult Community Services** (excluding EquipU) are underspent by £464,000 (M04, £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 £224,000 (M04, £161,000). This reflects the additional spend as a result of Integration Fund initiatives. The equivalent budget variance at month 6 last year was £121,000 and so, although it is early to be forecasting a full-year position with any degree of confidence, it is likely to be considerably 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 £316,000 (M04, £307,000). Additional monies from Mental Health Innovation Funding have now been assumed 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 £63,000 (M04, £102,000). Patient and Children's Teams ('PACT') services are overspent by £208,000 (M04, £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 £221,000 (M04, £146,000). Homelessness Services are underspent by £211,000 (M04, £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 £273,000 (M04, £113,000). This is largely the result of BUPA partnership beds and other Elderly Mental Illness services 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 £651,000 (M04, £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. In addition, funding has been provided from this area for non-recurring School Nursing savings and for a shortfall in the funding available for purchased beds in Darnley and Quayside for adults with incapacity, discharged from Acute beds.

3.3 Social Work Services Budget Variances

3.3.1 There remains a pressure in direct employee costs of £1.6m within directly provided **Older People's Residential Care**, which includes overtime and agency costs incurred in order to maintain sufficient cover in staffing rotas.

3.3.2 **Homelessness** is currently underspent by £511,000. There is an underspend in employee costs (£604,000) as a result of the 17 week dispute in community casework teams and rent costs are underspent by (£546,000). This position is partially offset by an under recovery in housing benefit subsidy income (£534,000), and in temporary furnished flats rental income (£542,000). 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 Third party payments are underspent by £1,939,000 in respect of the provision of care packages for service users. This position reflects slippage within the Integrated Care Fund to offset pressures linked to 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 £365,000 at period 7.

3.3.5 **Children and Families** shows a net overspend of £2,268,000. Following a period of relative stability during 2014/15 in the number of purchased residential school placements, the current year has seen a significant increase, from 103 at the end of 2014/15 to 120 at Period 7. In addition, the complex needs of a number of these placements have resulted in associated high costs. As a consequence, we have seen a steady increase in the full year commitment, as reflected in this statement. We have also seen a slowing down in the number of applications to the Council for potential foster carers, and this issue has been exacerbated by recent legislative restrictions on the number of placements that can be made with a foster carer. This is one of the reasons for the increase in higher cost purchased foster placements. The position does not reflect any potential growth in numbers.

The key areas are:

- **Employee Costs** have a significant overspend on Superannuation costs (£357K at P7) which has increased compared to previous years due to Automatic Enrolment of employees into a workplace pension scheme.

- Placement numbers in **Residential Schools** have increased by 2 since period 6 and total 120 at P7, with an increase in full year commitment of £648,000. The full year projected overspend is £3.9m, which includes 11 placements within secure establishments. At period 7 the overspend is £2.1m.

- **Purchased residential placements** total 437, a reduction of 3 since period 6, with a net increase in full year commitment of £169,000. The full year projected overspend is £72,000, with period 7 showing an overspend of £42,000. Purchased fostering placements have increased by 1 since period

6 and total 334. Young people in transition to adult services are reflecting an underspend of £100,000 at period 7.

- **Transport** continues to be an on-going pressure £384,000 overspend at Period 7. This is mainly in transportation services provided by Cordia LLP.

There are also underspends in various areas including, provided foster care (£209,000), adoption allowances (£213,000), shared care and community respite (£213,000) and supplies and services (£178,000).

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
- Alternative arrangements will require to be implemented at short notice to procure appropriate accommodation for young adults to facilitate their transition from residential care, thus creating capacity within this service
- 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
- Utilisation of slippage within the Integrated Care Fund to offset other pressures within Older People

4.2 In addition, we will look for further efficiencies within the overall HSCP budget to assist recovery of the financial position.

5. Recommendations

5.1 The Shadow Integration Joint Board 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.

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	2,528	2,376	(153)	(6.0%)
Addictions - Hosted	26,653	13,530	13,553	22	0.2%
Adult Community Services	23,613	11,841	11,601	(240)	(2.0%)
Child Services - Community	13,222	6,592	6,655	63	1.0%
Child Services - Specialist	33,184	16,127	16,443	316	2.0%
Fhs - Gms	86,805	43,183	43,183	0	0.0%
Fhs - Other	88,569	43,042	43.042	0	0.0%
Fhs - Prescribing	122,135	61,287	61,287	0	0.0%
Hosted Services	17,800	8,124	7,903	(221)	(2.7%)
Integrated Care Fund	12,404	4,427	4,427	0	0.0%
Learn Dis - Community	2,204	1,113	1,019	(93)	(8.4%)
Men Health - Adult Community	17,351	8,661	8,557	(104)	(1.2%)
Men Health - Adult Inpatient	64,540	32,161	32,244	83	0.3%
Men Health - Elderly Services	26,105	12,895	12,698	(197)	(1.5%)
Men Health - Other Services	38,693	19,098	19,042	(55)	(0.3%)
Other Services	27,323	11,350	12,001	651	5.7%
Planning & Health Improvement	8,882	3,771	3,713	(58)	(1.5%)
Resource Transfer - LA	65,412	32,706	32,705	(1)	(0.0%)
Sexual Health Services	11,352	5,639	5,505	(134)	(2.4%)
NHS Sub Total	**691,302**	**338,074**	**337,953**	**(122)**	**(0.0%)**
Social Work					
Expenditure					
Community Care	385,450	165,189	163,695	(1,494)	(0.9%)
Children & Families	130,803	66,741	69,090	2,349	3.5%
Criminal Justice	16,615	7,586	7,586	0	0.0%
Fieldwork	8,277	4,596	4,565	(31)	(0.7%)
Support Services	13,489	8,026	7,957	(69)	(0.9%)
Sub Total	**554,634**	**252,138**	**252,893**	**755**	**0.3%**
Income					
Community Care	135,130	63,497	62,271	(776)	(1.2%)
Children & Families	1,985	773	854	81	10.5%
Criminal Justice	18,584	9,114	9,114	0	0.0%
Fieldwork	1,806	1,045	1,044	(1)	(0.1%)
Support Services	366	309	312	3	1.0%
Sub Total	**157,871**	**74,738**	**74,045**	**(693)**	**(0.9%)**
Social Work Net Sub Total	**396,763**	**177,400**	**178,848**	**1,448**	**0.8%**
Grand Total	**1,088,065**	**515,474**	**516,801**	**1,326**	**0.3%**

Item No. 7

Meeting Date **1st December 2015**

Shadow Integration Joint Board

Report By: **Chief Officer Designate**

Contact: **Allison Eccles, Head of Business Development**

Tel: **0141 287 8751**

PERFORMANCE REPORT

Purpose of Report:	To present an overview on the partnership's performance in delivery of health and social care services as at October 2015

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

Implications for IJB:

Financial:	None

Personnel:	None

Legal:	The Integration Joint Board when established will be required by statute to produce a performance report within four months of the end of each financial year.
Economic Impact:	None

Sustainability:	None

Sustainable Procurement and Article 19:	None

Equalities:	None

Implications for Glasgow City Council:	Social Care functions as outlined in the appended report are not yet delegated and remain the responsibility of the Council at this time

Implications for NHS Greater Glasgow & Clyde:	Health functions as outlined in the appended report are not yet delegated and remain the responsibility of the Health Board at this time

1. Purpose

1.1 The purpose of this report is to present an overview on the Health and Social Care Partnership's performance in delivery of health and social care services as at October 2015

2. Performance Reporting

2.1 The Shadow Integration Joint Board have previously been advised that work is ongoing to develop an integrated approach to performance management across the Health and Social Care Partnership.

2.2 This work is ongoing and proposals will be presented to the Shadow Integration Joint Board, or Integration Joint Board proper, early in 2016.

2.3 The Shadow Integration Joint Board is invited to review and note the latest performance reports relating to those social care and health functions which will be delegated upon establishment of the Integration Joint Board and implementation of the Strategic Plan.

2.4 Health and Social Work reports, and a summary of variations between localities are appended to this report.

3. Recommendations

3.1 The Shadow Integration Joint Board is asked to note this report

NHS CORPORATE PERFORMANCE REPORT OCTOBER 2015

1. PURPOSE OF THE REPORT

The purpose of this report is to present the latest NHS performance information available for the HSCP and its Localities.

2. STRUCTURE

In Appendix 1, data when available is shown at HSCP, Locality and Board wide levels. In order to demonstrate trends over time, performance information is included for several periods, with the exact period covered depending upon how regularly the data in relation to each indicator is produced. Data in relation to national/Health Board target indicators comes from the Health Board Sharepoint site which is updated continuously, with the latest available data at the time of writing the report being included. Data in relation to the local performance indicators comes from local management systems and is generally updated on a less frequent basis.

Appendix 1 consists of the following sections:

LDP Targets and Key Performance Indicators

In the first section, performance is shown graphically for the LDP targets/standards and for those indicators which have been previously identified as being areas requiring particular attention i.e. Key Performance Indicators (KPIs). This section is split into three parts. The first part highlights those indicators classified as Red (R), where performance is more than 5% from the target. The next part highlights those indicators classified as amber (A) where performance is less than 5% from the specified target. The final section highlights those indicators where the targets are being met and performance is classified as Green (G). Please note that for data before 2012/13 these classifications are based upon 10% variances, rather than 5%.

All Other Performance Indicators

In the second section, a standard tabular reporting format is used to highlight performance for All Other Performance Indicators (O) which have been identified locally or specified by the Health Board or nationally. Within this section, where targets exist, performance is also categorised in accordance with the above performance classification system. There are a number of indicators, however, for which no targets exist. In the case of these, performance data and trends are simply shown.

4. PERFORMANCE SUMMARY

Performance against all indicators with targets is summarised at the start of Appendix 1. A total of 42 indicators are included. Of these 42, 22 are GREEN, 5 are AMBER and 15 are RED.

18 of the indicators are either LDP targets/standards or KPIs. Of these, currently 9 are GREEN, 2 are AMBER, and 7 are RED.

APPENDIX 1

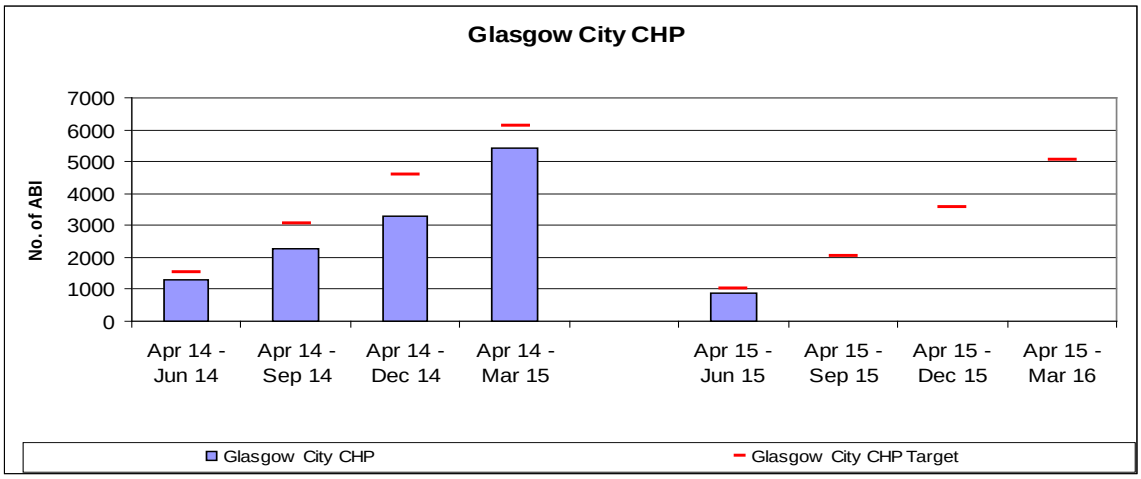
CORPORATE PERFORMANCE TEMPLATE – OCTOBER 2015

PERFORMANCE SUMMARY

STATUS	Key	No. Of Indicators			
		LDP	KPIs	Other	Total
Red	Performance is outwith 5% of target	5	2	8	**15**
Amber	Performance within 5% of target	1	1	3	**5**
Green	Performance either meets or exceeds target	6	3	13	**22**
Total		**12**	**6**	**24**	**42**

1i. LDP TARGETS & STANDARDS/KPIS - RED

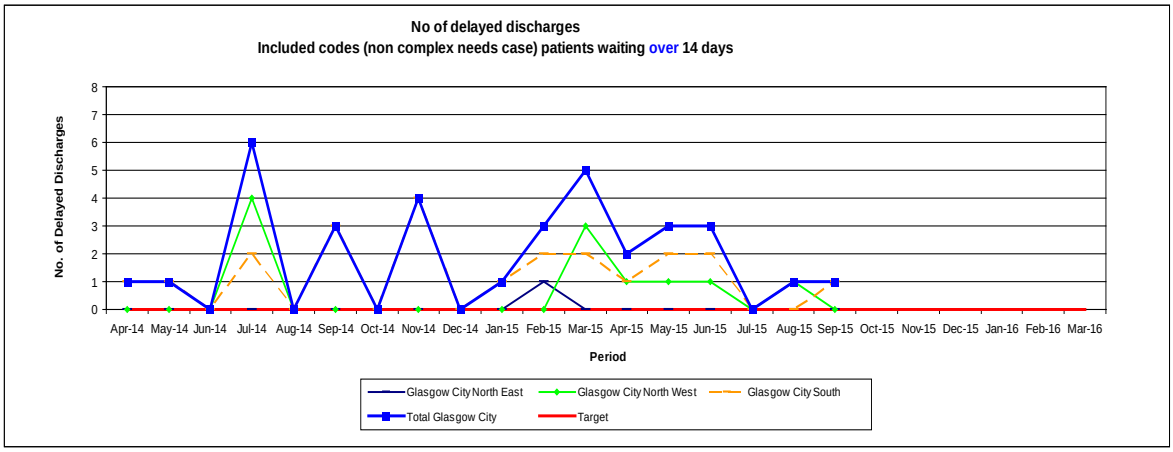
Target/Ref **(LDP1)**	**1. Achieve agreed number of screenings using the setting-appropriate screening tool and appropriate alcohol brief intervention, in line with SIGN 74 guidelines during 2011/12. (LDP Standard)**
Performance	Performance Red for the first quarter of 2015/16.



Number of Brief Interventions (Cumulative)	**Apr 15 – June 15 Target**	**Apr 15 – Jun 15 Actual**	**Status**
North East Sector	328	236	N/A
North West Sector	317	345	N/A
South Sector	369	281	N/A
Glasgow City HSCP	**1014**	**879**	**Red**
Glasgow City HSCP Target			N/A

Commentary
New target figures have been agreed for the Health Board for 2015/16, which take account of the Camglen boundary change, with Glasgow's target now 5006 for the year. Performance slightly below target for the first quarter.

Target/Ref **(LDP2)**	**2. No people will wait more than 14 days to be discharged from hospital into a more appropriate care setting, once treatment is complete from April 2015 (includes codes) (LDP Target).**
Performance	Performance remains above target and classified as RED. However, it has shown a clear reduction over the last five months. Variation evident across localities with the North East having no delays over this period, with the others improving performance.

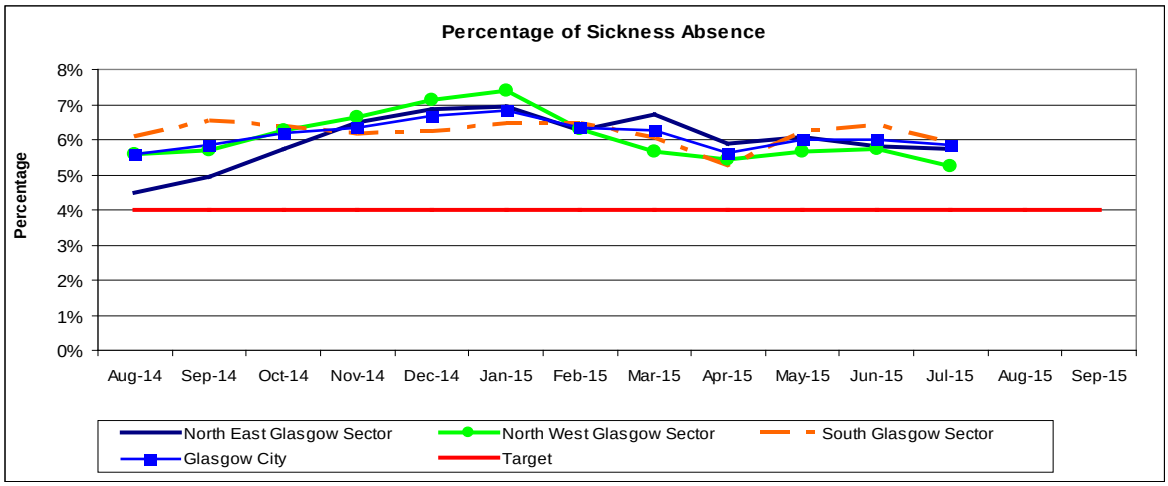


Delayed Discharges - Included codes (non complex needs case) patients waiting over 2 weeks

HSCP	Apr-15	May-15	June 15	July 15	Aug 15	Sep 15	Status
North East Sector	0 (G)	0 (G)	0 (G)	0 (G)	0 (G)	0	Green
North West	18 (R)	11 (R)	6 (R)	5 (R)	9 (R)	7	Red
South Sector	17 (R)	11 (R)	7 (R)	3 (R)	3 (R)	4	Red
Glasgow City	**35 (R)**	**22 (R)**	**13 (R)**	**8 (R)**	**12 (R)**	**11**	**Red**
Target	0	0	0	0	0	0	

Commentary
Patient numbers delayed have shown a decline following the introduction of step down provision across the city. The process to support 72 hour discharge is established in each sector. North East remains the best performing locality, but performance in the other areas is improving as the process matures. Specific work is underway to utilise existing and additional care home places for both the patients going directly from hospital and also to support the throughput in step down facilities. A commissioning strategy is in place to provide a sustainable model of intermediate care to support this target. In addition, work is underway to ensure more effective use of community provision to ensure that an increasing number of patients return home.

Target/Ref (LDP3)	**3. NHS Boards to achieve a sickness absence rate of 4% from 31 March 2009 (LDP Standard)**
Performance	Performance remains classified as RED in all localities though actual absence figures have reduced over the last four months in all areas.

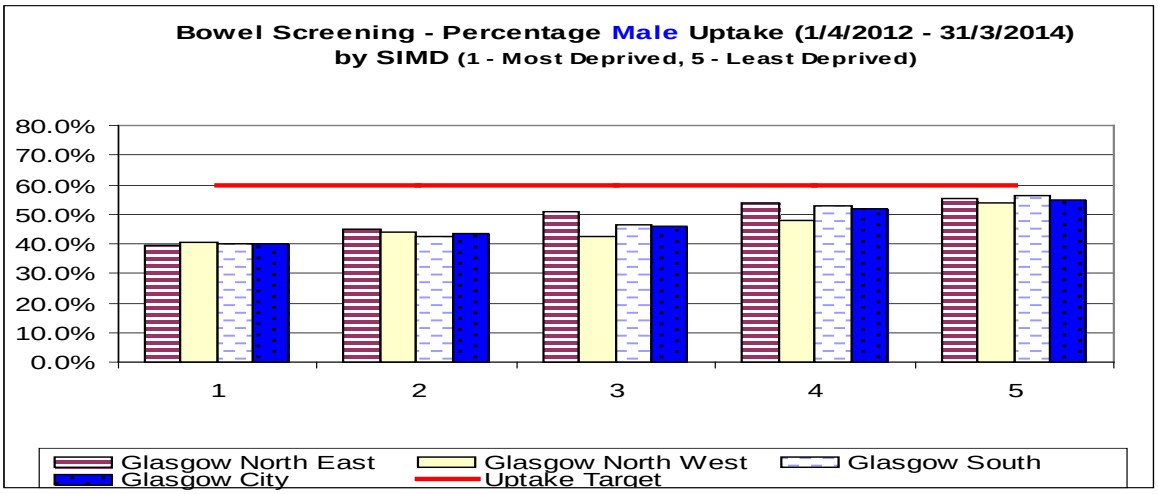


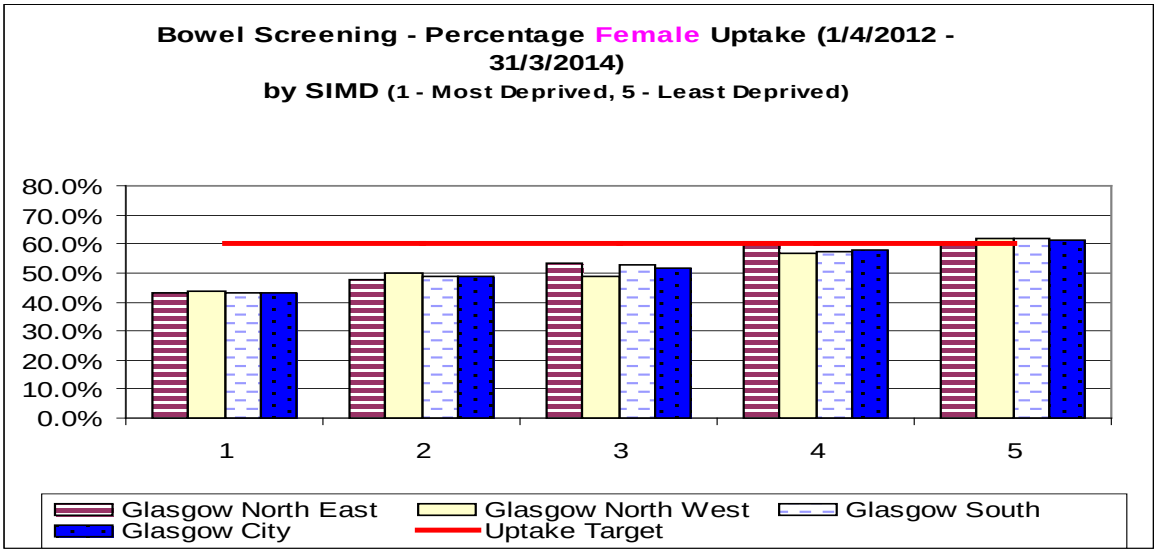
HSCP	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Status
North East	6.7% (R)	5.9% (R)	6.1% (R)	5.8% (R)	5.7%	Red
North West	5.7% (R)	5.4% (R)	5.7% (R)	5.7% (R)	5.2%	Red
South	6.0% (R)	5.3% (R)	6.2% (R)	6.4% (R)	5.9%	Red
Glasgow City	**6.3% (R)**	**5.6% (R)**	**6.0% (R)**	**6.0% (R)**	**5.9%**	**Red**
NHSGGC [1]	5.8% (R)	5.6% (R)	5.4% (R)	5.5% (R)	5.7%	Red
Target	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%

Commentary

There is an ongoing focus on absence management within NHS services. Absence levels continue to be actively managed and reviewed on an ongoing basis to ensure procedures are followed and any necessary actions in place. There is an expectation that all staff on Long Term Sickness absence have an individual plan regarding the management of their absence.

Target/Ref (KPI 1)	**4. To meet target of 60% of those invited undertaking bowel screening**
Performance	Below target and remains classified as RED. Variations evident by gender, SIMD and Sector. Increase in both male and female screening rates since the last round.





	Uptake by SIMD category 2012-14 (%) Most deprived					Least deprived	2012-14	2010-13
	1	**2**	**3**	**4**	**5**	**Unassigned***	**Total**	**Total**
Female								
North East	42.9%	47.7%	53.5%	60.7%	59.9%	47.1%	46.8%	45.1% (R)
North West	43.9%	50.1%	48.5%	56.9%	61.6%	42.3%	50.0%	48.2% (R)
South Sector	42.9%	48.7%	52.5%	57.1%	61.6%	32.6%	48.9%	47.5% (R)
HSCP	**43.2%**	**48.8%**	**51.4%**	**58.1%**	**61.5%**	**38.4%**	**48.6% (R)**	**47.0% (R)**
NHSGGC	44.3%	50.9%	55.4%	61.4%	65.5%	36.3%	53.9% (R)	52.3% (R)
Male								
North East	39.5%	44.9%	50.8%	53.9%	55.5%	34.9%	43.1% (R)	41.0% (R)
North West	40.3%	44.1%	42.3%	48.1%	53.6%	35.3%	44.4% (R)	42.3% (R)
South Sector	40.2%	42.3%	46.6%	53.0%	56.5%	34.8%	44.5% (R)	42.3% (R)
HSCP	**40.0%**	**43.3%**	**46.0%**	**51.9%**	**54.7%**	**34.9%**	**44.0% (R)**	**41.9% (R)**
NHSGGC	40.9%	46.1%	50.4%	54.9%	59.2%	35.2%	48.9% (R)	46.8% (R)
Total								
North East	41.2%	46.3%	52.2%	57.3%	57.7%	37.0%	45.0% (R)	43.1% (R)
North West	42.1%	47.1%	45.3%	52.5%	57.6%	39.5%	47.2% (R)	45.2% (R)
South Sector	41.6%	45.5%	49.5%	55.1%	59.2%	33.7%	46.7% (R)	44.9% (R)
HSCP	**41.6%**	**46.1%**	**48.7%**	**55.1%**	**58.1%**	**36.2%**	**46.3% (R)**	**44.4% (R)**
NHSGGC	42.6%	48.5%	52.9%	58.2%	62.4%	35.7%	51.5% (R)	49.6% (R)
Target	60%	60%	60%	60%	60%	60%	60%	60%

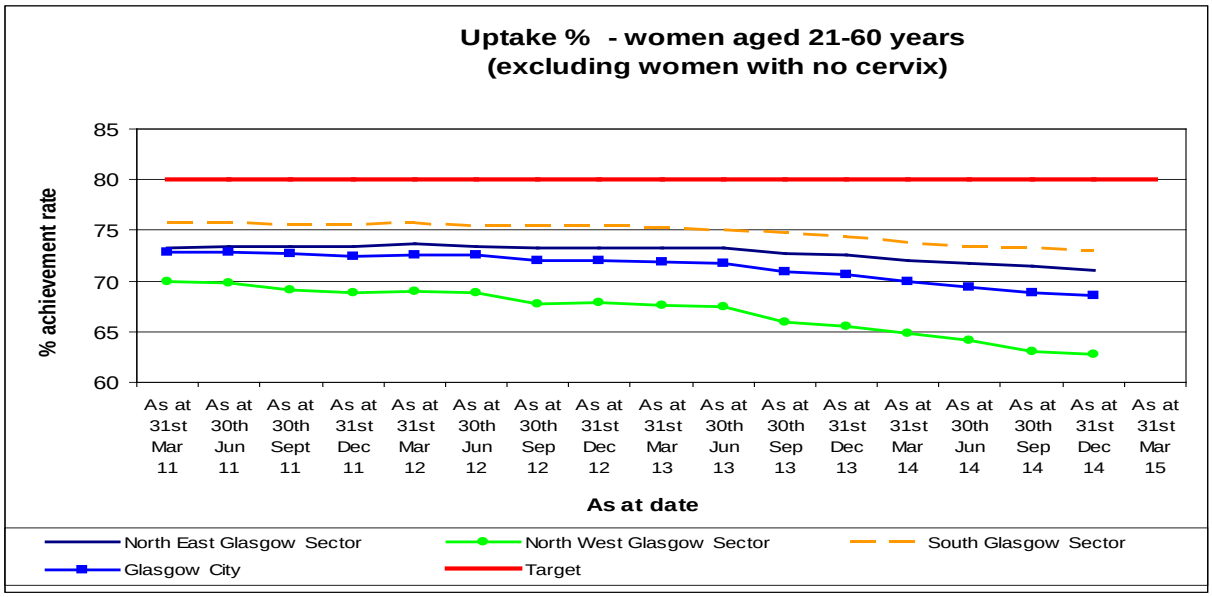
* Those with an incomplete/incorrect postcode or those outwith HSCP boundaries

Commentary

Locally, GHSCP have worked with Public Health to commission a telephone outreach service from Community Renewal to patients in SIMD 1 areas being offered bowel cancer screening for the first time, with 45 Glasgow practices participating. This will give further insight into why people do not complete their kits and will inform future methods of engagement. HSCP health improvement staff are also continuing to promote uptake and have delivered bowel cancer awareness sessions to BME groups, mental health service users, recovering addicts and ex-offenders.

Other initiatives which will support performance include the two year national sGMS bowel screening GP Practice initiative which saw 73% of practices in the city submitting action plans and started in 2013; and the 3 year partnership programme between NHS Greater Glasgow & Clyde and Cancer Research UK which provides primary care practitioners with practical support, information and educational resources to improve cancer outcomes and was introduced in 2014.

Target/Ref (KPI 2)	**5. To meet target of 80% of women attending for cervical screening**
Performance	Slight reduction over the last few reporting periods and performance continues to be below target for the HSCP and all Localities. Variations evident across areas and by SIMD categories with North West the lowest.



TARGET	AREA	31 Mar 14	30 Jun 14	30 Sep 14	31st Dec 14	Status
80%	NE	72.0% (R)	71.7% (R)	71.5% (R)	71.0%	Red
80%	NW	64.8% (R)	64.2% (R)	63.1% (R)	62.7%	Red
80%	S	73.8% (R)	73.4% (R)	73.2% (R)	73.0%	Red
80%	**HSCP**	**69.9% (R)**	**69.4% (R)**	**68.9% (R)**	**68.5%**	**Red**
80%	NHSGGC	73.8% (R)	73.4% (R)	73.0% (R)	72.6%	Red

Uptake by SIMD category 2010-13 (%) Most deprived					Least deprived
	1	**2**	**3**	**4**	**5**
Jun 13	73.35 (R)	71.40 (R)	66.86 (R)	65.59 (R)	68.59 (R)
Sep 13	72.75 (R)	70.15 (R)	65.40 (R)	63.27 (R)	66.93 (R)
Dec 13	72.46 (R)	69.89 (R)	65.19 (R)	63.25 (R)	67.09 (R)
Mar 14	72.32 (R)	69.78 (R)	64.83 (R)	63.30 (R)	66.94 (R)
Jun 14	72.25 (R)	69.67 (R)	64.28 (R)	62.97 (R)	66.56 (R)
Sep 14	71.79 (R)	68.86 (R)	63.37 (R)	61.68 (R)	65.18 (R)

* Those with an incomplete/incorrect postcode or those outwith HSCP boundaries

Commentary
Screening data routinely incorporated into the Practice Activity Reports and can be reviewed as part of practice quality improvement visits. Variations are examined and where required, discussed with practices, and support offered by the Primary Care Development Officers. A number of other resources have been developed to support practices including a "Top Tips: Cervical Screening" document; a self assessment tool to enable practices to reflect on their systems and procedure; WebEx style seminars; and presentation materials for practices to enable them to undertake in-house training sessions.

Target/Ref (LDP4)	6. % able to book an appointment with a GP in advance (LDP Standard)
Performance	This LDP standard relates to the ability of patients to book an appointment specifically with a GP more than 48 hours in advance. The latest national GP Patient Experience Survey indicates that the HSCP and all localities were below target. All were RED with the exception of the South which was AMBER.

Area	% valid responses that were positive 13/14	Target for 13/14	13/14 Status	11/12 Survey Results %
North East Glasgow Sector	78.5	90.0	Red	
North West Glasgow Sector	82.5	90.0	Red	
South Glasgow Sector	85.8	90.0	Amber	
Glasgow City	**82.5**	**90.0**	**Red**	**83.7**
NHSGGC	81.3	90.0	Red	

Commentary
As part of the latest QOF, 25 points were available for practices that complete Indicator QS002, which involves undertaking a review of access using an agreed tool and providing a practice action report of the findings to the Health Board. Training is also being offered to practices to support their service improvement work in this area. Access has also been discussed with 17c practices at practice visits and at peer support sessions which led to some reviewing their arrangements and introducing changes to their appointment systems.

Target/Ref (LDP 5)	**7. Achieve agreed Quit Rates at 3 months from the 40% most deprived areas (LDP Target).**
Performance	HSCP and all localities slightly below target for the first quarter of 2015/16.

Area	**Actual quits at 3 months follow-up Apr 15 – Jun 15 (Cumulative)**	**Target quits (Cumulative)**	**Status**
North East	738	759	Red
North West	485	544	Red
South	594	658	Red
Glasgow	**1817**	**1961**	**Red**
NHSGGC	2571	2765	Red

Commentary

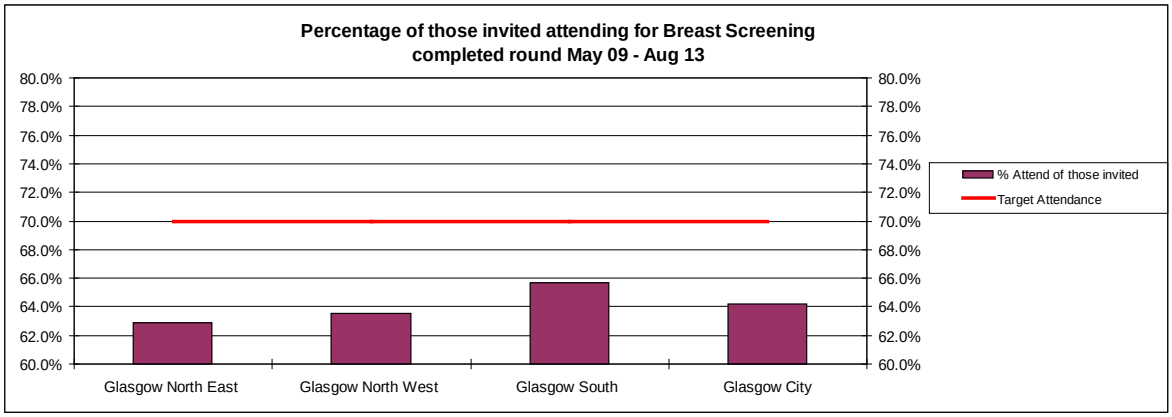
This target was adjusted in 2014/15 by the Scottish Government to reflect smoking status at 12 rather than 6 weeks post quit. HSCP and all localities were RED last year which was reflective of the situation across NHS Boards since the target change. Two notable changes contributed to this:

- 36% fewer people are seeking NHS support to stop smoking
- 12 week follow-up proving more difficult for pharmacies to complete and there are significantly more where no follow-up is recorded (which is classed as failed attempt). National negotiations are in progress to remedy this pharmacy follow-up system

Initial findings for the Adult Health and Well-being survey (2014) did, however, show a significant fall in smoking rates in the last three year period. Overall rates fell from 35.1% in 2011 to 28% in 2014 (7.1% reduction). For those living in the lowest 15% SIMD, the decline was slightly smaller, falling from 43.1% in 2011 to 36.4% in 2014 (a 6.8% reduction).

1ii. LDP TARGETS & STANDARDS/KPIS - AMBER

Target/Ref (KPI 3)	**8.To meet target of 70% of women attending for breast screening**
Performance	Remains below target and AMBER for the HSCP, South and North West. North East is RED.



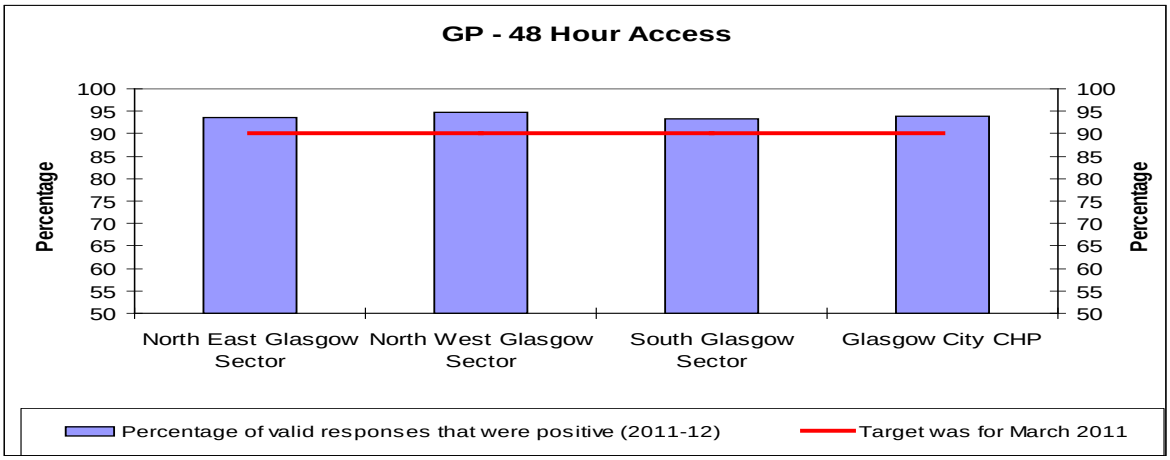
TARGET	AREA	2006-09 Round	2009-13 Round	Status
70%	NE		62.9	Red
70%	NW		63.5	Amber
70%	S		65.6	Amber
70%	**HSCP**	**67.7% (A)**	**64.2**	**Amber**
70%	NHSGGC	70.9% (G)	69.1	Amber

Commentary

Below target in all areas and a slight reduction evident since the 2006-09 round for the HSCP as a whole. The primary care development workers continue to support practices in reviewing data and encouraging their patients to attend for screening, with the actual co-ordination and delivery of the screening service a national responsibility.

The classification system used in relation to this indicator is based upon that used prior to 2012-13, with performance classified as RED when it is 10% or more off target (i.e. 63 or below). The majority of indicators within this report are based upon a 5% tolerance as more recent data is available for them.

Target/Ref (LDP6)	9. Provide 48 hour access to an appropriate member of the GP Practice team (LDP Standard)
Performance	This LDP standard relates to the ability of patients to access an appropriate healthcare professional within 48 hours. The latest national GP Patient Experience Survey indicated that the HSCP and all localities were below the target, with performance declining slightly since the last survey.



Area	11/12 Survey Results %	% valid responses that were positive 13/14	Target for 13/14	13/14 Status
North East	93.6	93.2	95.0	Amber
North West	94.8	94.4	95.0	Amber
South	93.4	93.5	95.0	Amber
Glasgow City	**93.9**	**93.7**	**95.0**	**Amber**
NHSGGC	94.0	93.6	95.0	Amber

Commentary
The above information is taken from the latest national GP patient experience survey. As part of the latest QOF, 25 points were available for practices that complete Indicator QS002, which is to undertake a review of access using an agreed tool and provide a practice action report of the findings to the Health Board. Training is being offered to practices to support their service improvement work in this area. See also HT4 above.

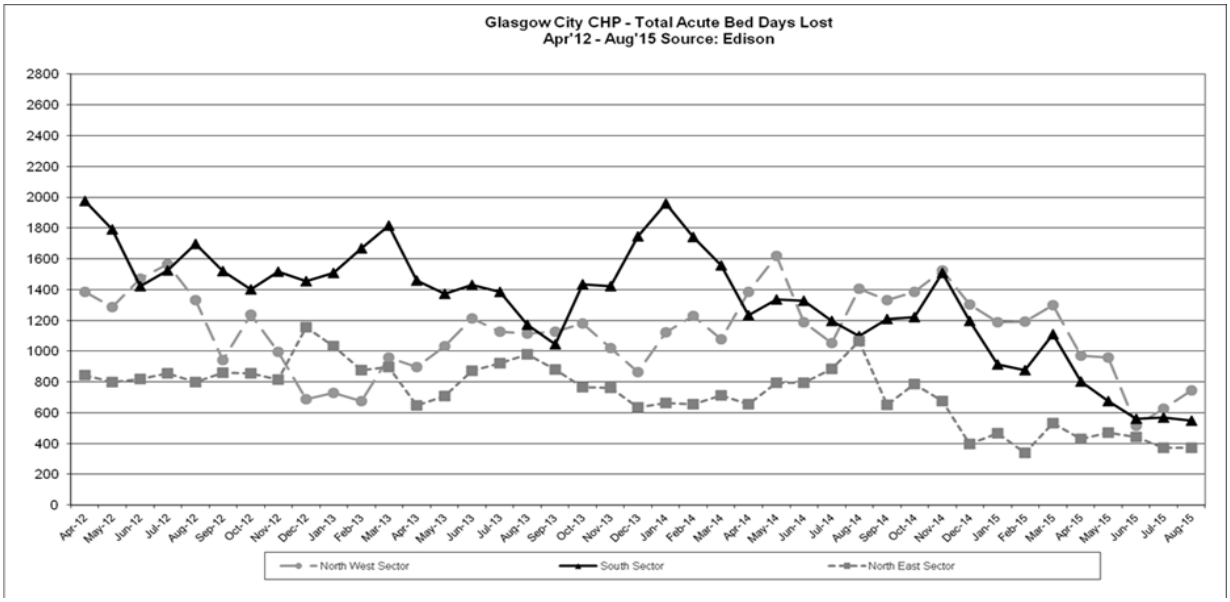
1iii. LDP TARGETS & STANDARDS /KPIS – GREEN

Target/Ref ***(LDP 7)***	**10. % of pregnant women in each quintile who book for antenatal care by the 12th week of gestation (LDP Target).**
Performance	Some variation across SIMD categories but overall the HSCP's performance moved from RED to GREEN in the last reporting period, as did the South and North West with North East moving from AMBER to GREEN

	Jan-Mar 2014	Apr-Jun 2014	Jul - Sep 2014	Oct - Dec 2014	Jan - Mar 2015	Target	Status
NE							
Quintile 1	81.58%	75.72%	74.67%	77.94%	82.10%	80%	Amber
Quintile 2	69.23%	67.08%	74.36%	85.59%	81.16%	80%	Green
Quintile 3	73.97%	71.95%	73.33%	67.86%	84.62%	80%	Green
Quintile 4	86.54%	80.77%	87.04%	85.48%	90.91%	80%	Green
Quintile 5	92.86%	85.71%	84.21%	66.67%	75.00%	80%	Green
NE Total	78.10%	73.81%	76.06%	79.51%	82.94%	80%	**Green**
NW						80%	
Quintile 1	76.67%	74.24%	76.16%	72.79%	78.95%	80%	Green
Quintile 2	79.17%	81.51%	82.88%	72.41%	86.11%	80%	Green
Quintile 3	74.75%	77.08%	73.75%	75.31%	89.89%	80%	Green
Quintile 4	73.00%	77.38%	80.72%	72.97%	90.00%	80%	Green
Quintile 5	81.32%	83.33%	85.39%	76.62%	87.18%	80%	Green
NW Total	76.86%	78.23%	79.57%	73.85%	85.26%	80%	**Green**
South						80%	
Quintile 1	72.40%	69.19%	67.01%	74.42%	82.93%	80%	Green
Quintile 2	69.78%	73.44%	76.26%	73.13%	80.72%	80%	Green
Quintile 3	66.49%	75.23%	79.12%	70.93%	80.00%	80%	Green
Quintile 4	76.92%	78.26%	73.24%	82.46%	86.51%	80%	Green
Quintile 5	81.48%	85.25%	89.74%	71.43%	95.45%	80%	Green
South Total	71.97%	74.51%	74.54%	74.52%	83.12%	80%	**Green**
HSCP						80%	
Quintile 1	77.43%	73.28%	72.44%	75.39%	81.52%	80%	Green
Quintile 2	71.96%	73.75%	77.34%	77.29%	82.28%	80%	Green
Quintile 3	70.22%	75.00%	76.71%	71.52%	83.60%	80%	Green
Quintile 4	77.27%	78.67%	78.14%	80.40%	88.56%	80%	Green
Quintile 5	82.39%	84.21%	86.39%	74.56%	89.23%	80%	Green
HSCP Total	75.28%	75.43%	76.49%	75.79%	83.72%	80%	**Green**

Commentary
Performance varies across localities and by SIMD quintile. The HSCP continues to work collaboratively with acute to support delivery of this target.

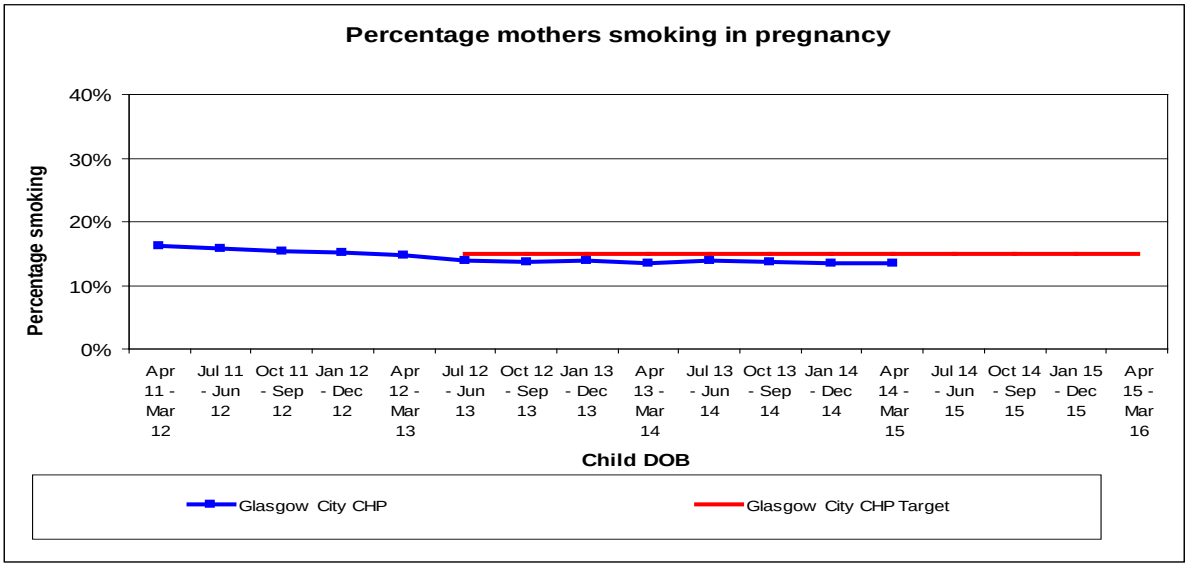
Target/Ref (KPI 4)	**11. Number of Bed Days Lost to Delayed Discharge.**
Performance	Performance has been improving for the HSCP as a whole and monthly bed days lost have fallen to their lowest levels and are now below the target (which is based upon achieving 50% of the 09/10 baseline). Variation evident across the Localities.



AREA	09/10 Baseline	12/13 Actual	13/14 Actual	14/15 Actual	Jun 15	Jul 15	Aug 15	Total	Target to date
HSCP	**53,110**	**43,185 (R)**	**39,929 (R)**	**38,152 (R)**	**1513 (G)**	**1571 (G)**	**1668 (G)**	**9062 (G)**	**11064**
NE	12,914	10,615	9003	13424	440	374	374	2089	N/A
NW	17,502	13,267	13,200	7515	514	626	746	3817	N/A
S	22,694	19,303	17,726	14269	559	571	548	3156	N/A

Commentary
Actions being taken to achieve improvement are described above in relation to Target 2 - Delayed Discharges.

Target/Ref (KPI 5)	**12. To meet the target of less than 15% of women smoking in pregnancy – General Population**
Performance	HSCP, North West and South consistently meeting target. North East remains below target and RED.

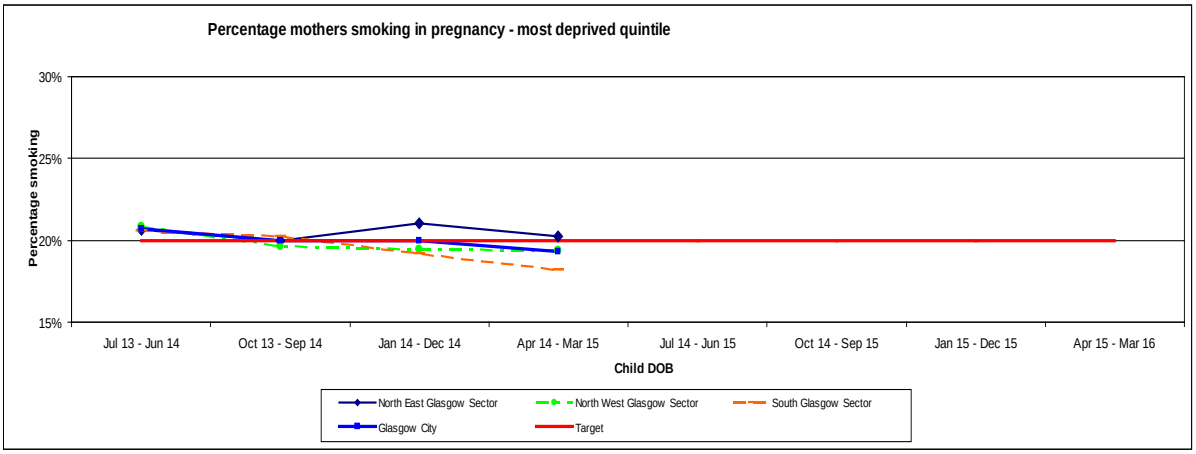


TARGET	AREA	Apr 13-Mar 14	Jul 13 - Jun 14	Oct 13-Sep 14	Jan 14 - Dec 14	Apr 14-Mar 15	Status
15%	NE	16.7% (R)	16.9% (R)	17.1% (R)	17.5% (R)	17.6% (R)	Red
15%	NW	12.2% (G)	12.6% (G)	12.2% (G)	11.7% (G)	11.7% (G)	Green
15%	S	12.4% (G)	12.7% (G)	12.2% (G)	11.9% (G)	11.6% (G)	Green
15%	**HSCP**	**13.6% (G)**	**13.9% (G)**	**13.6% (G)**	**13.5% (G)**	**13.4% (G)**	Green
20%	NHSGGC	13.4% (G)	13.7% (G)	13.3% (G)	13.3% (G)	13.0% (G)	Green

Commentary
The HSCP as a whole, North West and South remain GREEN with the North East RED. The smoking in pregnancy service has been re-established and cessation services have been linked to maternity hubs.

Target/Ref **(KPI 6)**	**13. To meet target of less than 20% of women smoking in pregnancy – most deprived quintile**
Performance	HSCP remained GREEN as has the North West and South. The North East has moved from RED to AMBER.

AREA	Target	July 13-June 14	Oct 13-Sep 14	Jan 14-Dec 14	Apr14-Mar15		Status
NE	20%	20.6% (A)	20.0% (G)	21.0% (R)	20.2% (A)		Amber
NW	20%	20.8% (A)	19.6% (G)	19.4% (G)	19.4% (G)		Green
S	20%	20.6% (A)	20.2% (A)	19.2% (G)	18.2% (G)		Green
HSCP	20%	**20.7% (A)**	**20.0% (G)**	**20.0% (G)**	**19.3% (G)**		**Green**
NHSGGC	20%	22.2% (A)	21.3% (R)	21.3% (R)	20.9% (A)		Amber



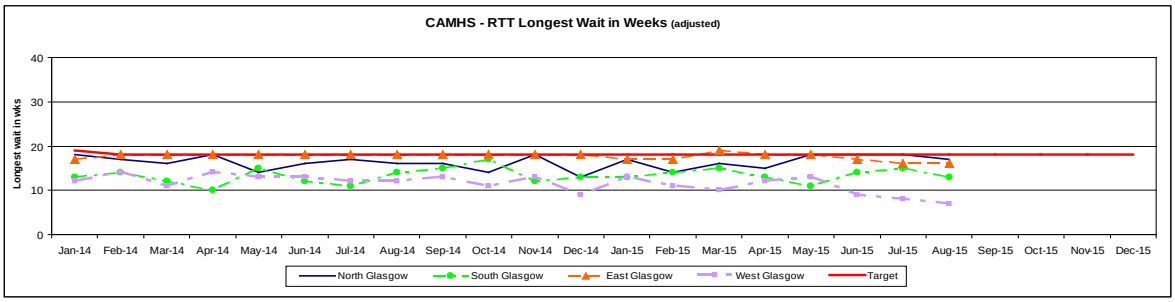
Commentary
While there have been variations between localities, there has been an improvement in performance over the course of the last year with Glasgow as a whole moving from AMBER to GREEN. Rates for Glasgow and all localities remain below the Board wide average.

Target/Ref (LDP 8)	**14. To maintain the proportion of people with a diagnosis of dementia on the Quality and Outcomes Framework (QOF) dementia register and other equivalent sources (LDP Standard).**
Performance	Performance remains GREEN.

AREA	**TARGET**	End June 2015	End July 2015	End August 2015		
NE	**1215**	1430	1449	1441		
NW	**1227**	1256	1270	1304		
S	**1504**	1529	1539	1562		
HSCP **exc nursing homes**	**3946**	**4215 (G)**	**4258 (G)**	**4307 (G)**		

Commentary
NHSGGC was the top performing board for numbers registered with dementia in the UK in 2012 and it is widely accepted that there is limited capacity to improve on numbers much beyond this level. The Dementia Strategy Group continues to monitor the number of people with a diagnosis of Dementia placed on GP QoF registers, and to work with practices locally to encourage registration. The Dementia Post Diagnosis Support Service launched in June 2014 provides greater incentives for earlier referrals for diagnosis.

Target/Ref (LDP 9)	**15. Deliver faster access to specialist Child and Adolescent Mental Health Services (CAMHS) services from March 2013 - Longest wait in weeks (LDP Target).**
Performance	These figures relate to the geographies used by specialist children's services and the target has reduced over time in line with an agreed trajectory with a slight reduction in August to a maximum of 17 weeks.



Area	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Status
North Glasgow	16 (G)	15 (G)	18 (G)	18 (G)	18 (G)	17 (G)	Green
South Glasgow	15 (G)	13 (G)	17 (G)	14 (G)	15 (G)	13 (G)	Green
East Glasgow	19 (R)	18 (G)	18 (G)	17 (G)	16 (G)	16 (G)	Green
West Glasgow	10 (G)	12 (G)	13 (G)	9 (G)	8 (G)	7 (G)	Green
Glasgow City HSCP	**18 (G)**	**18 (G)**	**18 (G)**	**18 (G)**	**18 (G)**	**17 (G)**	**Green**
NHSGGC	18 (G)	18 (G)	18 (G)	18 (G)	18 (G)	18 (G)	Green
Indicative target	18	18	18	18			

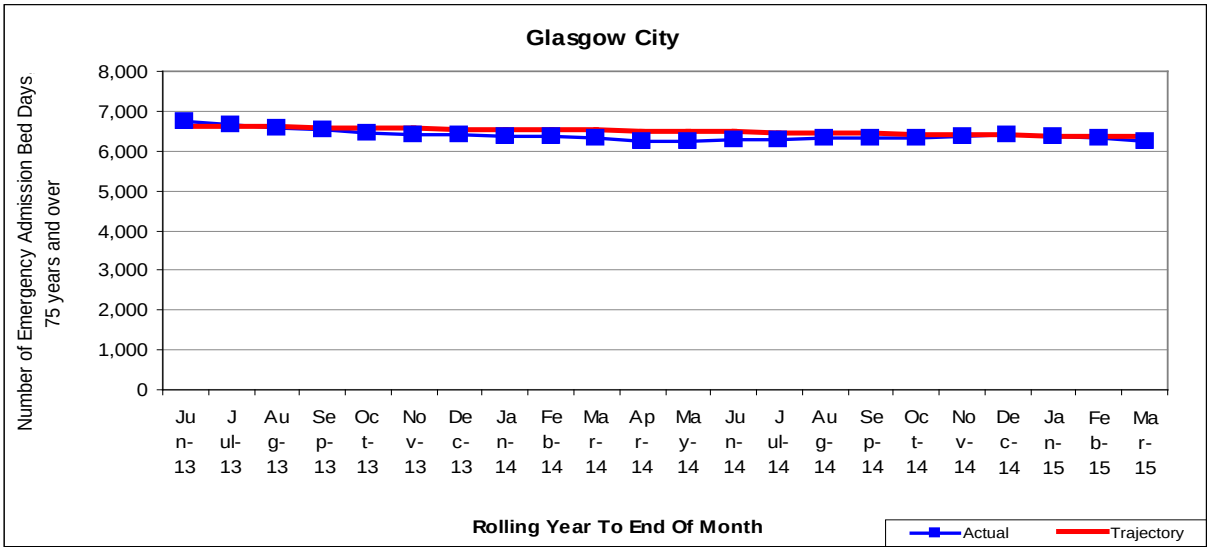
Commentary
Performance has improved against this indicator over the last three years and it has been consistently GREEN for the last 21 months. CAMHS is complimented in GHSCP by the school based Place2be service and the Lifelink contract for 12-18 year olds. These provide resilience, talking and youth counselling components.

Target/Ref (LDP 10)	**16. Psychological Therapies: % of people waiting over 18 weeks Referral to Treatment (RTT) (LDP Target).**
Performance	North East and South remained GREEN in the last period, as did the HSCP as a whole. North West remained RED.

	% of People who started treatment within 18 weeks of referral				**Status**
	Jul 14-Sep 14	**Oct 14 – Dec 14**	**Jan 15 -Mar 15**	**Apr 15-Jun-15**	
NE	90.5% (G)	95.9% (G)	96.6% (G)	95.0% (G)	Green
NW	94.0% (G)	88.7% (A)	85.4% (R)	82.8% (R)	Red
S	96.2% (G)	96.9% (G)	95.4% (G)	96.1% (G)	Green
HSCP Actual	**93.8% (G)**	**93.7% (G)**	**92.7% (G)**	**91.2% (G)**	**Green**
HSCP Target	**85%**	**90%**	**90%**	**90%**	
NHSGGC Actual	95.3% (G)	95.0% (G)	95.7% (G)	91.0% (G)	Green

Commentary
Practices within PCMHTs and CMHTs across the city have been reviewed and plans progressed to improve performance, with the assistance of a number of demand and capacity planning tools. Actions have included undertaking waiting list initiatives; exploring ways of working more flexibly; improving recruitment processes to respond to ongoing retention challenges; and improving data accuracy.

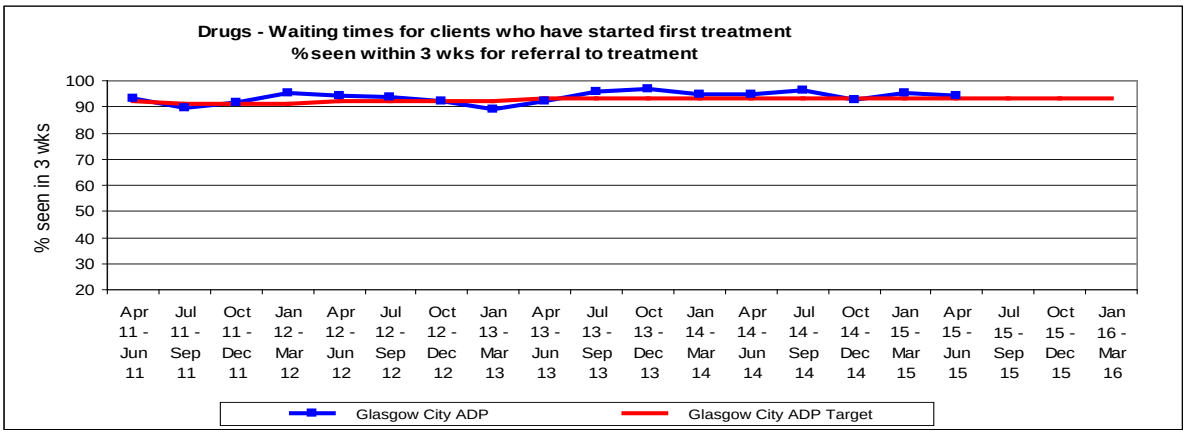
Target/Ref **(LDP 11)**	**17. To Reduce the Rate of Emergency Admission (Unplanned) Acute Bed Days for Ages 75+ by at least 12% between 2009/10 and 2014/15 (Rate per 1000 population) (LDP Target).**
Performance	The numbers have been consistently reducing and performance remains GREEN in relation to the agreed trajectory.

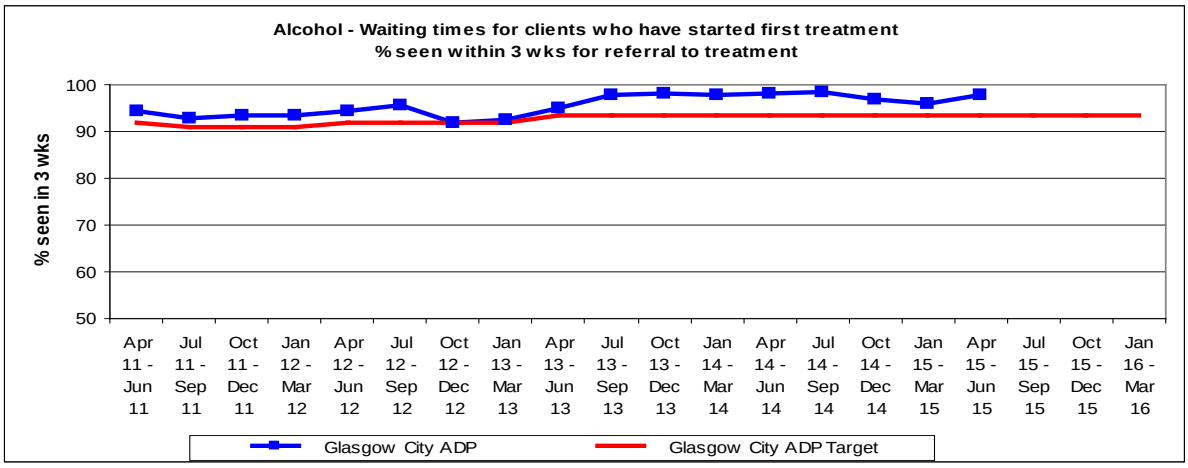


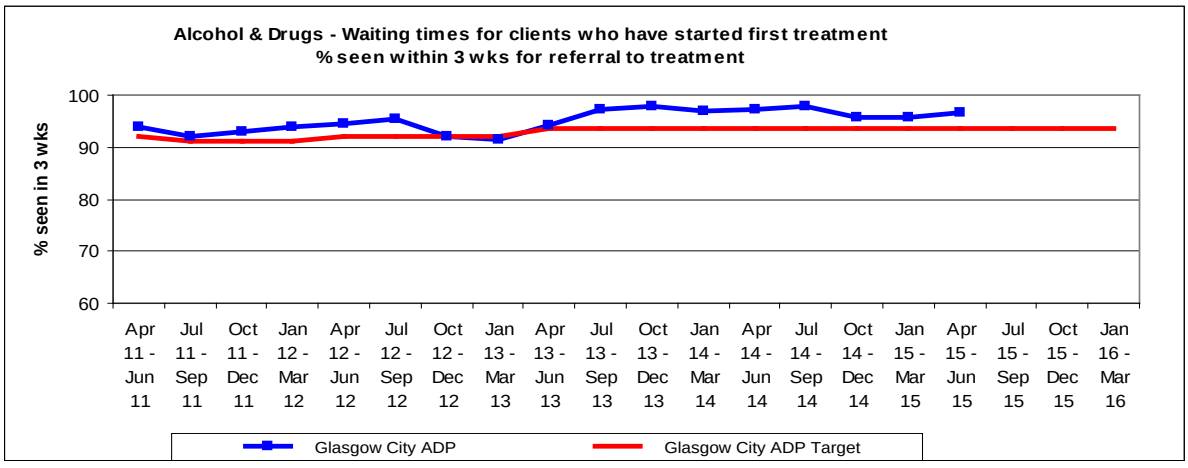
	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Rolling Year to End of Month	**6305 (G)**	**6376 (G)**	**6378 (G)**	**6357 (G)**	**6309 (G)**	**6257 (G)**
Trajectory Target	6421	6408	6394	6381	6368	6355

Commentary
Performance against this indicator has remained GREEN though the rates have fluctuated more recently. Performance is being supported by the actions being taken to reduce length of stay and delayed discharges (see HT2) and by Integrated Care Fund projects which aim to reduce emergency admissions.

Target/Ref (LDP 12)	**18. % of clients commencing alcohol or drug treatment within 3 weeks of referral (LDP Standard).**
Performance	Performance remains GREEN for alcohol and drugs combined and individually for alcohol and for drugs. These figures relate to those clients who have already commenced treatment.







TARGET	AREA	Q2 14/15	Q3 14/15	Q4 14/15	Q115/16	Status
93.5% (Drugs)	**HSCP**	**96.2% (G)**	**92.8% (A)**	**95.3% (G)**	**94.3% (G)**	**Green**
91.5	GGC	95.1% (G)	93.6% (G)	95.0% (G)	92.8% (G)	Green
93.5% (Alcohol)	**HSCP**	**98.4% (G)**	**96.8% (G)**	**96.0% (G)**	**97.8% (G)**	**Green**
91.5	GGC	98.2% (G)	96.8% (G)	95.6% (G)	97.4% (G)	Green
93.5% (Drugs & Alcohol)	**HSCP**	**97.7% (G)**	**95.7% (G)**	**95.8% (G)**	**96.7% (G)**	**Green**
91.5	GGC	97.3% (G)	95.9% (G)	95.5% (G)	96.1% (G)	Green

Commentary
Performance GREEN for alcohol and drugs combined and for both individually. Differential targets have been set for each ADP.

2. ALL OTHER PERFORMANCE INDICATORS

A. Acute Services/Unplanned Care								
O1. Reduce number of DNAs	**TARGET**	**AREA**	**Jul13-Jun14**	**Oct13-Sep14**	**Jan14-Dec14**	**Apr14-Mar 15**	**Jul14-Jun15**	HSCP and all localities remain above target and classified as RED. Clinical Directors review individual practice DNA rates and follow up with practices as appropriate, in line with the Board strategy, which emphasises the need for a joint approach between primary and secondary care.
	11.3%	NE	15.6% (R)	15.2% (R)	14.7% (R)	15.1% (R)	15.0% (R)	
	11.3%	NW	15.3% (R)	14.9% (R)	15.0% (R)	14.7% (R)	14.8% (R)	
	11.3%	S	14.7% (R)	14.5% (R)	14.5% (R)	14.7% (R)	14.8% (R)	
	11.3%	**HSCP**	**15.2% (R)**	**14.8% (R)**	**14.9% (R)**	**14.8% (R)**	**14.9% (R)**	
	11.3%	GGC	12.5% (R)	12.2% (R)	12.3% (R)	12.2% (R)	12.7% (R)	
B. Alcohol and Drugs								
O2. Number of drug related deaths (per 100,000 pop)	**TARGET**	**AREA**	**2010**	**2011**	**2012**	**2013**	**2014**	Glasgow City is above the NHSGGC and Scottish averages though it has increased between 2013 and 2014 as has the Board average. However, this is calculated on a population basis and takes no account of the extremely high drug prevalence rates within Glasgow. From previous data available, when these are taken into account, Glasgow rates are below NHSGCC and Scottish averages.
	N/A	**HSCP**	**15.9**	**19.7**	**20.3**	**17.3**	**19.0**	
	N/A	GGC	13.9	15.9	15.9	12.1	16.5	

O3. Number of alcohol related deaths (per 100,000 pop)	**TARGET**	**AREA**	**2011**	**2012**	**2013**			HSCP and all localities above the NHSGGC average, though there has been a slight reduction between 2012 and 2013. North East consistently the highest.
	N/A	NE	73.7	44.7	45.2			
	N/A	NW	40.0	39.6	35.6			
	N/A	S	42.3	38.4	38.8			
	N/A	**HSCP**	**50.7**	**40.7**	**39.6**			
	N/A	GGC	43.6	35.4	33.6			
O4. Reduce rate of alcohol related emergency admissions (aged 16+ and per 1000 population)	**TARGET**	**AREA**	**Jul13-Jun14**	**Oct 13-Sep 14**	**Jan14-Dec14**	**Apr14-Mar15**	**Jul14-Jun15**	The rates have been reducing across the city over the last four periods. Rates vary across Localities, with North West consistently below the GCC average and North East and South consistently higher.
	N/A	NE	14.9	15.0	14.6	13.9	13.5	
	N/A	NW	9.1	9.4	9.0	8.8	8.9	
	N/A	S	12.7	11.9	11.7	11.1	10.6	
	N/A	**HSCP**	**12.1**	**11.9**	**11.7**	**11.1**	**10.9**	
	N/A	GGC	10.4	10.3	10.1	9.7	9.4	

C. Child and Maternal Health								
Breastfeeding: O5. 6-8 weeks (Exclusive)	**TARGET**	**AREA**	**Jul 13-Jun 14**	**Oct 13-Sep 14**	**Jan 14-Dec 14**	**Apr14-Mar15**	**July14-Jun 15**	Performance has improved over the last year and remains above the Board average and is GREEN for the HSCP and all localities. Impact from the Family Nurse Partnership team on breastfeeding rates for first time teenage mothers may be contributing to this improvement. The Maternal and Infant Nutrition Framework has an established structure with the Breastfeeding Sub-Group which the HSCP participates in.
	15.6%	NE	18.5% (G)	17.0% (G)	17.5% (G)	17.7% (G)	17.7% (G)	
	30.8%	NW	29.9% (A)	30.6% (A)	30.4% (A)	31.7% (G)	32.7% (G)	
	26.2%	S	25.5% (A)	26.6% (G)	26.7% (G)	27.4% (G)	27.4% (G)	
	24.0%	**HSCP**	**24.9% (G)**	**25.1% (G)**	**25.1% (G)**	**25.7% (G)**	**26.1% (G)**	
	24.4%	GGC	24.5% (G)	24.4% (G)	24.6% (G)	25.2% (G)	25.2% (G)	
O6. At health visitors first visit (Exclusive)	**TARGET**	**AREA**	**Jul13-Jun14**	**Oct13-Sep 14**	**Jan14 - Dec14**	**Apr14-Mar15**	**July14-Jun 15**	Differential targets are in place across the city. The HSCP has moved from RED to AMBER over the last two reporting periods with all localities also moving from RED to AMBER. See also 05 above
	24%	NE	23.4% (A)	22.5% (R)	22.5% (R)	23.7% (A)	23.3% (A)	
	38.8%	NW	35.9% (R)	35.8% (R)	35.3% (R)	36.2% (R)	36.9% (A)	
	33.7%	S	30.6% (R)	31.5% (R)	31.6% (R)	32.6% (A)	32.7% (A)	
	32.4%	**HSCP**	**30.2% (R)**	**30.2% (R)**	**30.1% (R)**	**31.0 (A)**	**31.2% (A)**	
	33.8%	GGC	30.3% (R)	30.3% (R)	30.1% (R)	30.9 (R)	31.0% (R)	

O7. 6-8 weeks - In deprived population – 15% most deprived data zones (Exclusive)	**TARGET**	**AREA**	**Jul 13 - Jun 14**	**Oct13-Sep 14**	**Jan 14-Dec 14**	**Apr14-Mar15**	**July14-Jun 15**	Although RED we have had a rise in exclusive breastfeeding at 6-8 weeks in deprived areas, over the last four reporting periods for the city as a whole. Our rate is higher than GGC and all other partnership areas. Variations across areas with North West now GREEN. Targets been adjusted during 2015. Significant improvement will continue to rely on more women living in deprived areas breastfeeding at birth, discharge and during the first 10 days, and with a higher health visitor staff complement we should see further progress in retaining breastfeeding at 6/8 weeks.
	18.0%	NE	15.2% (R)	14.1% (R)	14.6% (R)	14.3% (R)	14.4% (R)	
	21.4%	NW	16.0% (R)	18.5% (R)	18.5% (R)	21.0% (R)	22.4% (G)	
	21.3%	S	18.2% (R)	19.4% (R)	19.4% (R)	18.9% (R)	19.5% (R)	
	20.1%	**HSCP**	**16.4% (R)**	**17.1% (R)**	**17.2% (R)**	**17.6% (R)**	**18.1% (R)**	
	21.8%	GGC	14.8% (R)	15.2% (R)	15.6% (R)	15.7% (R)	16.3% (R)	
O8. 6-8 weeks Breastfeeding (mixed)	**TARGET**	**AREA**	**Jul13-Jun 14**	**Oct13-Sep 14**	**Jan 14 Dec 14**	**Apr14-Mar15**	**Jul14-Jun15**	Rates slightly increased over the last year for the HSCP. Although it remains RED, rates are above the Board average for the HSCP, South and North West, with the latter remaining GREEN. The North East has remained below the Board average. See also 05 above
	45%	NE	29.6% (R)	28.0% (R)	28.6% (R)	28.7% (R)	28.4% (R)	
	45%	NW	44.4% (A)	44.9% (A)	45.3% (G)	45.1% (G)	46.9% (G)	
	45%	S	41.4% (R)	42.2% (R)	41.1% (R)	42.0% (R)	42.6% (R)	
	45%	**HSCP**	**38.9% (R)**	**38.9% (R)**	**38.7% (R)**	**38.9% (R)**	**39.7% (R)**	
	45%	GGC	36.4% (R)	36.4% (R)	36.6% (R)	36.8% (R)	37.0% (R)	

Dental	**TARGET**	**AREA**	**2010**	**2012**	**2014**	2014 results show an increase though performance remains AMBER.
O9. % of P1 children with no obvious decay experience in 2010	60%	HSCP	-	**56.5% (A)**	**58.8% (A)**	
	60%	GGC	58.2% (R)	63.2% (G)	61.3% (G)	
	60%	E	42.93% (R)			
	60%	N	50.46% (R)			
	60%	SE	50.88% (R)			
	60%	SW	52.68% (R)			
	60%	W	58.48% (A)			
O10. % of P7 children with no obvious decay experience.	**TARGET**	**AREA**	**2011**	**2013**		
	60%	HSCP	**55.33% (A)**	**60.6% (G)**		Performance improved since the last reporting period and moved from AMBER to GREEN.

O11. Number of 0-2 year olds registered with a dentist	**TARGET**	**AREA**	**31 Mar 13**	**30 Sep 13**	**31 Mar 14**	**30 Sep 14**	**31 Mar 15**	Registration rates fluctuating and remain AMBER but also above the NHSGGC average
	55%	**HSCP**	**50.7% (A)**	**51.9% (A)**	**53.1% (A)**	**51.4% (A)**	**50.8 (A)**	
	55%	GGC	49.8% (R)	51.2% (R)	51.5% (R)	50.8% (R)	50.5% (A)	
O12. Number of 3 – 5 year olds registered with a dentist	90%	**HSCP**	**92.0% (G)**	**94.4% (G)**	**100% (G)**	**100% (G)**	**100% (G)**	Registration rates remain GREEN and higher than both the target and the NHSGCC average.
	87.9%	GGC	90.2% (G)	94.2 (G)	95.0 (G)	95.1 (G)	95.9 (G)	

MMR: O13. At 24 months	**TARGET**	**AREA**	**2013/14**				**2014/15**	The HSCP has moved back to GREEN from AMBER in the last reporting period, as has the South. The North West has remained AMBER and the North East remained GREEN.
			Q4	**Q1**	**Q2**	**Q3**	**Q4**	
	95%	NE	96.6% (G)	96.3% (G)	97.1% (G)	96.3% (G)	96.1% (G)	
	95%	NW	92.8% (A)	93.1% (A)	95.7% (G)	93.8% (A)	94.4% (A)	
	95%	S	96.6% (G)	94.8% (A)	96.1% (G)	93.8% (A)	95.3% (G)	
	95%	**HSCP**	**95.5% (G)**	**94.7% (A)**	**96.4% (G)**	**94.5% (A)**	**95.3% (G)**	
	95%	GGC	95.9% (G)	95.5% (G)	96.5% (G)	95.6% (G)	95.3% (G)	
MMR: O14. At 5 years	**TARGET**	**AREA**	**2013/14**				**2014/15**	The HSCP and all localities remain GREEN.
			Q4	**Q1**	**Q2**	**Q3**	**Q4**	
	95%	NE	98.1% (G)	97.6% (G)	98.7% (G)	97.8% (G)	97.1% (G)	
	95%	NW	94.5% (A)	95.9% (G)	97.4% (G)	96.4% (G)	95.4% (G)	
	95%	S	96.5% (G)	96.5% (G)	98.0% (G)	97.1% (G)	96.2% (G)	
	95%	**HSCP**	**96.3% (G)**	**96.7% (G)**	**98.0% (G)**	**97.1% (G)**	**96.2% (G)**	
	97%	GGC	96.9% (A)	97.0% (G)	98.1% (G)	97.1% (G)	97.0% (G)	

	TARGET	AREA	Aug13-Jun14	Aug13-Dec14				
O15. % of children with a Fluoride Varnishing Application signed consent form	91%	NE	76%(R)	84% (R)				Local indicator. Changes being implemented following development session in September 2014 which accommodates compliance and consent.
	91%	NW	92%(G)					
	91%	S	76%(R)					
	91%	**HSCP**	**82%(R)**					
O16. % of children reaching 30 months receiving assessment	95%	NE NW South **HSCP**	July-Sep 14	90.3% (A) 81.6% (R) 84.5% (R) **85.4% (R)**				New local indicator. Performance varies across areas with North East AMBER and the other two localities RED.
D. Adult Mental Health								
O17. Deaths for which the underlying cause was classified as 'intentional self-harm'	**AREA**		**2011**	**2012**	**2013**	**2014**		Numbers slightly reduced for HSCP as a whole between 2011 and 2014. Locality variations evident with numbers in the North West higher in the last two years than the other areas.
	NE		25	14	23	19		
	NW		26	35	29	29		
	S		27	24	19	23		
	HSCP		**78**	**73**	**71**	**71**		
	GGC		144	126	141	128		

Delayed Discharge Adult Mental Health:	**TARGET**	**AREA**	**May-15**	**Jun-15**	**Jul-15**	**Aug-15**	**Sep-15**	Numbers fluctuate but remain very small.
Delayed discharge - Included codes O18. > 14 days	0	NE	0 (G)	0 (G)	0 (G)	0 (G)	0 (G)	
		NW	1 (R)	1 (R)	0 (G)	1 (R)	0 (G)	
		S	2 (R)	2 (R)	0 (G)	0 (G)	1 (R)	
		HSCP	**3 (R)**	**3 (R)**	**0 (G)**	**1 (R)**	**1 (R)**	
	0	GGC	3 (R)	3 (R)	0(G)	2(G)	1(R)	
Delayed discharge- Exception codes O19. > 14 days	**TARGET**	**AREA**	**May-15**	**Jun-15**	**Jul-15**	**Aug-15**	**Sep-15**	Numbers fluctuate but continue to be relatively small.
	N/A	NE	1	0	0	0	0	
		NW	0	0	1	1	2	
		S	2	2	2	2	2	
		HSCP	**3**	**2**	**3**	**3**	**4**	
	N/A	GGC	4	2	3	4	4	
O20. PCMHT – referral to 1st appointment - % within 28 days.	**TARGET**	**AREA**	**Feb 15**	**Mar 15**	**Apr 15**	**May 15**	**Jun 15**	Variations across localities with South consistently the highest. The call back system operating in the South has been implemented in the North West from April 2015 and improvements are evident both here and in the North East over the last two periods. The North East have also been expanding their group activity to increase capacity.
	N/A	NE	81%	51%	54%	89%	90%	
	N/A	NW	63%	56%	35%	71%	82%	
	N/A	S	97%	97%	92%	98%	93%	
	N/A	GGC	78%	67%	60%	82%	87%	

O21. PCMHT – referral to 1st treatment - % within 63 days.	N/A	NE	23%	24%	25%	14%	5%	Variations across localities. South consistently significantly higher than the other two areas. See also O20 above.
	N/A	NW	18%	11%	21%	22%	17%	
	N/A	S	97%	100%	97%	100%	99%	
	N/A	GGC	69%	71%	66%	66%	73%	
E. Cancer								
O22. Uptake of 3rd dose HPV vaccinations – routine cohorts (ages 12-13)	**TARGET**	**AREA**	**11-12**	**12-13**	**13-14**			Last updated December 2014. Rates have decreased and the HSCP and South locality are now RED with the other two localities AMBER.
	80%	NE	93.2% (G)	91.8% (G)	76.5% (A)			
		NW	91.3% (G)	92.2% (G)	78.3% (A)			
		S	89.5% (G)	90.1% (G)	72.2% (R)			
		HSCP	**91.2% (G)**	**91.2% (G)**	**75.2% (R)**			
O23. Uptake of 3rd dose HPV vaccinations – catch-up cohorts (ages 13-18)	N/A	NE	59.9%					All localities below Board average. Last updated September 2014.
		NW	56.7%					
		S	59.9%					
		HSCP	**58.8%**					
		GGC	65.5%					

F. Long Term Conditions								
Crude discharge rate (per 100,000 pop)	**TARGET**	**AREA**	**Jul 13 - Jun 14**	**Oct 13 - Sep 14**	**Jan14- Dec 14**	**Apr 14 - Mar 15**	**Jul 14- Jun 15**	
COPD	N/A	NE	1257.7	1368.9	1452.1	1516.7	1571.8	Numbers been increasing for the 'all conditions' rate over the last four periods. Range of work ongoing to improve performance including Managed Clinical Networks, primary care LES/QOF activity, the use of SPARRA data, and the implementation of a number of Integrated Care Fund projects.
	N/A	NW	954.4	965.0	944.8	966.1	1000.4	
	N/A	S	1132.9	1114.8	1146.1	1123.4	1113.0	
	N/A	**HSCP**	1110.9	1140.9	1170.6	1188.5	1212.5	
	N/A	GGC	888.8	916.8	945.9	960.6	964.1	
Asthma	N/A	NE	219.2	222.0	234.9	256.3	249.0	
	N/A	NW	190.9	179.8	186.8	218.7	215.1	
	N/A	S	249.3	243.4	269.7	277.0	274.7	
	N/A	**HSCP**	220.9	215.9	231.8	251.4	247.3	
	N/A	GGC	202.5	197.6	206.3	221.7	218.0	
Diabetes	N/A	NE	239.4	238.8	245.6	258.5	287.7	
	N/A	NW	173.7	186.8	202.5	196.4	202.5	
	N/A	S	257.5	251.2	241.2	239.4	262.0	
	N/A	**HSCP**	224.3	226.1	229.7	230.8	249.9	
	N/A	GGC	211.3	211.9	215.6	211.2	219.1	
CHD	N/A	NE	1738.2	1770.8	1801.1	1756.1	1797.7	
	N/A	NW	1253.4	1367.0	1321.6	1311.0	1364.5	
	N/A	S	1215.9	1198.6	1156.0	1114.3	1159.2	
	N/A	**HSCP**	1384.1	1425.2	1403.4	1371.1	1417.8	
	N/A	GGC	1436.0	1467.4	1470.9	1450.1	1473.6	
O24. ALL	N/A	NE	3454.4	3600.5	3733.7	3787.6	3906.2	
	N/A	NW	2572.5	2698.7	2655.8	2692.1	2782.5	
	N/A	S	2855.6	2808.0	2813.0	2754.1	2808.9	
	N/A	**HSCP**	2940.2	3008.1	3035.5	3041.8	3127.5	
	N/A	GGC	2738.7	2793.7	2838.8	2843.6	2874.8	

G. Older People/Carers								
O25. Number of acute bed days lost to delayed discharge for Adults with Incapacity	**12/13 Actual**	**13/14 Actual**	**14/15**	**Year to Date Actual**	**Year to Date Target**			Numbers below target for 14/15 and again so far this year. Power of Attorney campaign expected to be having an impact upon this indicator. See also KPI4 above.
	9341 (G)	**8936 (G)**	**8987 (G)**	**3897 (G)**	**3869**			
O26. Unplanned acute bed days (65+) i. Numbers	**09/10 Base-Line**	**11/12 Actual**	**12/13 Actual**	**13/14 Actual**	**14/15 Actual**	**Year to Date Actual (Aug)**		These are being impacted upon by work being undertaken in relation to delayed discharges; emergency admissions and length of stay, including Integrated Care Fund projects. Numbers slightly increased during 2014/15, having reduced over previous years since 2009/10. However, numbers so far in 2015/16 have reduced so far.
	369,715	360,428	354,632	318,653	325,545	123,777		
ii. Rates/1000 pop.	4534	4419	4248	3,964	3,913	1482		
O27. No. Unplanned Admissions by SIMD SIMD 1 (most deprived)	**09/10 Base-line**	**11/12 Actual**	**12/13 Actual**	**13/14 Actual**	**14/15 Actual**	**Year to Date Actual (Aug)**		Admissions continue to vary according to the SIMD categories with the higher number of admissions coming from the lower (more deprived) SIMD categories.
SIMD 2	9771	8607	8,871	8808	9,252	4051		
SIMD 3	7292	8439	8,228	7757	7,096	3010		
SIMD 4	4742	5341	5,438	4912	4,844	2055		
SIMD 5 (least deprived)	2954	3494	3,637	3459	3,345	1471		
	1443	1400	1,466	1366	1,700	699		

O28. Emergency Admissions (65+) i. Numbers	**09/10 Base-line**	**11/12 Actual**	**12/13 Actual**	**13/14 Actual**	**14/15 Actual**	**Year to Date Actual (Aug)**		14/15 total slightly below (0.8%) the 13/14 total which in turn was 5% below the corresponding figure for 12/13. Rates so far in 2015/16 are at slightly higher levels than the monthly average for 2014/15. See also HT11 above.
ii. Rates/1000 pop	26,202	27,432	27,839	26,436	26,237	11,286		
	321	336	341	329	315	135		
O29. Emergency Admissions (75+) i. Numbers	**09/10 Base-line**	**11/12 Actual**	**12/13 Actual**	**13/14 Total**	**14/15 Actual**	**Year to Date Actual (Aug)**		14/15 totals slightly below (1.3%) the 13/14 total which was 5.6% below the corresponding figure for 12/13. Rates so far in 2015/16 are at slightly higher levels than the monthly average for 2014/15. See also HT11 above
ii. Rates/1000 pop	16,225	17,589	17,734	16,742	16,530	7222		
	414	449	450	422	416	182		
O30. Hospital Lengths of Stay	**09/10 Base-line**	**11/12 Actual**	**12/13 Ave.**	**13/14 Ave.**	**14/15 Ave.**	**July 15**	**Aug 15**	Length of stay reduced between 11/12 and 14/15. A range of actions are being progressed by acute to reduce lengths of stay, including improved discharge management and a number of Integrated Care Fund projects which are supporting this aim.
65+	14.2	14.0	13.3	12.4	12.9	10.1	10.8	
75+	-	16.2	15.3	14.5	14.7	11.4	12.3	
O31. Number of older people on anticipatory care plans	**TARGET**	**AREA**	**DATE**	**ACTUAL**				
	200	HSCP	Mar 15	**5542-GP/QoF (G).**				Above target and GREEN.

O32 Completed Carers Assessments	**TARGET**	**To date 15/16 (Q2)**						Figures relate to Integrated Care Fund projects.
	500	**282 (G)**						
H. Effective Organisation								
O33. Staff with an e-KSF (%)	**TARGET**	**AREA**	**May 15**	**Jun 15**	**Jul 15**	**Aug 15**	**Sep 15**	Work continues to raise activity levels across the HSCP. Work continuing across the Localities to increase rates, including the '6 week' challenge in the South where reviewers were asked to schedule 1 review per week to ensure numbers increase steadily, and we move away from the situation whereby peak activity is concentrated between January and March every year.
	80%	**HSCP**	**60.26 (R)**	**59.79 (R)**	**59.82 (R)**	**59.69 (R)**	**59.29 (R)**	
	80%	GGC	67.97 (R)	66.61 (R)	66.39 (R)	65.73 (R)	64.94 (R)	
O34. % staff with standard induction training completed within the deadline	**TARGET**	**AREA**	**Jan-15**	**Feb-15**	**Mar-15**	**Apr-15**	**May-15**	Performance fluctuates between localities but has shown some improvement over recent months, though the HSCP remains consistently RED. The monthly compliance returns from central Learning and Education contain named information which ensures that managers are alerted to any inductions not completed in order to ensure compliance.
	100%	S	80% (R)	100% (G)	100% (G)	100% (G)		
	100%	NE	89% (R)	80% (R)	100% (G)	80% (R)	86% (R)	
	100%	NW	50% (R)		0% (R)	88% (R)	60% (R)	
	100%	**HSCP**	**81% (R)**	**80% (R)**	**24% (R)**	**83% (R)**	**69% (R)**	

I. Quality								
O35. Responding to complaints within 20 working days (%)	**TARGET**	**AREA**	**14/15 Q1**	**14/15 Q2**	**14/15 Q3**	**14/15 Q4**	**15/16 Q1**	HSCP remains GREEN, with all localities also now GREEN. A revised operating procedure has been implemented across localities and the quality of responses and any trends in the types of complaints are monitored.
	70%	NE	72.8% (G)	88.9% (G)	90.9% (G)	91.3% (G)	100% (G)	
		NW	91.7% (G)	66.7% (A)	54.5% (R)	57.1% (R)	91% (G)	
		S	62.5% (R)	86.7% (G)	80% (G)	100.0% (G)	67% (G)	
		Corp.	96.8% (G)	94.6% (G)	94.7% (G)	97.1% (G)	99.0% (G)	
		HSCP	**76.1% (G)**	**82.2% (G)**	**79.3% (G)**	**81.8 (G)**	**93.0% (G)**	
		GGC	93.8% (G)	93.6% (G)	92.8% (G)	95.1% (G)	92.0% (G)	
J. Equalities								
	TARGET	**AREA**	**DATE**	**ACTUAL**				
O36. Number of work placements for vulnerable groups	60	HSCP	Oct 2014	18 (HSCP) 17 (Vol/Ind localities) **(G)**				Board indicator. This relates to students who have been provided with placements in the over the current academic year.
O37. Number of referrals to financial inclusion and employability advice	3,300	HSCP	Sep 2014	1660 **(G)**				Board indicator. Target being met on pro-rata basis.

O38. Additional income generated as a result of financial inclusion advice received	£2.5m	HSCP	Apr-Sep 2014	£3.254m **(G)**				Board indicator. Target being met.
O39. Number of staff participating in inequalities learning programme.	560	HSCP	Sep-14	365 (learnpro) 40 (face to face) **(G)**				Board equalities indicator. Above target on a pro-rata basis. Next report due in March 2015. Figures include those attending face to face training; special equality events (LGBT); and those completing e-modules. 51 hotel services staff attended training on Equality Act 2010 on 6&7th Feb in Leverndale Hospital. There are plan to extend this training to all hotel services staff in Glasgow HSCP.

Social Work Performance Report

October 2015 Report

The Social Work data below has been broken down by locality for the following quarters: Q4 2014/15 (Jan-Mar 2015), Q1 (Apr-Jun 2015) and, where available, Q2 (Jul-Sept 2015). They have been grouped in line with the National Outcomes framework.

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 setting in their community.

Indicator	Target 2015/16	Locality	Quarter 4 2014/15	Quarter 1 2015/16	Quarter 2 2015/16	Comments
Number of people remaining in acute hospitals **2 weeks** or more after being assessed as ready for discharge	0	North East	1	0	0	At Q4 this indicator reported on discharges delayed more than **4 weeks**. From 01/04/15 the timeframe for discharge has reduced to within **2 weeks**.
	0	North West	18	6	7	
	0	South	16	7	4	
	0	Glasgow	35	13	11	

3. People who use health and social care services have positive experiences of those services, and have their dignity respected.

Indicator	Target 2015/16	Locality	Quarter 4 2014/15	Quarter 1 2015/16	Quarter 2 2015/16	Comments
% of service users satisfied or very satisfied with Reablement service	90%	North East	91%			This figure is reported annually.
	90%	North West	84%			
	90%	South	100%			
	90%	Glasgow	89%			
Number of complaints received	n/a	North East	*150*	28	21	*Q4 column shows total number of complaints received in 2014/15*
		North West	*107*	34	26	
		South	*181*	46	59	
		Homelessness	*34*	4	6	
		Centre	*132*	20	14	
		Glasgow	*604*	132	126	
% of complaints handled within 15 working days	65%	North East	86%	89%	92%	
		North West	65%	74%	72%	
		South	62%	57%	63%	
		Homelessness	76%	75%	100%	

		Centre	64%	85%	76%	
		Glasgow	70%	73%	72%	
% of complaints handled within 28 calendar days (statutory deadline)	85%	North East	95%	96%	96%	
		North West	86%	91%	87%	
		South	86%	87%	90%	
		Homelessness	94%	75%	80%	
		Centre	73%	95%	91%	
		Glasgow	86%	91%	90%	
Number of elected member enquiries received per quarter	n/a	North East	53	67	67	
		North West	72	72	91	
		South	114	103	98	
		Homelessness	63	38	17	
		Centre	122	107	80	
		Glasgow	424	387	353	
% of elected member enquiries handled within 10 working days (deadline)	80%	North East	100%	99%	100%	
		North West	81%	96%	93%	
		South	91%	91%	82%	
		Homelessness	95%	95%	88%	
		Centre	93%	91%	96%	
		Glasgow	93%	93%	92%	

4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.						
Indicator	**Target 2015/16**	**Locality**	**Quarter 4 2014/15**	**Quarter 1 2015/16**	**Quarter 2 2015/16**	**Comments**
Total number of LAC (looked after children) and LAAC (looked after and accommodated children)	n/a	North East	1,415	1,425	1,407	
	n/a	North West	893	921	914	
	n/a	South	1,002	1,020	1,029	
	n/a	Glasgow	3,477	3,450	3,428	
% of children looked after at home (% of the total looked after)	60%	North East	60%	59%	58%	
	60%	North West	56%	56%	55%	
	60%	South	54%	53%	53%	
	60%	Glasgow	58%	56%	56%	

Number of LAAC aged under 5 (accommodated for greater than 6 months)	n/a	North East	61	63	68	
	n/a	North West	39	43	39	
	n/a	South	58	61	61	
	n/a	Glasgow	164	173	173	
Percentage of looked after and accomodated children aged under 5 (who have been looked after for 6 months or more) who have had a permanency review	90%	North East	87%	84%	93%	
	90%	North West	79%	72%	79%	
	90%	South	86%	85%	85%	
	90%	Glasgow	85%	81%	87%	
Purchased Residential Placements: % of older people (65+) reviewed in the last 12 Months	100%	North East	30%	29%	29%	
	100%	North West	38%	36%	34%	
	100%	South	33%	30%	38%	
	100%	Glasgow	34%	32%	34%	
Home Care: % of older people (65+) reviewed in the last 12 months	85%	North East	88%	88%	90%	
	85%	North West	81%	78%	82%	
	85%	South	85%	81%	81%	
	85%	Glasgow	85%	82%	84%	
% of service users with Personalised services taking support in the form of a Direct Payment (DP)	15%	North East	17%	13%	16%	Decrease in DP numbers at Q1 was the result of a change in methodology by finance (some DPs included previously were related to ILF rather than personalisation). From Q1 on, only DPs progressed via Personalisation have been included.
		North West	14%	12%	12%	
		South	14%	11%	13%	
		Glasgow	15%	12%	14%	
Percentage of young people receiving a leaving care service who are known to be in employment, education or training	75%	North East	70%	67%	65%	
	75%	North West	66%	66%	63%	
	75%	South	58%	66%	67%	
	75%	Glasgow	66%	67%	65%	
% Recording of the employment	100%	North East	97%	94%	93%	

% Recording of the employment status of young people leaving care.	100%	North West	100%	100%	100%	
	100%	South	93%	99%	97%	
	100%	Glasgow	96%	97%	96%	
Number of new Community Payback Orders (CPOs)	n/a	North East	251	231	228	
	n/a	North West	188	234	214	
	n/a	South	265	227	239	
	n/a	Glasgow	704	692	681	
% of CPO work placements commenced within 7 days of sentence	80%	North East	77%	74%	74%	Target increased to 80% from 01/04/2015
	80%	North West	75%	79%	80%	
	80%	South	69%	72%	72%	
	80%	Glasgow	76%	77%	77%	
% of CPOs with a Case Management Plan within 20 days	85%	North East	83%	81%	89%	Target increased to 85% from 01/04/2015
	85%	North West	72%	77%	80%	
	85%	South	89%	91%	93%	
	85%	Glasgow	82%	83%	88%	
% of CPOs 3 month Reviews held within timescale	75%	North East	66%	58%	53%	
	75%	North West	58%	75%	89%	
	75%	South	64%	64%	64%	
	75%	Glasgow	63%	65%	68%	
Client Attendance Rate at CPO Review (%)	65%	North East	37%	31%	32%	
	65%	North West	35%	56%	67%	
	65%	South	31%	40%	40%	
	65%	Glasgow	34%	41%	45%	
% of individuals receiving appropriate drug/alcohol treatment that supports their recovery within 21 days	90%	North East	96.0%	99%	not yet available	
	90%	North West	96.6%	99%	not yet available	
	90%	South	80.5%	86%	not yet available	
	90%	Glasgow	90.8%	94%	not yet available	

6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing.

Indicator	Target 2015/16	Locality	Quarter 4 2014/15	Quarter 1 2015/16	Quarter 2 2015/16	Comments
Number of Carers who have started an Assessment during the quarter	700	North East	*635*	166	118	*Q4 column shows the total number of Carer Assessments completed during 2014/15.* *Revised annual target from 01/04/2015 - 2,100 ie. 700 per locality
	700	North West	*402*	111	126	
	700	South	*581*	92	117	
	2100*	Glasgow	*1601 (annual)*	368	360	

7. People using health and social care services are safe from harm						
Indicator	**Target 2015/16**	**Locality**	**Quarter 4 2014/15**	**Quarter 1 2015/16**	**Quarter 2 2015/16**	**Comments**
The percentage of Parental Assessments completed within 30 days (NEW INDICATOR)	75%	North East	n/a	61%	not yet available	New indicator from 01/04/2015
	75%	North West	n/a	76%	not yet available	
	75%	South	n/a	74%	not yet available	
	75%	Glasgow	n/a	69%	not yet available	
Number of **NEW** SCRA reports (offence and non-offence based) requested by the Reporter	n/a	North East	*252*	33	not yet available	*Q4 column shows the total number of SCRA requests received during 2014/15.*
	n/a	North West	*208*	22	not yet available	
	n/a	South	*238*	68	not yet available	
	n/a	Glasgow	*715 (annual)*	126	not yet available	
% of **NEW** SCRA reports submitted within 20 days/on time (CareFirst)	55%	North East	64%	64%	not yet available	
	55%	North West	56%	64%	not yet available	
	55%	South	69%	57%	not yet available	
	55%	Glasgow	64%	60%	not yet available	
Percentage of looked after children (LAC) with a primary worker	100%	North East	98%	99%	99%	
	100%	North West	93%	92%	93%	
	100%	South	90%	90%	98%	
	100%	Glasgow	89%	93%	95%	
[illegible]	100%	North East	100%	100%	99%	

Percentage of looked after children and accommodated children (LAAC) with a Primary worker	100%	North West	100%	100%	100%	
	100%	South	100%	100%	100%	
	100%	Glasgow	99%	99%	99%	
Number of ASP referrals per quarter	n/a	North East	*1301*	330	not yet available	*Q4 column shows the total number of ASP referrals received in 2014/15.*
	n/a	North West	*1755*	374	not yet available	
	n/a	South	*2042*	509	not yet available	
	n/a	Glasgow	*5182 (annual)*	1231	not yet available	
ASP enquiries/investigations completed during the quarter: Percentage of GP relationships recorded.	95%	North East	97%	96%	not yet available	
	95%	North West	97%	96%	not yet available	
	95%	South	95%	94%	not yet available	
	95%	Glasgow	95%	96%	not yet available	

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.

Indicator	Target 2015/16	Locality	Quarter 4 2014/15	Quarter 1 2015/16	Quarter 2 2015/16	Comments
Sickness Absence Rate (SW)	5%	North East	5.88%	4.32%	not yet available	Locality % based on Leadership Reporting covering the period 1st April - 3rd July 2015 (periods 1 to 4)
		North West	5.98%	6.54%	not yet available	
		South	6.59%	6.92%	not yet available	
		Glasgow	5.95% (3.0 average	5.20%	not yet available	

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

Indicator	Target 2015/16	Locality	Quarter 4 2014/15	Quarter 1 2015/16	Quarter 2 2015/16	Comments
Number of financial placements issues (FPIs) outstanding	n/a	North East	99	97	not yet available	These totals include FPIs from hospital placements.
		North West	86	106	not yet available	
		South	77	65	not yet available	
		Glasgow	310	292	not yet available	
Number of open OT activities at assessment stage assigned to worker or team.	n/a	North East	741	590	not yet available	
	n/a	North West	631	579	not yet available	
	n/a	South	1609	1743	not yet available	
	n/a	Glasgow	3012	2925	not yet available	
Open OT activities at assessment stage assigned to worker or team: **% over one year**	n/a	North East	5%	4%	not yet available	
	n/a	North West	0%	1%	not yet available	
	n/a	South	11%	23%	not yet available	
	n/a	Glasgow	8%	15%	not yet available	

Item No. 8

Meeting Date **1st December 2015**

Shadow Integration Joint Board

Report By: **Chief Finance and Resources Officer**

Contact: **Sharon Wearing**

Tel: **0141 287 8838**

WORKPLAN FOR IJB GOVERNANCE DOCUMENTATION

Purpose of Report:	To advise the Shadow Integration Joint Board of the various documents, strategies, policies and arrangements which must be put in place by or on behalf of the Glasgow City Integration Joint Board upon or following its establishment, and to present a workplan for production of these items.

Recommendations:	The Shadow Integration Joint Board is asked to note this report and associated workplan.

Implications for IJB:

Financial:	The workplan notes a number of finance documents which must be produced on behalf of the Integration Joint Board. Development of items within the workplan will be carried out within existing resources.

Personnel:	The workplan notes items which relate to workforce and organisational development, any implications of these items will be reported to the Integration Joint Board in due course.

Legal:	The Public Bodies (Joint Working) (Scotland) Act 2014, associated Regulations and Orders, and the Integration Scheme make a number of provisions relating to governance with which the Integration Joint Board must comply. There are also a number of additional statutory requirements on the Integration Joint Board with regard to governance due to its status as a Public Body.

Economic Impact:	None

Sustainability:	None

Sustainable Procurement and Article 19:	None

Equalities:	None

Implications for Glasgow City Council:	Implementation of some items on the workplan may require corresponding amendments to the governance structures, policies or practices of the Council.

Implications for NHS Greater Glasgow & Clyde:	Implementation of some items on the workplan may require corresponding amendments to the governance structures, policies or practices of the Health Board.

1. Purpose

1.1 The purpose of this paper is to advise the Shadow Integration Joint Board of the various documents, strategies, policies and arrangements which must be put in place by or on behalf of the Glasgow City Integration Joint Board upon or following its establishment, and to present a workplan for production of these items.

2. Background

2.1 The Public Bodies (Joint Working) (Scotland) Act 2014, supporting statutory and non-statutory guidance and the Integration Scheme set out a number of provisions relating to governance with which the Integration Joint Board, Council and Health Board must comply.

2.2 As a separate legal entity, and a public body, there are also a number of additional statutory requirements placed on the Integration Joint Board with regard to governance, accountability and transparency as apply to any other public body.

3. Requirements

3.1 A document summarising the range of documents, strategies, policies and other arrangements which the Integration Joint Board must put in place is appended to this report.

3.2 The appended document notes each item, the timescale by which it must be produced and its current status. Timescales given are based on either statutory or practical requirements, or as noted, within the Integration Scheme.

3.3 Reports will be provided to the Shadow Integration Joint Board and, upon establishment, the Integration Joint Board on progress of each item.

4. Recommendations

4.1 The Shadow Integration Joint Board is asked to note this report and associated workplan.

Item	Due by	Status	RAG Rating
Scheme of delegation (including delegation from Health Board and Council)	First meeting of IJB	In development, reviewing documents produced by other partnerships and legislative requirements.	Green
Paper recommending appointment of Chief Officer	First meeting of IJB	Report will be presented to first meeting of IJB	Green
Paper regarding appointment of Members to the IJB	First meeting of IJB	Report will be presented to first meeting of IJB	Green
Standing Orders for conduct of meetings of IJB and its committees	First meeting of IJB	Draft to December meeting of Shadow IJB for comment.	Green
Code of Conduct for Members	First meeting of IJB	IJB to adopt a Code of Conduct based on model in development by Scottish Government . Report on Members obligations to first IJB.	Green
Establishment of committees of IJB and terms of reference	First meeting of IJB	Report will be presented to first meeting of IJB	Green
Governance Relationship with Council	First meeting of IJB	To be finalised on approval of integration Scheme	Green
Governance Relationship with Health Board	First meeting of IJB	To be finalised on approval of integration Scheme	Green

2. Finance

Item	Due by	Status	RAG Rating
Financial Statement (Budget)	1 April 2016	In development. Final figures cannot be prepared until 2016/17 financial allocation from Council and Health Board to IJB is agreed - dependancy on UK Government Spending Review, Scottish Government budget statement and subsequent allocations to local authorities and health boards	Amber
Financial regulations, management and control code of practice	First meeting of IJB	In development	Green
Statement of financial assurance (due diligence)	1 April 2016	In development	Green

3. Strategy, Planning and Performance

Item	Due by	Status	RAG Rating
Strategic Plan	1 April 2016	Consultation underway. Final draft to be presented to IJB for approval ahead of 1 April	Green
Annual Performance Report	July 2017	Reporting frameworks and formats in development. Statutory guidance on annual performance reports expected early in 2016	Green
Quarterly Performance Report	End of each financial quarter	Reporting frameworks and formats in development.	Green
Equalities Outcomes for IJB	30 April 2016	In development	Green
Participation and Engagement Strategy	Within one year of IJB establishment	In development, draft strategy to be presented to IJB significantly ahead of timescale outlined in Integration Scheme	Green
Workforce Development and Support Plan	Within one year of IJB establishment	In development	Green
Organisational Development Strategy	Within one year of IJB establishment	In development	Green
Risk Management Strategy	First meeting of IJB	In development. Model strategy prepared for use across Greater Glasgow and Clyde and will be adapted to local requirements.	Green
Risk Register	First meeting of IJB	In development	Green
Memorandum of Understanding / approach to management of functions within IJB remit previously not managed within Social Work Services or Glasgow CHP	1 April 2016	In development. Not a statutory requirement but good practice	Green

4. Governance (other statutory requirements)

Item	Due by	Status	RAG Rating

Item	Due by	Status	RAG Rating
Records Management Plan	First meeting of IJB	Summary report will be presented to first meeting of IJB	Green
FOI Process	First meeting of IJB	Summary report will be presented to first meeting of IJB	Green
Complaints Procedure	First meeting of IJB	Report will be presented to first meeting of the IJB.	Green
Liability Arrangements- IJB	First meeting of IJB	Report will be presented to first meeting of IJB. Intention is to apply to join CNORIS Scheme with costs reimbursed by Health Board.	Green
Information Sharing Protocol	First meeting of IJB	Agreement already in place between Council and Health Board. Review underway to identify amendments required following establishment of IJB	Green

Item No. 9

Meeting Date **1st December 2015**

Shadow Integration Joint Board

Report By: **Chief Officer, Finance & Resources**

Contact: **John Dearden, Head of Business Administration**

Tel: **0141 287 0394**

Draft Standing Orders for the Proceedings and Business of the Glasgow City Integration Joint Board

Purpose of Report:	To allow members the opportunity to review a draft set of Standing Orders governing the Proceedings and Business of the Integration Joint Board.

Recommendations:	Members are asked to comment on the suitability of the attached document.

Implications for IJB:

Financial:	The obligations on members to declare financial interests are set out.

Personnel:	Copies of the final Standing orders are to be provided to members and to senior officers of the H&SCP.

Legal:	Standing Orders are required to be prepared under secondary legislation made under the Public Bodies (Joint Working) (Scotland) Act 2014
Economic Impact:	None

Sustainability:	None

Sustainable Procurement and Article 19:	None

Equalities:	None

Implications for Glasgow City Council:	Aspects determine the rights of the Council e.g. in appointing members to the IJB

Implications for NHS Greater Glasgow & Clyde:	Aspects determine the rights of the Health Board e.g. in appointing members to the IJB

1.0 BACKGROUND

1.1 The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 (as amended), provides that an Integration Joint Board must make Standing Orders to regulate its procedure and business, both at meetings of the Board and its Committees.

1.2 It is the intention to present the Standing Orders to the first meeting of the Integration Joint Board for approval. The attached initial draft is presented for comment on its content. Much of what it required to be in Standing Orders is prescribed in the above Order. The Standing orders also cover additional issues to bring together in a single document the main rules about the procedures of the Board.

2.0 GENERAL LAYOUT OF STANDING ORDERS

1. Definitions
2. Membership provisions
3. Terms of office/resignation
4. Removal of members
5. Disqualification of members
6. Chair & Vice Chair
7. Meetings
8. Admission of Public & Media to meetings
9. Notice of meetings
10. Conduct of meetings
11. Committees
12. Codes of Conduct and Conflict of Interest
13. Execution of documents

3.0 MANDATORY PROVISIONS

3.1 The Order requires that certain issues must be included in Standing Orders. These include:-

- Arrangements for calling meetings

- The Quorum for meetings which is set at half the voting members i.e. 8 members.
- Conduct of meetings
- A dispute resolution mechanism to be used in the case where there is an equality of votes
- Provision to allow Board Members to contribute to a Board Meeting through remote access.
- Requirement to record members present and to prepare a minute of meetings.

4.0 ISSUES ON WHICH MEMBERS MAY WISH TO COMMENT

Article 2.4 – Non-voting stakeholder members:

There is provision for the IJB to determine the term of appointment of non-voting stakeholder members. The term must not exceed 3 years. Is the Board content with terms of 3 years or is a lesser period preferred?

Article 8 – Admission of public & media:

There is no statutory provision about making meetings open to the public. The legislation for Joint Boards is silent on this issue. Provision has been made at section for meetings to be open to the public and for appropriate public notice of meetings to be given. For Committees, it is suggested that these decide for themselves whether they are open to the public and media. Some, such as Audit, may have need to exclude the public and media on occasions due to the nature of the business.

Article 10.12 – Failure to Agree:

There is no provision within the IJB constitution for the Chair to have a second or casting vote. There is a requirement that a procedure be established for the situation where there is an equality of votes i.e. where the members cannot agree on an issue. The proposed procedure is set out at article 10.12 on which comments are invited.

Article 12 – Code of Conduct and Conflict of interest:

A separate paper will be prepared covering this, the role of members and of the Standards Commission.

D R A F T

Attachment to Item No 9

Standing Orders for the Proceedings and Business of the Glasgow City Integration Joint Board

30th October 2015 Draft Version 4.0

D R A F T

1. General

1.1 These Standing Orders for the conduct and proceedings of the Glasgow City Integration Joint Board and its Committees are made under the Public Bodies (Joint Working) (Scotland) Act 2014 and the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014.

1.2 These Standing Orders shall be the rules and regulations for the proceedings of the Glasgow City Integration Joint Board and its Committees and Sub-Committees.

1.3 In these Standing Orders:

"Chief Officer" means an officer appointed under Section 10 of the Public Bodies (Joint Working) (Scotland) Act 2014.

"constituent authorities" means Glasgow City Council (the Council) and Greater Glasgow Health Board, more commonly known as NHS Greater Glasgow & Clyde (the Health Board).

"Council" means Glasgow City Council.

"Health Board" means Greater Glasgow Health Board, commonly known as NHS Greater Glasgow & Clyde

"Integration Joint Board" means the Glasgow City Integration Joint Board established in terms of the Public Bodies (Joint Working) (Integration Joint Board Establishment) (Amendment) (Scotland) No xx[1] Order 2015

"Integration Joint Boards Order" means the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 SSI 2014 No 285 (as amended)

"Non-executive members of the Health Board" excludes members of the Health Board who are Councillors.

"The Act" means the Public Bodies (Joint Working)(Scotland) Act 2014

"Integration Scheme" means the document produced by the constituent authorities in accordance with section 2(3) of the

[1] Reference No to be inserted once Statutory Instrument made

1.4 Any statutory provision, regulation, order or direction issued by the Scottish Ministers shall have precedence if they are in conflict with these Standing Orders.

1.5 Any one or more of these Standing Orders may be suspended on a duly seconded motion, incorporating the reasons for suspension, if carried by a majority of members present, provided that suspension is consistent with the Integration Joint Boards Order.

1.6 The Chief Officer shall ensure that a copy of these Standing Orders is provided to each member of the Integration Joint Board on appointment and to each member of the Senior Management Team of the Health & Social Care Partnership[2].

2. Membership Art 3

2.1 The Integration Joint Board shall comprise:-

(a) The Chief Officer appointed by the Integration Joint Board as a non-voting member
(b) Voting members
(c) Non- voting professional members
(d) Non-voting stakeholder representatives

2.2 Voting membership of the Integration Joint Board shall comprise:

(a) eight non-executive members of the Health Board nominated by the NHS Board. Where the NHS Board is unable to fill its places with non-executive members it may nominate a member of the Board who is not a Councillor, but at least two of the total nominees must be non-executive members.

(b) eight Councillors nominated by the Council.

2.3 Non-voting professional membership of the Integration Joint Board shall comprise, in additional to the Chief Officer who is appointed by the Integration Joint Board:-

(a) the chief social work officer of the council;
(b) the proper officer of the Integration Joint Board appointed

[2] The Health & Social Care Partnership is the common name for the management structure put in place by the constituent authorities to deliver the functions delegated to the Integration Joint Board.

under section 95 of the Local Government (Scotland) Act 1973;

(c) a registered medical practitioner whose name is included in the list of primary medical services performers prepared by the Health Board in accordance with Regulations made under section 17P of the National Health Service (Scotland) Act 1978;

(d) a registered nurse who is employed by the Health Board or by a person or body with which the Health Board has entered into a general medical services contract;

(e) a registered medical practitioner employed by the Health Board not providing primary medical services.

The members at (c) to (e) shall be determined by the Health Board.

2.4 Following establishment, the Integration Joint Board must appoint at least one non-voting stakeholder member in respect of each of the following categories:-

a. One member in respect of staff of the constituent authorities engaged in the provision of services provided under integration functions;
b. One member in respect of third sector bodies carrying out activities related to health or social care in the area of the local authority.
c. One member in respect of service users residing in the area of the local authority;
d. One member in respect of persons providing unpaid care in the area of the local authority; and
e. Such additional members as the Integration Joint Board sees fit. Such a member may not be a councillor or a non-executive director of the Health Board.

2.5 If a voting member is unable to attend a meeting of the Integration Joint Board the constituent authority which nominated the member is to use its best endeavours to arrange for a suitably experienced proxy, who is either a Councillor or, as the case may be, a Member of the Health Board, to attend the meeting in place of the voting member. Named Depute members for members of the Integration Joint Board may be appointed by the constituent authorities. The member, who is unable to attend, shall notify the Chief Officer (or nominee) and arrange with the nominating body a proxy to attend in their place. A proxy nominated under these provisions shall be able to vote on any decision put to the meeting.

2.6 If a member who is not a voting member is unable to attend a meeting of the Integration Joint Board, they shall be entitled to arrange for a suitably experienced proxy to attend the meeting on their behalf. Such proxy shall be notified to the Chief Officer (or nominee).

3. Term of Office/Resignation Art 7 & 9

3.1 The term of office of voting members is to be determined by the constituent authorities (i.e. Council and Health Board), but shall not exceed three years. Members appointed under article 2.3 (a) or (b) shall remain a member for so long as they hold office in respect of which they are appointed.

3.2 The term of office of stakeholder members shall be determined by the Integration Joint Board, but shall not exceed three years.

3.3 A member (other than a member appointed under article 2.3 (a) or (b) may resign their membership of the Integration Joint Board at any time by giving written notice to the Chief Officer (or nominee). The resignation shall take effect from the date stated in the notification, or in the absence of a specified date, the date of receipt of the notice.

3.4 Where a voting member gives notice of resignation, the Integration Joint Board must inform the constituent body which nominated the member of the resignation. Where a member resigns or otherwise ceases to hold office, the person appointed in his/her place shall be appointed for the unexpired term of the Member replaced.

3.5 On expiry of a Member's term of appointment the Member shall be eligible for re-appointment provided that he/she remains eligible and is not otherwise disqualified from appointment.

4. Removal of Members Art 10

4.1 If a member has not attended three consecutive meetings of the Integration Joint Board, and their absence was not due to illness or some other reasonable cause approved by the Integration Joint Board, the Integration Joint Board may remove the member from office by providing the member with one month's notice in writing.

4.2 If a member acts in a way which brings the Integration Joint

Board into disrepute or in a way which is inconsistent with the proper performance of the functions of the Integration Joint Board, the Integration Joint Board may remove the member from office with effect from such date as the Integration Joint Board may specify in writing.

4.3 If a member becomes disqualified under article 8 of the Integration Joint Boards Order during a term of office they shall be removed from office immediately.

4.4 If a member who is a Councillor appointed on the nomination of the Council ceases, for any reason to be a Councillor during a term of office, they shall cease to be a member of the Integration Joint Board with effect from the day they cease to be a Councillor.

4.5 A constituent authority may remove a member who it nominated by providing one month's notice in writing to the member and the Integration Joint Board.

5. Disqualification Art 8

5.1 No person may be appointed as a Member of the Integration Joint Board, if they:-

(a) have been within a period of five years immediately preceding the proposed date of appointment been convicted of any criminal offence in respect of which the person has received a sentence of imprisonment (whether suspended or not) for a period of not less than three months (without the option of a fine);
(b) have been removed or dismissed for disciplinary reasons from any paid employment with a health board or local authority;
(c) are insolvent [3];
(d) have been removed from a register maintained by a regulatory body other than where the removal was voluntary [4];
(e) have been subject to a sanction under Section 19(1)(b) to (e) of the Ethical Standards in Public Life etc. (Scotland) Act 2000; all as defined in the Integration Joint Boards Order.

6. Chair and Vice Chair Art 4 + Schedule para 3

6.1 The Chair and Vice Chair shall be appointed from the Health Board and Council voting members on the Integration Joint Board. The Council and the Health Board shall alternate which of

[3] Insolvency is defined in Article 8(4)(a) of the Integration Joint Boards Order
[4] The definition of relevant Regulatory Bodies is set out in Article 8(4)(b) of the Integration Joint Boards Order.

them is to appoint the Chair and Vice Chair. Whenever a Council member is to serve as Chair then the Vice Chair will be a member nominated by the Health Board and vice versa.

6.2 The appointment of Chair and Vice Chair shall not exceed a period of three years; and unless the constituent authorities agree otherwise, it shall be for a one year term. The Council or Health Board may change their appointee as Chair or Vice Chair during the period of their appointment.

6.3 The Vice-Chair may act in all respects as the Chair of the Integration Joint Board if the Chair is absent or for any reason otherwise unable to perform his/her duties.

6.4 At every meeting of the Integration Joint Board the Chair, if present, shall preside. If the Chair is absent from any meeting the Vice-Chair, if present, shall preside. If both the Chair and the Vice-Chair are absent, a Chair shall be appointed from within the voting members present for that meeting. Any proxy Member attending the meeting may not preside over that meeting.

6.5 The Chair and Vice Chair may resign office at any time and it shall be the responsibility of the constituent authority to appoint a replacement as soon as practicable to complete the term of office of the outgoing Member.

6.6 The decision of the Chair on all matters within his/her jurisdiction as set out in these Standing orders shall be final.— Deference shall at all times be paid to the authority of the Chair and Members shall address the Chair while speaking

6.7 The Chair (and in his/her absence the Vice Chair) shall amongst other things:-

(a) encourage full debate on the issues presented for discussion and seek to obtain a consensus view on all matters before the Integration Joint Board;

(b) ensure that due and sufficient opportunity is given to voting and non-voting members who wish to speak to express views on any subject under discussion;

(c) ensure that the views of non-voting members are recorded in the Minutes of the meeting on request;

(d) preserve order and ensure that every Member is able to fully express views;

(e) decide on matters of relevancy, competency and order, and whether to have a recess during the meeting, having taken into account any advice offered by the Chief Officer or other relevant officer in attendance at the meeting;

(f) determine the order in which speakers shall be heard;

(g) if requested by any Member to ask the mover of a motion, or an amendment, to state its terms;

(h) at his/her discretion, order the exclusion of any person who is deemed to have caused disorder or misbehaved.

7. Meetings Schedule para 1

7.1 The first meeting of the Integration Joint Board shall be convened at a time and place to be determined by the Chair. Thereafter the Integration Joint Board shall meet at such place and such frequency as may be agreed by the Integration Joint Board.

7.2 The Chair may convene Special Meetings if it appears to him/her that there are items of urgent business to be considered. Such meetings will be held at a time, date and venue as determined by the Chair. If the Office of Chair is vacant, or if the Chair is unable to act for any reason the Vice-Chair may call such a meeting.

7.3 If the Chair refuses to call a meeting of the Integration Joint Board after a requisition for that purpose specifying the business proposed to be transacted, signed by at least two thirds of the voting Members, has been presented to the Chair or if, without so refusing, the Chair does not call a meeting within seven days after such requisition has been presented, those Members who presented the requisition may forthwith call a Meeting provided no business shall be transacted at the Meeting other than specified in the requisition.

8. Admission of Public & Media to Meetings

8.1 Members of the public and representatives of the media shall be admitted to meetings of the Integration Joint Board to observe the proceedings, unless the Integration Joint Board adopt a resolution to exclude the public and media on grounds that publicity for any

item under discussion would be prejudicial to the public interest due to the confidential nature of the business to be transacted or for other reason specified in the resolution.

8.2 Members of the public and representatives of the media shall not be permitted, without the approval of the Integration Joint Board, to record the proceedings other than by the making of written notes.

8.3 Members of the public may at the Chair's sole discretion be permitted to address the Integration Joint Board for an agreed period, but shall not generally be permitted to participate in discussion at a meeting.

8.4 Nothing in these Standing Orders shall preclude the Chair from requiring the removal from a meeting of any person or persons who persistently disrupt the meeting.

9. Notice of Meeting Schedule para 2

9.1 Before every meeting of the Integration Joint Board, a notice of the meeting, specifying the date, time, place and business to be transacted at it and signed by the Chair, or by a member authorised by the Chair to sign on that person's behalf, shall be delivered to every member or sent electronically to every member, or sent to the usual place of residence of every member so as to be available to them at least five clear days before the meeting. Members may opt in writing addressed to the Chief Officer (or nominee) to have notice of meetings delivered to an alternative address. Such notice will remain valid until rescinded in writing. Lack of service of a notice of a meeting on any member shall not affect the validity of anything done at that meeting.

9.2 In the case of a meeting of the Integration Joint Board called by members, in default of the Chair, the notice shall be signed by those members who requisitioned the meeting.

9.3 At a meeting of the Integration Joint Board, no business other than that on the agenda shall be discussed or adopted except where by reason of special circumstances, which shall be agreed at the meeting and specified in the minutes, the Chair is of the opinion that the item should be considered at the meeting as a matter of urgency.

9.4 Notice of all Integration Joint Board meetings shall be posted at

the principal offices of the Integration Joint Board and published on the Internet a minimum of five days before each meeting.

10. Conduct of Meetings Schedule para 3, 4 & 5

10.1 No business shall be transacted at a meeting of the Integration Joint Board unless there are present a quorum of at least one half of the voting members of the Integration Joint Board.

10.2 For the purpose of Article 10.1, a member may be classed as present, but not at the same physical location as other members, if the member is able to participate in the meeting remotely by hearing other members at the venue notified for the meeting [5].

10.3 Subject to article 10.9, each question put to a meeting of the Integration Joint Board shall be decided by a majority of the votes of members present and entitled to vote.

10.4 If within ten minutes after the time appointed for the commencement of a meeting of the Integration Joint Board, a quorum is not present, the meeting will stand adjourned to such date and time as may be fixed by the Chair and notified to members.

10.5 If after a meeting has commenced, the quorum shall fall below one half of the voting members and this is drawn to the attention of the Chair, the meeting will be adjourned to such date and time as the Chair may determine.

10.6 If it is necessary or expedient to do so, otherwise by virtue of a lack of quorum, a meeting of the Integration Joint Board may be adjourned to another date, time or place**.** A decision to adjourn a meeting shall be moved and seconded and put to the meeting without debate. If such a motion is carried by a simple majority of those present and entitled to vote, the meeting shall be adjourned to the day, time and place specified in the motion.

10.7 A record must be kept of the names of the members attending every meeting.

10.8 Minutes of the proceedings of each meeting, including any decisions made at that meeting, shall be drawn up and submitted to the next ensuing meeting for agreement as to their accuracy, after which they shall be signed by the person presiding at that subsequent meeting.

[5] This would include teleconferencing or video conferencing into the meeting.

10.9 A vacancy in the membership of the Integration Joint Board shall not invalidate anything done or any decision made by the Integration Joint Board.

10.10 Where there is a temporary vacancy in the voting membership of the Integration Joint Board, the vote which would be exercisable by a member appointed to that vacancy may be exercised jointly by the other members nominated by the relevant constituent authority.

10.11 Where a formal motion is put to a meeting of the Integration Joint Board, the following procedure will apply:-

(a) If required by the Chair any motion or amendment shall be put in writing, and after being seconded, shall not be withdrawn without the leave of the Integration Joint Board.

(b) No motion or amendment shall be spoken upon, except by the mover, until it has been seconded.

(c) After debate, the mover of any original motion shall have the right to reply. In replying he/she shall not introduce any new matter, but shall confine himself/herself strictly to answering previous observations.

(d) Immediately after his/her reply, the question shall be put to the meeting by the Chair without further debate.

(e) Any Member in seconding a motion or an amendment may reserve his/her speech for a later period of the debate.

(f) When more than one amendment is proposed, the Chair of the meeting shall decide the order in which amendments are put to the vote.

(g) All amendments carried shall be incorporated in the original motion which shall be put to the meeting as a substantive motion.

(h) A motion to adjourn any debate on any question or for the closure of a debate shall be moved and seconded and put to the meeting without discussion. Unless otherwise specified in the motion, an adjournment of any debate shall be to the next meeting.

10.12 In the event that the Integration Joint Board is unable to come to a consensus view on any issue due to an equality of votes in favour and against a proposal the following procedure shall apply:

(a) The Chair shall call on the Chief Officer to outline the consequences of each potential outcome and to make a recommendation.
(b) The Chair shall immediately thereafter call for a show of hands on the motion before the meeting.
(c) If the result remains a tie, the meeting will be adjourned by the Chair for such period as he/she may determine later the same day to allow for discussion between members.
(d) On reconvening, the Chair shall call for any amendment to the motion before the meeting and the meeting will consider such amendment and substantive motion in accordance with article 10.11.
(e) If there remains no consensus on the issue concerned the Chair shall adjourn the meeting to such time and place on the next following working day once all outstanding business other that the unresolved item has been concluded.
(d) On the meeting reconvening, the Chair will call a further vote. If the result remains a tie, the Integration Joint Board shall consider how it should proceed to reach resolution on the disputed item.

11. Committees Art 17

11.1 The Integration Joint Board may establish Committees and Sub-Committees of its members for the purpose of carrying out such functions as the Integration Joint Board may determine.

11.2 Any Committee or Sub Committee established must have its constitution and terms of reference approved by the Integration Joint Board and must include an equal number of voting members of the Integration Joint Board from each of the constituent authorities. Any decision of a Committee relating to the carrying out of functions under the Act or to integration functions must be agreed by a majority of the votes of the voting members who are members of the Committee.

11.3 The Integration Joint Board is responsible for the appointment of Chairs of Committees and Sub-Committees.

11.4 A Committee or Sub-Committee may, notwithstanding that a matter is delegated, refer any matter for decision to the Integration Joint Board.

11.5 Minutes of Committees and Sub-Committees shall be presented to the Integration Joint Board, or Parent Committee (as appropriate), at the first scheduled meeting not less than 10 working days after the day the Committee or Sub-Committee meets.

11.6 The constitution, remit and Membership of Committees shall be reviewed annually at the Integration Joint Board held in April, or as soon as practicable thereafter.

11.7 These Standing Orders apply equally to Committees of the Integration Joint Board as they do the Integration Joint Board, subject to any modification as is required to meet the terms of reference and constitution of Committees.

11.8 Meetings of Committees and Sub Committees shall not be routinely open to the public and media, but may at their discretion agree to allow the public and media to attend generally or for specific meetings.

12. Codes of Conduct and Conflict of Interest Schedule para 5

12.1 Members of the Integration Joint Board shall subscribe to and comply with the Standards in Public Life - Code of Conduct for Integration Joint Boards[6]. These Standards are deemed to be incorporated into these Standing Orders. All Members shall be obliged on taking up membership, to agree in writing to be bound by the terms of the Code of Conduct.

12.2 All Members are required to complete a register of interests in a standard format to comply with their obligations under the Code of Conduct within a month of appointment and when any changes occur. A form to register interests will be sent to all Members on appointment and shall be renewed annually. Details of declarations made are published on the Internet and made available for inspection at the Principal Offices of the Integration Joint Board.

12.3 If any Member has a financial or non-financial interest as defined in the Code of Conduct and is present at any meeting at which the matter is to be considered, he/she must as soon as practical,

[6] It is understood that a Separate Model Code of Conduct will be developed for Integration Joint Boards. It will then be for individual Boards to submit a Code of Conduct based on this to the Scottish Government for approval. Once approved, the Code will apply to all Members of the Board.

after the meeting starts, disclose:-

(a) that he/she has an interest;
(b) the nature of that interest

The member shall determine if the interest is such that he/she should exclude themselves from the debate on the issue. [7]

12.4 If a Member or any associate of theirs has any pecuniary or any other interest direct or indirect, in any contract or proposed contract or other matter and that Member is present at a meeting of the Integration Joint Board, that Member shall disclose the fact at the commencement of the meeting and advise on the nature of the relevant interest. A Member shall not be treated as having any interest in any contract or matter if it cannot reasonably be regarded as likely to significantly affect or influence the voting by that Member on any question with respect to that contract or matter.

13. Execution of Documents N/A

13.1 Any document or proceeding requiring authentication by the Integration Joint Board shall be subscribed by two of the Chief Officer (or nominee); the Chief Officer Finance & Resources (or nominee); the Chief Officer Planning & Strategy & Chief Social Work Officer (or nominee) and Chief Officer Operations (or nominee).

13.2 The Chief Officer Finance & Resources shall maintain a record of officers authorised to sign documents on behalf of the Integration Joint Board in accordance with provisions of Standing Financial Instructions.

13.3 Where a document requires for the purpose of any enactment or rule of law relating to the authentication of documents under the Law of Scotland, or otherwise requires to be authenticated on behalf of the Integration Joint Board, it shall be signed by the Chief Officer or any person duly authorised to sign under the Scheme of Delegation to Officers in accordance with the provisions of the Requirements of Writing (Scotland) Act 1995.

[7] Under current legislation where a member declares an interest it is for the IJB to determine if the member declaring the interest is to be prohibited from taking part in discussion. This is contrary to the Codes of Conduct issued through the Standards Commission. Scottish Government has intimated an intention to amend this part of the legislation. Precise details of the change of wording have not yet been published. The Standing Orders as drafted reflect the position once the legislative change is made.

13.4 Before authenticating any document, the person authenticating the document shall satisfy themselves that all necessary approvals in terms of the Integration Joint Board's procedures have been satisfied. A document executed by the Integration Joint Board in accordance with this Article shall be self-proving for the purpose of the Requirement of Writing (Scotland) Act 1995.

13.5 Any authorisation to sign documents granted to any individual shall terminate upon that person ceasing (for whatever reason) from holding a position of authority with the Integration Joint Board, without further intimation or action by the Integration Joint Board.

Item No. 10

Meeting Date **1st December 2015**

Shadow Integration Joint Board

Report By: **Chief Officer, Finance & Resources**

Contact: **John Dearden, Head of Business Administration**

Tel: **0141 287 0394**

Future Membership of the Integration Joint Board

Purpose of Report:	The membership of the Integration Joint Board is determined by Order made under the Public Bodies (Joint Working)(Scotland) Act 2014. The Council and Health Board nominate the voting members of the Joint Board. There are certain appointments made by the Joint Board where the Board needs to determine the term of office of appointees and the persons to be appointed. There is also discretion on the Board to appoint some additional members. In advance of formal constitution of the Joint integration Board this paper is submitted to obtain views of current members on aspects of the future appointment process.
Recommendations:	The Shadow IJB is asked to consider:- (a) Arrangements for the appointment of stakeholder members and their term of office; (b) Whether any additional non-voting Members should be appointed as permitted under the constitution; and (c) The arrangements for the notification of deputies for all members.

Implications for IJB:

Financial:	None
Personnel:	None

Legal:	The Public Bodies (Joint Working) (Integration Joint Boards)(Scotland) Order 2014 (as amended) sets out the criteria for the appointment of various categories of members.
Economic Impact:	None

Sustainability:	None

Sustainable Procurement and Article 19:	None

Equalities:	In appointing members the Board should take into account the requirements of the Equalities Act.

Implications for Glasgow City Council:	Requirement to maintain Councillor representation on the IJB, including the provision of deputies.

Implications for NHS Greater Glasgow & Clyde:	Requirement to maintain Non-Executive representation on the IJB, including the provision of deputies.

1. Integration Joint Boards

1.1 Integration Joint Boards are created as a new legal entity that binds the health board and the council together in a joint arrangement. The membership of an Integration Joint Board reflects equal participation by health board and council members to ensure that there is joint decision making and accountability.

1.2 The Integration Scheme sets out the number of council and health members that sit on the IJB. In Glasgow City this is 8 members from each authority. Nominating authorities are required to make their best endeavours to ensure that a deputy is available to stand in for any absent member.

1.3 The Members from the council and health board are the voting members on the IJB. Each has a single vote and the Chair does not have a second or casting vote.

1.4 From the voting members there is appointed by agreement a Chair and Vice Chair. Provision is made that where the Chair is a Councillor, the Vice Chair will be a health board member and vice versa.

1.5 All voting members are appointed for a term which shall not exceed three years.

1.6 At the end of their term of appointment a member may be appointed for a further term of office.

1.7 In addition to the voting members there are non-voting professional and stakeholder members.

2. Professional members

2.1 The professional members comprise:-

- The Chief Officer of the IJB (appointed by the IJB)
- The Chief Social Work Officer of the Council, appointed by the local authority
- The Section 95 Officer of the Integration Joint Board (Chief Finance Officer), appointed by the local authority
- A registered medical practitioner who is included in the list of primary medical services performers (i.e. a GP), appointed by the health board
- A registered nurse who is employed by the health board or by a person or body the health board has entered into a general medical services contract, appointed by the health board
- A registered medical practitioner employed by the health board and not providing primary medical services, appointed by the health board.

2.2 This totals 6 professional members. Three hold office by virtue of the office they hold (Chief Officer, Chief Social Work Officer and Chief Finance Officer (Section 95 Officer)). The remaining members are appointed by the Health Board who determines the period of appointment. Appointment periods must not exceed three years, but there is provision for re-appointment.

2.3 Guidance issued by the Scottish Government states:-

- The professional members appointed will bring professional experience and knowledge to inform the Integration Joint Board decision making in terms of planning, operational delivery and the effectiveness of major reforms. This advice will ensure the Integration Joint Board can fully take account of safety and quality of care matters. As such, the appointed person must be able to demonstrate the appropriate experience, skills and competencies to fulfil this role. The appointed member must demonstrate their ability to work at a senior level and have experience of operating at a strategic level;

- Professional members should have a named, appointed deputy, able to demonstrate a similar level of skill and experience as the substantive appointment. Deputies should be expected to attend only where absolutely necessary to ensure continuity of advice from the professional.

2.4 Consideration needs to be given to the identification of suitable deputies for the professional members.

3. Stakeholder representatives

3.1 There is also a requirement to appoint stakeholder representatives as non-voting members comprising at least one from:-

- staff of the constituent authorities engaged in the provision of services provided under integration functions (this has been taken by the Shadow IJB to be Staff Side representatives – one each from the council and health) as nominated by the relevant staff side orgnisations;
- third sector bodies carrying out activities related to health or social care in the area of the local authority appointed by the IJB from nominations received;
- service users residing in the area of the local authority appointed by the IJB from nominations received; and
- persons providing unpaid care in the area of the local authority from nominations received.

3.2 These appointments are made by the voting members on the Joint Board for a term not exceeding 3 years. There is provision for a member to be re-appointed for a subsequent term. As with other members there is a right to appoint a proxy to represent any stakeholder representative who cannot attend meetings.

3.3 Guidance issued by the Scottish Government states:-

The ways in which stakeholder members will be identified and appointed to these positions on the Integration Joint Board will vary due to the local circumstances of each Integration Joint Board, such as type and number of representative groups working within their area. Although there will not be a uniform approach in appointment of the stakeholder members, it is important that they are able to appropriately fulfil their roles. The Integration Joint Board should follow the principles set out below:

- Stakeholder members will reflect the views of the groups they represent on the Integration Joint Board; naturally the individuals that comprise these stakeholder groups will be diverse. As such, the appointed person must be able to demonstrate the appropriate experience and skill to reflect the breadth and diversity of views and situations of the individuals or groups that they represent.

- The Integration Joint Board should ensure the appointed member has the resources and support to fulfil their responsibilities to the Integration Joint Board for the full term of their appointment.

- As effective strategic planning is key, the Integration Joint Board must ensure that the appointed stakeholder members are given specific training and support to contribute effectively to the Integration Joint Board, where such training is required.

- As with professional members, these principles should also be considered when the Integration Joint Board opts to appoint any additional stakeholder members. The implementation of each principle will depend on the nature and basis on which these additional members are appointed.

4. Additional members

4.1 Integration Joint Boards may additionally appoint such other members as it sees fit, but these additional appointments cannot be Councilors or Health Board members.

4.2 Guidance issued by the Scottish Government states:-

Whilst there is a required minimum membership for inclusion on the Integration Joint Board, there is also local flexibility for the Integration Joint Board to add additional members. The Independent Sector for example provide a significant proportion of social care services and will therefore play a key role in the successful delivery of integrated services in local areas. As part of their strategic planning responsibilities, Integration Joint Boards should consider their membership cohorts and seek appropriate additional representation as suggested by local priorities. Integration Joint Boards might also seek additional membership to reflect delegation of functions outside the minimum scope, for example additional professional advice.

4.3 In previous discussion it has been suggested that the Chief Officer, Operations should be a professional member of the Board. So too it has been suggested that it would be important to include a representative from the health board's acute services division. The value of including an officer from Development and Regeneration Services has also been identified.

5. Resignation/Removal/

5.1 There is provision in the Regulations for members to resign before completion of their term of office and for the removal of members in certain circumstances e.g. if a member ceases to be qualified to be a member or is disqualified from membership.

6. Current Appointments

6.1 A Schedule attached provides details of the current membership of the Shadow Board, with an indication of the future term of members, where this has been determined by the appointing body.

6.2 In preparation for the formation of the Integration Joint Board, members are invited to reflect on any adjustments required to membership. Stakeholder representation will need to be confirmed with terms of office agreed.

7. Possible Changes to Current Arrangements

7.1 It has been suggested that as there are three Clinical Directors covering Glasgow City, arrangements be agreed with the Health Board for the Clinical Directors to rotate as a Professional Member on a three yearly cycle.

7.2 As well as the appointment of the Chief Officer Operations as a Professional Member, it is suggested that representation be sought from a General Manager/Director within the Acute Services Division of the Health Board and a representative of Development and Regeneration Services of the Council.

7.3 On the term of stakeholder members, it is suggested that the six current members be reappointed (if willing to continue) and that by lot it is set that 2 of the 6 have a term of 1 year, 2 a term of 2 years and 3 have a term of 3 years initially. This will mean that every year one third the stakeholder members will retire e.g.

2 appointed for 1 year to March 2017
2 appointed for 2 years to March 2018
2 appointed for 3 years to March 2019

Thereafter each year the two whose term is due to end would be reviewed and either re-appointed or a replacement appointed. This will avoid the situation where all stakeholder representatives retire at the same time.

7.4 There is provision for all members to have deputies. In the case of the voting members the council and the health board are required to use their best endeavours to ensure that where a member is absent they are represented by a suitably qualified deputy i.e. person who meets the appointment criteria.

Members of the Glasgow City Shadow integration Board as at 16th November 2015

Category of membership	Term	Category of Membership	Term
Council Voting Members		**Health Board Voting Members**	
Cllr James Adams	Council to confirm	**John Brown**	Three years from establishment so long as remains member of Health Board
Baillie Aileen Colleran	Council to confirm	**Simon Carr**	Three years from establishment so long as remains member of Health Board
Cllr Matt Kerr	Council to confirm	**Ian Fraser**	Three years from establishment so long as remains member of Health Board
Cllr Marie Garrity	Council to confirm	**Trisha McAuley (Vice Chair)**	Three years from establishment so long as remains member of Health Board
Cllr Emma Gillan	Council to confirm	**Robin Reid**	Three years from establishment so long as remains member of Health Board
Cllr Archie Graham (Chair)	Council to confirm	**Norman Shanks**	Three years from establishment so long as remains member of Health Board
Baillie Razaq Mohammed	Council to confirm	**Donald Sime**	Three years from establishment so long as remains member of Health Board
Cllr Russell Robertson	Council to confirm	**Vacancy**	Three years from establishment so long as remains member of Health Board

Category of membership	Term	Category of Membership	Term
Professional Members		**Stakeholder Representatives**	
David Williams **Chief Officer Designate**	So long as holds office	**Annie Craig (John McVicar deputy)** **Carers Representative**	IJB to confirm
Susanne Millar **Chief Officer Planning & Strategy and CSWO**	So long as holds office	**Ian Leech and Dorothy McErlean** **Staff Side Representatives**	IJB to confirm
Sharon Wearing Chief Officer, Finance & Resources	So long as holds office	**Peter Millar** **Independent Sector Housing Representative**	IJB to confirm
Alex MacKenzie **Chief Officer Operations**	Three years from establishment	**Anne Scott** **Social Care Users Representative**	IJB to confirm
Richard Groden **Clinical Director**	Three years from establishment	**Ann Souter (Deputy Robert Smith)** **PPF Representative**	IJB to confirm
Mari Brannigan **Director of Nursing**	Three years from establishment	**Shona Stephen** **Third Sector Representative**	IJB to confirm
Michael Smith Lead Associate Medical Director	Three years from establishment		

Item No. 11

Meeting Date **1st December 2015**

Shadow Integration Joint Board

Report By: **Chief Officer Designate**

Contact: **Chris Melling, Service Manager NW**

Tel: **0141 276 7200**

GLASGOW'S AUTISTM STRATEGY

Purpose of Report:	To receive, the draft Glasgow Autism Strategy for submission to the Scottish Government. The final version of the document that will be sent to the Scottish Government will be formatted by the Education's graphics section, pending agreement of the report by Social Work, Education and NHS GG&C.

Recommendations:	a) To note the draft Glasgow Autism Strategy is a multi-disciplinary approach involving Social Work, NHS and Education. b) To note the ASD Working Group has been regularly informed and updated on the progress of the development of the draft Strategy.

Implications for IJB:

Financial:	Not applicable

Personnel:	Not applicable

Legal:	Not applicable
Economic Impact:	Not applicable

Sustainability:	Not applicable

Sustainable Procurement and Article 19:	Not applicable

Equalities:	Not applicable

Implications for Glasgow City Council:	Glasgow's Strategy will be a formal record of the HSCP's, and Education's autism plans for the next 5 years.

Implications for NHS Greater Glasgow & Clyde:	Glasgow's Strategy will be a formal record of the HSCP's autism plans for the next 5 years.

1. Background

1.1 In November 2011, the Scottish Government launched the Scottish Strategy for Autism. This is a ten year strategy with associated recommendations for "Good Practice Across Scotland". The national Strategy sets out an ambition to revitalise and invigorate autism services principally through the development of six new One Stop Shops, transition support, employability, training, learning and development and other identified key areas.

1.2 Historically, Glasgow's approach to the delivery of autism services has centred around the functions of the Autism Resource Centre which essentially already 'ticked the boxes' in respect of the national strategy and has been rightly regarded nationally as a centre of excellence for many years. It is a 'one stop shop' resource, supporting individuals and families with many of the areas identified as priorities in the national strategy.

1.3 Notwithstanding that, there is an expectation within the national Strategy that local authority areas also produce a local strategy for autism and it is considered that of itself, the provision of an Autism Resource Centre, excellent and highly regarded though it is, is not of itself a strategy.

1.4 The draft strategy therefore is comprehensive and multi-agency in its development and approach. The Glasgow Strategy has been produced in jointly by Social Work, Education and NHS GG&C.

1.5 The Strategy as a current draft was submitted to the Glasgow City Council Health & Social Care Policy Development Committee and Glasgow City Council Children & Families Policy Development Committee in November for consideration.

1.6 Further consideration needs to be given to the Strategy in the context of the emerging Integration Joint Board's Strategic Plan for the delivery of all health and social care services in Glasgow.

1.7 The strategy sets out priorities to delivery of the four key outcomes set out in the national strategy. These outcomes are:

1. A Healthy Life
2. Choice and Control
3. Independence
4. Active Citizenship

1.8 The priorities set out in the strategy are:

- Transitions
- Earliest identification, assessment, diagnosis
- Intervention and support
- Training, capacity and awareness-building, in mainstream services
- Effective data collection methods
- Employment

Glasgow's Strategy for Autism

Need design for front page

Logos from HSCP and Education Services

Foreword

We are working hard to make life easier for people with autism of all ages and their carers.

Glasgow remains a city of contrasts. As Scotland's largest city, our challenges in addressing deprivation, health and inequality are well documented. Although the city is coming out of the economic downturn in a stronger position, the city's significant challenges on poverty and inequality remain. Autism is a national priority, and has been fully embraced as a priority in Glasgow. We recognise that support and services to people with autism have been developed over the years, and we have secured a number of improvements to autism services.

However, the Scottish Strategy for Autism provides the catalyst to continue to develop and improve services delivered locally within a national context. It is the opportunity for Glasgow to be responsive and develop a fully integrated, co-ordinated and inclusive strategy within an evolving education, health and social care policy landscape.

Our vision is to mainstream the range of services for all people with autism, their families and carers, across all ages within Glasgow and to provide high quality, flexible and responsive services that protect children and adults from harm, promote independence and deliver positive outcomes for Glasgow citizens. People with autism should have the same choice, opportunities and access to services as everyone else.

To achieve success, it is essential that we continue to work together with people with autism, their carers, and other stakeholders and agencies, to ensure positive outcomes in line with the Scottish Government's 10 year strategy for autism.

Photos and signatures to be included

Contents

Chapter 1 Context of the Strategy

We are committed to continuing to improve the work that already exists in and across Glasgow and involve people with autism and their carers in service planning. Partnership working across agencies is a strength within Glasgow where we have developed shared priorities to ensure people with autism across all ages are provided with joined up support and services; services that are linked and cohesive at the point of planning and delivery.

The formation of the Health and Social Care Partnership (HSCP) will become a major driver for change through joint working to improve service delivery and encourage service re-design where it will lead to better efficiencies and targeted supports. The HSCP believes through its vision statement 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 service for better lives. The HSCP believes that stronger communities make healthier lives.

To date, Glasgow has followed the recommendations made in The Scottish Strategy for Autism (2011) and in particular benchmarking our success against the 5 years targets set out in the context of a person's "Whole life journey: by 5 years". We would regard a number of our autism services as having a significant positive impact on the lives of people with autism and their carers. Feedback from users and carers show that many of our services are valued. These services include a range of supports such as a comprehensive training programme, transitions support, group work provision, information and advice, and support to carers.

Key to all of our work in Glasgow is the importance of working alongside people with autism and their carers and families. While most of the work is done on an autism specific basis, there are also many instances of more generic work. Joint work is carried out at a number of levels to promote the co-production of appropriate supports. Examples of this include face to face assessment and care planning; targeted service provision in Health, Social Work and Education; strategic planning on a city wide basis; and promoting good working relationships with the third sector.

Tackling health and social inequalities through prevention and early intervention is a key priority for Glasgow Community Planning Partnerships. Particular challenges for Glasgow are faced as a consequence of poverty levels, the scale of vulnerability and the economic environment whilst meeting the rising demand across all our public services.

Financial challenges and efficiency savings experienced across public sector services and the third sector has resulted in a requirement to re-think how services are most effectively designed and delivered to meet the needs of the most vulnerable in our communities. This has resulted in the necessity to introduce stringent prioritisation of services as access to available funding sources becomes

less secure and more stretched. Within Social Work, people with autism and their families are now more aware of the new eligibility criteria, the challenges of Personalisation, the payment of client contributions, and the difficulty in providing consistent care management.

Training, raising awareness, building a culture of confidence, knowledge and best practice across all staff groups and within communities is integral to Glasgow's strategy within the context of early intervention and mental health promotion and prevention. Ongoing work continues at a strategic planning level across Glasgow's partners, as well as at an individual service level to evaluate the effectiveness of our collaborative working in the context of outcomes for people with autism. The benchmarking approach to test progress and improvements incorporates the recommendations of the Autism Strategy's ten indicators for best practice in conjunction with relevant nation policy and frameworks. (See Appendix i).

Chapter 2 Impact of Autism

Autism is a lifelong developmental condition that affects how a person communicates with and relates to other people and their environment. It is a spectrum condition which means that while all people with autism share certain challenges, their condition will affect them in different ways. As autism is a lifelong condition, the impact is likely to change throughout a person's lifetime. While people often share common features, every person with autism is unique. Each person has particular strengths and requirements for support in order to enhance their wellbeing, improve life skills and self-esteem. As described in the "Scottish Strategy for Autism's Menu of Interventions" (2013), people with autism typically find challenges in the following areas:

- Understanding the implications of an autism spectrum diagnosis
- Development of effective means of communication
- Development of social communication
- Developing and maintaining relationships
- Social isolation for individual with autism
- Social isolation for family
- Learning to learn skills
- Predicting and managing change
- Behaviour and emotional regulation protecting wellbeing
- Restricted and repetitive interests and behaviours
- Motivation issues
- Sensory issues
- Daily living skills
- Co-existing conditions (epilepsy, anxiety etc.)

Glasgow is promoting well-being for people with autism through early and effective intervention. A key priority is to ensure that partnership arrangements across education, social care and health work effectively to assess and plan for people with autism. This enables appropriate supports at the right time, and enhances life-long transitions. Managing and supporting all transitions is essential throughout the individuals' life, but particularly for the key transition stage of moving from children's service to the adult world. Providing appropriate support to children and their families will have major benefits as people reach adulthood.

Our aim is to work towards supporting people with autism to become more independent, and improve their quality of life across their lifespan.Our overarching goal is to provide choice and flexibility of support for people with autism and their friends and family throughout lifelong transitions.

Glasgow is committed to further improving services and support for people with autism. Therefore this Strategy has been developed through a process of collaboration between professionals from education, health and social care, as well as people with autism, their families and carers. This process has informed our priorities and has laid the foundation for our action plan for the next 5 years. In forming clear and achievable priorities for Glasgow we have taken into account the advancing research and best practice. These priorities include:

- Transitions
- Earliest identification, assessment, diagnosis
- Intervention and support
- Training, capacity and awareness-building, in mainstream services
- Effective data collection methods
- Employment

We are also committed to developing our cultures, practices and policies to ensure we make the right services available at the right time and are developing a responsive, flexible continuum of support that promotes inclusion and maximises opportunities for people with autism. Therefore, through Glasgow's multi-agency forum for improving services for people with autism, we monitor and evaluate progress towards the main priorities outlined in our action plan (Appendix 1). Information from national findings, evaluation of our current delivery, and the information gathered by the service map informs our action plan priorities. Building on good progress to date, we continue to embed and improve approaches within our key priority areas to sustain our shared vision and deliver a service that is outcome focused, consistent and joined up. We continue to ensure that pathways are individual and needs based.

Social Work compile figures for people with learning disability and autism for the "Same as You" annual return to the Scottish Government. The latest figures estimate that there are 323 people with a dual diagnosis. Within Education, we carry out an annual survey of school age children. At the last survey, the figures suggest that there are 1575 children and young people with autism in Glasgow City Council establishments (2.4% of the pupil population). Health do not compile figures in any formal annual return. Overall, there is no single definitive figure for the number of people with autism.

Working on the basis of the latest prevalence figures of autism, there are indications that 1.1% of the general population may have autism. In Glasgow, this amounts to 6525 people. This group of people will have various levels of functioning – from low levels of functioning, to people who are very able. Presentation can vary in complexity and may be masked by other conditions.

The prevalence of mental health difficulties in adults with autism has been found to vary considerably. Environmental factors related to major life transitions, loss, inadequate support, or social isolation seems to be related to onset of mental health issues in many cases. Approximately 30-40% of people with autism also have a learning disability. Those people with a learning disability in addition to autism may need significant support with day to day living. However, the pattern of difficulties presented can vary across a person's lifespan.

Outcomes for some people with autism can be poor. This has implications for planning and delivery of autism services within Glasgow. In Glasgow this is seen by disproportionately high poverty levels of unemployment, poverty and lack of opportunity resulting in people with autism being further disadvantaged. Behaviours associated with autism can lead to significantly greater issues; particularly with regard to housing and social inclusion.

It is well established that family members report higher rates of stress, distress, depression and physical morbidity than the general population. Autism can create significant challenges for families and accessing services and developing and maintaining social networks can be very difficult. Glasgow now has a range of services in place targeted at carers, parents and family members.

Chapter 3 - Developing Autism Service Provision within the Whole Life Journey

Glasgow's priorities for supporting people with autism

Glasgow recognises the four key strands for the "Whole Life Journey: by 5 years" as detailed in the Scottish Strategy for Autism (2011), and has based its services on these principles:

- Access to integrated service provision across the lifespan to address the multi-dimensional aspect of autism.
- Access to appropriate transition planning across the lifespan
- Consistent adoption of good practice guidance in key areas of education, health and social care across local authority areas
- Capacity and awareness building in mainstream services to ensure people are met with recognition and understanding of autism.

In 2015, the Scottish Government developed these four key strands further and published "Priorities 2015-17 Strategic Outcomes" highlighting four key outcomes for people with autism:

1. A Healthy Life
2. Choice and Control
3. Independence
4. Active Citizenship

This strategy focuses on these four outcomes looking at current and future provision and performance for health, social care and education. Below is an overview of the services and developments in Glasgow, with a clear pathway for improvement over the full 10 years of the strategy. We have taken a cradle to grave transitions approach to determining our current position and recommendations for future improvements.

Outcome 1

A Healthy Life: People with autism enjoy the highest attainable standard of living, health and family life and have timely access to diagnostic assessment and integrated support services.

Access to high quality information remains a key priority within the Glasgow strategy. Across children's services, we have a cohesive programme of resources for staff which supports a consistent network of high quality information provision and sharing. This includes resources to raise awareness and understanding amongst professionals about effective strategies for children and young people, including what can help as well as general and targeted training materials. It is our intention that this is re-visited within the action plan to address gaps and ensure continuous improvements.

Parents / carers, children and professionals work collaboratively to plan for children in a personalised, flexible and responsive way throughout their pre-school and educational career. As appropriate, children and young people will have a plan based on the well-being indicators and the principles of GIRFEC. This ensures that there is an appropriate level of support to provide the young person with a flexible pathway.

Early identification of need is central to the priorities set out by Glasgow's Healthy Children's Programme. As a consequence, care pathways have been reviewed and an extensive programme of building capacity and maximising the skilled workforce across the health family (and specifically universal services) has been integrated into joint working arrangements. This helps to ensure effective responses to well-being concerns specific to the child's development. This includes screening initiatives between health visiting and speech and language practitioners and supports capture of data specific to autism.

Specialist Children's Services across NHS Greater Glasgow and Clyde Health Board have undertaken progressive developments across Community Paediatric and Children and Adolescent Mental Health Services for children and young people. This includes developments to address waiting times whilst maintaining the quality of assessment and diagnostic services. An integrated pathway approach is in place to ensure access to practitioners who are highly skilled in understanding and assessing the complex needs of children and young people with autism in situations where co-morbidities are also present. Streamlined and effective support to children and families on the assessment journey, including their journey after assessment, has also been a focal point over 2014/15. An extensive evaluation has been completed in conjunction with children, parents/carers, siblings and partners in order to inform the interventions and supports best suited to meet the variety of needs facing children and young people with autism at this critical stage. The evaluation and engagement has identified the value and importance of services which support adjustment and

social inclusion as well as the need for tailored advice on understanding and managing behaviour.

Carer pathways specific to the needs of carers of children and young people with autism are supported through multi-agency planning structures. The delivery of parent, young carers and sibling support groups are strategically linked within a wider carer strategy framework and Glasgow's parenting programmes. One specific example is the provision of a rolling parent/carer education programme which can be accessed via a single system by children and families through all partners. This programme, which was introduced in direct response to feedback from families, provides families with information, support and targeted self-help strategies across a range of topics and life stages. Evaluation and feedback is integral to the programme format. Families and carers are invited to opt-into the programme which is well-attended and well-received.

Health Improvement Services continue to work collaboratively with Education Services in designing and delivering programmes to support a personalised approach to learning. Such programmes include use of person-specific social stories and pictorial timetables, a flexible school-based Cognitive Behaviour Therapy programme (The Homunculi Approach to Social and Emotional Wellbeing'[1]), and the Bounce Back programme. All of these are designed to help young people with autism understand their emotions, support self-acceptance, build resilience and raise self-esteem. There is also joint working around sleep including sleep counselling for nursery children/ pupils/families.

The importance of access to targeted early intervention which links to wider service delivery is recognised by NHS Greater Glasgow and Clyde through the ongoing provision of the Pre-School Early Intervention Parent/Child Programme delivered by Specialist Children's Service's Scottish Centre for Autism. This programme is delivered to pre-school children often under the age of 3 years and focuses on developing early social reciprocity and flexibility of behaviour. Parents are trained as co-therapist and consistently evaluate this programme as highly valuable and impactful.

Glasgow's One Stop Shop, the Autism Resource Centre (ARC), was established in 2004 as a multi–disciplinary approach to the delivery of autism services within Glasgow. In 2014 the ARC was subject to a full service review. The key priorities identified include closer working with partner agencies, service users and other stakeholders to ensure the most effective use and development of autism services and to continue to provide and further develop an integrated service by forging closer links with Children and Family Services to address the whole life journey.

The impact of providing a more generic One Stop Shop approach to parents and carers has been very successful. As well as providing the "Me, Myself and ASD"

[1] http://www.emotionworks.org.uk

programme to young people from the age of 14 years, it also runs Sexual Health and Relationship support programmes in conjunction with the Family Planning Association, Education Services and the Council's Young People's Sexual Health Team. These are clear examples of transition planning across the lifespan and crucially, a more joined up approach with other agencies. This fits in with the "traditional" ARC approach of providing group work provision for adults, and the development of active programmes. The needs of young people are now being included in all aspects of the ARC, demonstrating the strategic intent for delivering services that fully endorse and incorporate the principle that transition is lifelong.

A significant and progressive development has been the Autism Alert Card led by the ARC in partnership with people with autism their carers and other agencies and stakeholders. This enables those that who chose to carry the card to identify themselves to workers / individuals in organisations as having an Autism Spectrum Disorder and may include Police Scotland Emergency Services and other public services. The service is directly provided and administered by the ARC and 1,227 people with autism in Glasgow have an Autism Alert Card. Other key strategic developments have been the creation of Autism Aware DVD's specifically for Police Scotland and Glasgow Life (A Glasgow Partnership Agency) for the purpose of staff training and the most recent GOLD (Glasgow On Line Development Programme) Autism Awareness Module, which has been rolled out across Scotland as a no cost resource and available to all agencies and the general public. This has demonstrated the ARC's commitment to innovation and change involving and including people with autism.

A further key area of work has been improving the Learning and Development programme. This has provided a range and depth of training opportunities across Social Work Services, Education Services, Prison Service, third sector, and other stakeholders - both within and outwith Glasgow. This shows a commitment to provide in-depth training, as well as awareness training, and has been organised with the clear intention of building capacity, but also measuring impact and outcomes. As an example, the provision and co-delivery of autism training for Education Services has led to a more sustainable model of training that builds the capacity of staff in establishments to adapt the learning environment to suit the needs of children and young people with autism. Through the training framework, we are developing a coaching model that supports staff to collaborate and improve through peer reflection and evaluation.

NHS Greater Glasgow and Clyde provides support to people with autism through its Adult Autism Team (AAT). This is a multi-disciplinary specialist autism team that has been evolving alongside learning disability, mental health and mainstream services in Glasgow since 2004. The remit of the team is to enable adults with autism to access appropriate mainstream services, to support these services in working effectively with adults with autism, and to provide a range of targeted interventions to

enable the identification, support and social inclusion of people on the autism spectrum.

The fundamental assumption on which this model is based is that people with autism should be able to access good quality timely support from mainstream health, social care and independent sector providers, as opposed to having all their needs met by a specialist autism service.

The AAT works closely with a range of agencies across the care pathway, including mental health and learning disability teams, criminal justice, primary care and addictions to enable them to develop a good quality, innovative service for people with autism in their local area.

Goal – improve access to integrated service provision across the multi-dimensional aspects of autism

We will achieve this by:

- Progressing our commitment to effective partnerships to ensure delivery of integrated services through closer working with partner agencies, service users and other stakeholders.
- Ensuring that people with autism and their carers are involved in planning of services.
- Progressing further review and evaluation of one-stop shop (ARC), including re-location.
- Improving the reliability and accuracy of data collection systems and use this to inform planning in a streamlined way.
- Continuing to review and apply best practice models which promote quality and effectiveness in early identification, diagnosis and integrated intervention pathways.
- Delivering services that engage effectively with each other in a multi-agency context in order to meet the needs of people with autism.
- Reviewing the application of the education coaching model that supports staff to collaborate and improve through peer reflection and evaluation and use learning to inform the sharing of practice.

Outcome 2

Choice and control: People with autism are treated with dignity and respect and services are able to identify their needs and are responsive to meet those needs.

Glasgow's aim since the establishment of specific autism services has been to include people with autism and their families in the workings of our services. Co-production and regular consultation has been a key feature in our design and delivery of services, as outlined in the previous section.

The ability to communicate is an increasingly essential life skill for people, including children and young people in the twenty-first century. Communication is a fundamental human skill as recognised by the formal, public and multilateral declaration by UNICEF, UNESCO and the World Health Organisation, which lists communication as one of the ten core life skills. The significance of effective communication skills to support people to engage positively with the world around them is fully acknowledged across Glasgow partnership arrangements. It is recognised that without robust speech, language and communication skills children will struggle to learn, achieve, make friends, develop the skills for work and take their place in the world in later life. As a result the Glasgow approach across children's services uses the wider definition of speech, language and communication needs (SLCN). This enables partners to identify and support the communication, social and sensory needs of the wider population as well as people with an identified diagnosis.

As a result of receiving appropriate supports at the right time, there have been major benefits to enhancing lifelong chances for children and young people into adulthood. The strategic intent is recognised through an extensive planning framework which commenced in 2010. Specifically *Glasgow City Council "Education Service, Autism Spectrum Disorder Improvement Plan, 2011 – 2014"*, which places emphasis on the importance of effective communication. The second *GCC Education Service Autism Spectrum Disorder Improvement Plan* covers the period 2013 – 2015 and links to the *Education Service SLCN Strategy (2010)* building on the progress achieved through the previous *improvement plan (2010 – 2013)*. This is managed by the Education Service SLCN Steering Group and links with a range of associated multi-agency activities and planning structures across health, social work and education services. It is part of a continuous process of reflection on how well the learning and wellbeing needs of children and young people with autism are met, and has been informed by on-going research into autism. Our approach fits with the National Autism Strategy which was published by the Scottish Government in November 2011.

Overall, our plan aims to support innovation and improve continuously the educational experience of all our children and young people with autism by:

- Building the capacity of schools by extending, challenging and supporting schools in the self-evaluation process.
- Providing high quality robust information to support the self-evaluation process.
- Identifying, developing and sharing good practice in supporting children and young people with autism.

Whilst autism has a considerable impact on the child / young person it is also recognised that high levels of parenting stress are often and frequently experienced by parents, carers and families. In response to this Greater Glasgow and Clyde Health Board, Specialist Children's Services, in conjunction with partners, children and families/carers, has undertaken a comprehensive consultation process in order to scope and define how resources are best matched to meet the needs of families and carers within the context of the diagnostic journey. Parent conferences led by education services have provided our services with feedback and priorities for improvement. This extensive liaison with families, carers and siblings has informed services that they benefit from a compassionate, person centred and clear response from professionals at this important stage.

Feedback has highlighted the necessity for services to be connected and for support which promotes adjustment and social inclusion. This feedback and information received has informed the structure and design of provision of support to families which has linked strategically into the Carers Pathways across Glasgow. It also reinforces the importance of close liaison and partnership working across education and health services for children and families. Sibling and young carer support groups and workshops are delivered within a partnership context and continue to incorporate the views of siblings and young carers.

Development sessions are planned to assist parents/ carers to contribute to strategy, specific to children, and strengthen the arrangements in place to ensure parents and carers feel included and are actively involved in decisions about their child.

Many individuals using adult and older people's services may never have had a diagnosis of autism. Therefore, it is very important that staff working in adult services have an awareness of the presentation of autism in order to recognise difficulties the person may experience, especially with the loss of a carer, loneliness and difficulty functioning in their core daily living skills unsupported.

Similarly, people with autism can develop mental health problems, including anxiety, depression, addictions and obsessive compulsive disorder as well as other more serious mental health problems. Therefore, clinicians and care professionals need to be autism aware and able to tailor their consultations and practice to the needs of the person with autism.

Within the criminal justice system there is anecdotal evidence of a higher prevalence of autism within the prison system than in the general population. For this reason, training within criminal justice is a priority for all staff working with offenders who have autism. The Autism Resource Centre continues to provide a rolling programme of autism training to Youth Justice, criminal justice and prison service staff.

Many people with autism experience problems with housing and homelessness. Although in 2010, Glasgow developed and produced *'Glasgow - A practical guide for registered social landlords: housing and autism spectrum disorder (ASD)'*, much still requires to be done. The Housing Options approach has been spearheaded in Glasgow to respond to the challenges of homelessness and tenancy sustainment with a distinctive model attuned to the city's aspiration to securing better outcomes for vulnerable people in housing need. The model is based on a philosophy of early intervention, person centred service delivery and a collaborative approach to meeting the housing and underlying needs of the customer/ service user. Jointly developed by Glasgow City Council and Glasgow Housing Association with other Housing Associations, the NHS and the voluntary sector, the Steering Board is chaired by the Assistant Director Social Work Services.

The Glasgow Housing Options model has delivered comprehensive front line advice and support service for any customer / service user making a housing enquiry or identified as being at risk of losing their tenancy. The model represents a fundamental reorientation of systems and processes towards improved joint working and early intervention, maximising the synergies across housing management and care management to deliver much enhanced outcomes for service users/customers.

An integrated assessment tool was developed to support a full diagnostic assessment of customer needs and personal circumstances during a comprehensive housing options interview. This delivers a series of potential options and interventions and enables the sharing of information across housing options partners, within data protection standards, to enable collaboration across agencies to address complex needs. Fundamentally it introduced a process which supports a full discussion with the service user on their options based upon holistic assessment methodology shared across all partner locations ensuring consistent high quality advice and information alongside resource efficiency.

A Dedicated Service Contact System providing an active referral network was developed for all front line staff through a system of named contacts across specific Social work services, Health and Housing Benefit. This has led to much greater clarity for Housing colleagues on the referral pathways for vulnerable tenants, enabling a shift from selecting specific vulnerabilities to seeing the individual / family in the round with potential needs for assistance and support around a range of vulnerabilities.

By having these structures in place, we have achieved a faster, more creative response to particular customer/service user needs and have enabled a more informed and integrated approach to needs assessment. As staff are able to focus on their specific area of expertise within a coordinated partnership framework, we have made better use of resources across all partners and have a better understanding of the roles and capacity of all partners. This has led to a better quality of referral to the right agency at the right time. This approach has had obvious and clear benefits to service users/customers many of whom find it difficult to navigate social work, health and housing services. The customer satisfaction survey undertaken by the independent evaluation team provides compelling evidence of the positive impact the housing options approach has had on service users and customers.

Initially piloted in the North West of the city with further demonstration projects in the North East and South sectors, Housing Options has now been rolled out in the remainder of Glasgow.

While it is recognised that all mainstream services work with people with autism, more knowledge and experience would enable services to make meaningful adjustments to service provision that take account of the autistic presentation and therefore promote the efficacy of service for people with autism. The Adult Autism Team has developed a significant facilitative role in working closely with agencies across the care pathway to help them work better. The outcome of this approach is to improve the quality of life and social inclusion of adults with autism.

Patient specific interventions may involve working alongside social care and third sector care providers and often involves an element of patient specific training.

Goal - Consistent adoption of good practice guidance in key areas of education, health and social care across local authority areas

We will achieve this by:

- Supporting and meeting individual needs and strengths within a flexible, shared partnership approach which recognises that needs change over time.
- Ensuring that the Health and Social Care Partnerships enables improvements in joint health and social care planning and accountability for children and adult services.
- Continuing to provide flexible, enabling, personalised pathways for individuals with autism that take account of context and changing needs over time.
- Ensuring housing support remains as a key area for action..

- Continuing to work firmly within the principles and ambitions of Getting it Right for Every Child (GIRFEC) and the United Nations Convention on the Rights of the Child and the Early Years Collaborative for Children and Young People
- Continuing to work in partnership with people with autism to develop training and development materials.
- Continuing to design and develop services in an integrated way and embracing self-management models responsive to individuals at the point of needs

Outcome 3

Independence: People with autism are able to live independently in the community with equal access to all aspects of society. Services have the capacity and awareness to ensure that people are met with recognition and understanding.

In order to ensure appropriate supports which meet the broader range of needs of children and young people with autism and their families, services are designed and delivered to support access to mental health services on a local basis.

It is our aim that all educational establishments in Glasgow provide a language and communication friendly environment thereby making them accessible for all children and young people. This places the emphasis on need for the establishment and community to adapt rather than the person with autism. Education services have increased the level of support from specialist services for children and young people in mainstream establishments to support the flexible pathway and maintain local schooling where possible.

Glasgow has a detailed training programme that is outlined in Education Service's Autism Guidance and this involves general and bespoke training delivered by educational psychologists, speech and language therapists, occupational therapists and the Autism Resource Centre (ARC); working in partnership. This menu of training offers courses from introductory through to advanced level. Education and Health, working in partnership in all areas, run Support and Development Groups that are open to all staff in education. These groups operate using a coaching approach and are designed to support staff with meeting the needs of children and young people with autism based on their context. New ways of working have been introduced to build and sustain capacity. These include a link practitioner inclusion support model. This enables staff who are skilled in meeting the needs of children and young people to work in collaboration with staff in the establishment to provide further coaching and support in the classroom setting. In this situation, the link practitioner and teacher will work together to review the learning environment, strategies and resources planned for the child. This approach will support further the inclusion of children and young people in mainstream establishments thereby providing more opportunity for them to participate and be included in their local community. Education will continue to work towards a more flexible continuum of support offering personalised pathways for children and young people.

The long-standing autism training programme and practice network coordinated by health is delivered on an on-going basis and is designed to support practice standards, maintain and build capacity and ensure a programme of practice development is accessible to the range of professionals involved in diagnosis as part of a competency-based quality framework. It is proposed this key training strand will remain and continue to develop in line with the strategy.

An on-going strategic aim within the ARC has been to produce and further develop the Autism Learning and Development Programme within the full Glasgow City Council family. However, due to the demand for the service and our desire to build capacity, the programme has been extended to other local authorities, the third sector, Children's Panel members, the Scottish Prison Service, and a range of other service providers both within and outwith Glasgow. Building capacity will continue to be a priority for future planning and joint working with our partners.

Social Work Services have made significant changes in its assessment processes. This is in line with the Scottish Government's "Self Directed Support – A National Strategy for Scotland". Social Care (Self-directed Support) (Scotland) came into force in April 2014.

Glasgow has rolled out Personalisation (SDS) across most of its children and adult services. Personalisation is a new way of delivering social care that promotes independence and gives people more choice and control over the support they receive. It also means people have control over the budget for their support.

'Personalisation enables the individual alone, or in groups, to find the right solutions for them and to participate in the delivery of a service. From being a recipient of services, citizens can become actively involved in selecting and shaping the services they receive'. (Source: Service Development Group, Changing Lives, 21st Century Review of Social Work, Spring, 2009).

Part of Glasgow's vision is to promote independence and deliver positive outcomes for the people of Glasgow, including people with autism and their carers. Personalisation allows people to gain more control over their support, and become more independent. By focusing on what people want to achieve through their support, people are able to get the results they want. This increase in choice has meant that people with autism and their carers can shape the type of support most appropriate to meet their needs.

Within a climate of financial constraints, personalisation helps Glasgow Social Work Services to manage its resources effectively. The assessment process now allows for people with similar support needs to be allocated similar levels of resource, which is a fairer, clearer and more efficient use of public money.

However, the impact of eligibility criteria and client contributions have meant that many people with autism are no longer eligible for a service, or do not think it is worth paying a client contribution for a low level of support.

For people who present with significant care needs and or challenging behaviour there is a very limited choice of appropriate models of care for people requiring support – either for long-term care, or respite. Some people are placed outwith Glasgow, far away from their carers, families and local communities. These are

issues that Glasgow will need to tackle, in conjunction with neighbouring authorities, and the Scottish Government.

Within health services the Adult Autism Team (AAT) has two main areas of support to ensure its services respond to the needs of people with autism. Firstly the AAT supports the NHS workforce by providing specialist training, supervision and liaison for services across health-care, to develop staff competences in working effectively and efficiently with adults with autism. The AAT is also involved in the expert patient intervention programme – where people with autism are supported to communicate their needs in a way that make sense to services.

Goal - Capacity and awareness building in mainstream services to ensure people are met with recognition and understanding of autism

We will achieve this by:

- Ensuring effective sign-posting for people with autism and their cares in line with the eligibility criteria.
- Seeking the views from people with autism and their carers on how they would wish to be supported within their communities.
- Ensuring effective collaborations with other local authorities toward continuing the development of appropriate and joined up services, recognising the challenges being faced both locally and nationally.
- Continuing to develop a sustainable model of training and development that builds on local expertise and support networks thereby building capacity across the whole community.
- Continuing to link with Autism Network Scotland to share good practice, knowledge and information, at a local and national level.
- Collaborating with adult services to ensure the Expert Patient Intervention Programme outcome of a person-specific ‘guide’ is utilised as widely as possible.

Outcome 4

Active Citizenship: People with autism are able to participate in all aspects of community and society by successfully making the transition from school or college into adult life

Education services in conjunction with key partners continue to improve approaches to transition planning including from children to adult services to ensure continuity and progression in learning and to secure relevant and positive and sustained destinations for young people with autism. In response, the level of support from specialist services for children and young people in mainstream establishments to support the flexible pathway and maintain local schooling where possible has increased.

The availability of support for parents and carers throughout the lifetime of the person with autism, covering key life transition points before or as they arrive, has been recognised. Glasgow Carers' Partnership developed a Carers' Pathway for early identification, information, training & support to achieve better outcomes for carers of people with autism. This brings together Health and Social Work Services, voluntary sector carers centres and autism specific organisations. These partners work together to re-shape carer services developing a more cohesive partnership approach across the city that avoids duplication and maximises the use of available resources and expertise with equity of provision.

The pathway gives carers easy access to information through training leading to improved understanding of autism and improved coping mechanisms and as a consequence carers feel more supported in their caring role with improved communication links to services. As part of the pathway carers themselves have access to a variety of autism carers' training including understanding autism, communication, managing anxiety, anger and aggression, sleep, diet and sexual health to name a few. In addition there is a range of generic training available to all carers such as moving with assistance, back care, emergency first aid, and managing stress.

The pathway also enables early identification of carers through Health and Educational settings. The Whole Systems Approach adopted allows improved communication by partners, including carers themselves, thereby removing barriers to support. The pathway gives access to information, training, short breaks, carers peer group support, individual support and mechanisms for carers to have their views heard and to be involved. It is designed to support carers through the different stages of the person with autism from the point of diagnosis.

The city has a carers' planning structure, a network of stakeholders, carers groups and forums linking to a Carers Reference Group which feeds into the Carers Strategic Planning Forum. These mechanisms allow carers to have a voice in the

planning and re-shaping of autism services. An individual carer outcome-focused service evaluation is also used city-wide that is based on the 'Talking Points' approach, *Outcomes Important to Carers* and there are also evaluations conducted at each training session. All of this information informs planning and re-shaping of services for carers of people with autism in Glasgow.

Glasgow Carers Strategy multi-agency sub group for parent carers meet regularly to ensure the pathway for carers at critical junctions in the child cycle, such as transitions, and develops information and training accordingly. For example, SDS for parents of children in transition to adult services, and Positive Approach to Transitions to inform and equip carers to cope better during these critical times.

In order to promote active citizenship developing work around sexual health & relationships, to meet the needs of children with autism and their families has been identified as a particular work-stream. A ground-breaking conference in March 2013, 'Young People, Sexual Health & Relationships & Autism: starting the conversation', saw parents and a range of professionals from Glasgow City Council, Health and third sector organisations come together to improve their understanding and knowledge. As well as hearing directly from young people themselves, a short DVD was developed to showcase the voice of Glasgow parents who had already participated in training courses provided by Talk2. Talk2 is a service which supports parents to talk with their children about growing up, relationships and sexual health. These parental training courses are on-going, are very well received by parents and are now embedded into the city's parent / carer's pathway.

Again as part of wider work being undertaken in Education Services, children with autism are included in the school-based 'Sexual Health & Relationships Education' programme (SHRE), that is delivered in all non-denominational mainstream and Additional Support for Learning establishments. Delivered by trained teachers, the SHRE programme has been adapted to meet the needs of children on the autism spectrum by making better use of visual material, altering 'scenarios' to make them more relevant and introducing more material around social 'rules' and public and private behaviour.

To complement the schools-based work and that with parents, 2013-14 saw two different group-based programmes for young people tested-out, with 'younger' and 'older' teenagers, respectively. Working alongside staff from the ARC, one was led through Talk2 whilst the other was developed by staff from Family Planning Association. Whilst participants took something from the experience on an individual basis, neither of these approaches proved particularly successful as 'group-work' interventions and so the emphasis has been placed on supporting parents and schools and working on a one-to-one basis, where staff capacity allows.

A major transition is from school to adult life, and the need for supportive employment for people with autism. Glasgow has worked hard to develop employment opportunities with a range of other partners.

Project Search has been successful in taking forward a specific model which is well tested worldwide. The model not only improves employment opportunities for people with learning disabilities and/or autism but has improved the health and wellbeing of participants, increased family incomes, and changed cultures within large host employers.

Project Search is based on a partnership that includes a host employer, a college and a supported employment provider. All partners are vital to the success of the programme. The employer provides a training base, the work experience rotations, and a member of staff (business liaison) to link to the other partners. The college provides a full time lecturer who leads on the development and delivery of a tailored employability curriculum. The supported employment provider supplies job coaches that work with the students on their work experience rotations, and provide the on-going in-work support for those students who have gained employment and job searching support for those who continue to look for work.

There are currently two sites in Glasgow. The Glasgow sites are based with the host business NHS Greater Glasgow and Clyde (NHSGGC) and the University of Strathclyde which is an autism specific site. The partners provide tailored training, work experience, life skills development and education leading to increased employment outcomes, a more positive attitude to life, and improved mental health and positive relationships.

The development of the autism specific site at the University of Strathclyde has additional measures to support interns:

- professionals in the field of autism and a communication management consultant
- the development of a specialist curriculum aimed at improving a wider range of social communication skills to aid integration into society in general and not just the work place
- placing greater emphasis on family engagement to raise expectations and help build resilience within the family unit

In order to continue the excellent results from the first year, GCC SES and other Project Search Glasgow partners have developed an Employers' Network made up of private sector employers who are engaging in a variety of ways with the programme to ensure interns receive the very best preparation for the world of work.

Goal – Improve access to appropriate transition planning across the lifespan

We will achieve this by:

- Continuing to work collaboratively with people with autism, parents and carers to ensure resources and that pathways are developed to meet their needs.
- Developing our capacity to promote and generate community based facilities for people with autism.

  Ensuring continuity and progression for people with autism by preparing and supporting them, and their families, for change and transition.
- Promoting employment opportunities for people with autism. Linking with employers and other stakeholders in Glasgow to promote employability as a key area for action.
- Promote the understanding of life transitions and the potential impact on health and well-being.

Chapter 4 - Implementing the strategy

Glasgow's strategic plan has been designed to encourage multi-agency approaches with significant involvement of the third sector and independent sector organisations. In overall terms, this strategy is about a commitment to continually challenge all involved in the delivery of services in the context of creating opportunities for improvements which enhance outcomes and opportunities for individuals across all ages with autism.

Responsibility for the successful delivery of services to people with autism is widespread and is not specific to one single agency. Therefore, this strategy will operate within shared frameworks across professional, statutory and voluntary organisations in conjunction with service users and carers, and other stakeholders.

Key policy documents have been developed which describe how services across agencies are delivered, coordinated and monitored in order to ensure a locally supported partnership approach.

Glasgow City Council, along with NHS Greater Glasgow and Clyde, will be responsible for delivering the strategy. The strategy will be implemented through an action plan which identifies key partnerships, priorities for programs of work including suggested time frames, where appropriate. However, it is recognised that a concerted approach to improving lives and outcomes is a long-term process. The action plan therefore reflects the multi-agency response to continued shaping of the development of services and support and will be a working document which will be subject to review.

Ongoing work is required to address all the requirements of the strategy. To deliver this we will use established strategic partnerships and existing programs of work to link and coordinate the key actions from the action plan. Existing reporting structures across adult and children's services will be fully utilised to manage the governance arrangements.

Monitoring arrangements of the plan will be managed through the Glasgow City Health and Social Care Partnership and Education Services planning arrangements for autism. All monitoring arrangements, ratification requirements and any revisions to the plan will be carried out by our multi-agency forum. This forum will report annually on progress.

Chapter 5 - Action Plan

The Action Plan is be based on Glasgow's Strategy recommendations

How Glasgow will deliver the Strategy's Recommendations?

Recommendation	We will:
Outcome 1	***Goal – Improve access to integrated service provision across the multi-dimensional aspects of autism.***
1a - Commit to effective partnerships to ensure delivery of integrated services through closer working with partner agencies, service users and other stakeholders.	*Develop a self-evaluation framework to ensure services are integrated and effective partnership planning arrangements are in place.* *Work together to plan and deliver services that are flexible and responsive at the point of need.*
1b - People with autism and their carers are fully involved in planning of services.	*Continue to evaluate our progress in consultation with people who use our services with a particular focus on joining up our consultation activity across services/progress in integrated delivery.* *A further review and evaluation of one-stop shop (ARC), including re-location.* *Ensure that the views of people with autism and all stakeholders are fully represented across strategic planning arrangements.*
1c - Improve the reliability and accuracy of data collection systems and use this to inform planning, delivery and quality.	*Review current information systems with a view to developing a joined up approach to a data collection process which meaningfully informs progress, measures and planning.* *Use data and integrated partnerships to across universal and specialist services to promote earliest identification and access to diagnostic, assessment and interventions pathways.*

1d – Intervention and support	*Data collations systems will focus on learning, knowledge building capacity, quality and outcomes.* *Deliver an integrated and streamlined model of assessment across community paediatric services and Child and Adolescent Mental Health Services which focuses on competencies, access and quality* *Formalise learning on preventative, enabling and self-managements models across all agencies.* *Target support towards those individuals with co-existing problems around mental health, substance misuse and offending behaviour as part of the wider pathway. In particular those regarded as 'hard to reach' and non-engaging. Review the application of the education coaching model that supports staff to collaborate and improve through peer reflection and evaluation and use learning to inform the sharing of practice.*
Outcome 2 *2a - Provide flexible, enabling, personalised pathways that take account of context and changing needs over time.*	***Goal - Consistent adoption of good practice guidance in key areas of education, health and social care across local authority areas.*** *Planning arrangements will include a recognition that needs change over time and requirement for ongoing review and evaluation.* *Ensure that the Health and Social Care Partnership enables improvements in joint health and social care planning and accountability.* *Continue to work firmly within the principles and ambitions of Getting it Right for Every Child (GIRFEC), the United Nations*

2b - Re-visit housing support as a key area for action.	*Convention on the Rights of the Child and the Early Years Collaborative for Children and Young People.* *Continue to develop the application of the education coaching model that supports staff to collaborate and improve through peer reflection and evaluation and use learning to inform the sharing of practice.* *Support and meet individual needs and strengths within a flexible, shared partnership approach.* *Continuing to design and develop services in an integrated way and embracing self-management models responsive to individuals at the point of needs.* *Build the skills of all staff to enable then to respond effectively to the changing needs of individuals within an enablement context.* *Maximise the use and benefits of co-production in the design and delivery of services, including third sector and communities. Ensure that the needs of people with autism are reflected in local housing plans*
Outcome 3 *3a - Build and sustain effective partnerships*	***Goal - Capacity and awareness building in mainstream services to ensure people are met with recognition and understanding of autism.*** *Ensure effective sign-posting for people with autism and their cares.* *Promote access to self-help groups and peer support for individuals with autism, their families and carers including use of self-directed support.* *Collaborate with other local authorities to work together for the development of more appropriate and joined up services,*

	recognising the challenges being faced both locally and nationally. *Continue to develop a sustainable model of training and development that builds on local expertise and support networks thereby building capacity across the whole community.* *Link with Autism Network Scotland to share good practice, knowledge and information, at a local and national level.* *Ongoing review and update of multi-agency training needs analysis and develop a strategic training plan.* *Ongoing collaboration with adult services to ensure the Expert Patient Intervention Programme outcome, of a person-specific 'guide' is utilised as widely as possible.*

Outcome 4	***Goal - Improve access to appropriate transition planning across the lifespan.***
4a - Utilise approaches which inform the needs of people with autism, parents and carers	*Continue to work in collaboration with people with autism, families and carers to monitor, evaluate and plan service.*
4b - Develop capacity to promote and generate community based facilities for people with autism.	*Continue to provide access to self-help groups and peer support networks for individuals with autism, their families and carers.*
4c - Support through all key transitions are continued and developed.	*Ensuring continuity and progression for people with autism by preparing and supporting them, and their families, for change and transition. Ensure there is a robust transitions process in place at each important life stage with clear responsibility across health, social work and other relevant agencies"*
	Promote the understanding of life transitions and the potential impact on health and well-being for people with autism.
4d - Re-visit employability as a key area for action.	*Link with employers and other stakeholders in Glasgow to promote employment opportunities for people with autism, focusing on their strengths.*
	Develop opportunities to promote awareness amongst employers.

Appendix i

Policy and Legislative Framework

National Frameworks
Public Bodies (Joint Working) (Scotland) Act 2014
Self Directed Support (Scotland) Act 2013
The Scottish Strategy for Autism
The Scottish Strategy for Autism – Menu of Interventions
Optimising Outcomes – NHS Education for Scotland Autism Training Framework
The keys to life - Improving Quality of Life for People with Learning Disabilities 2013
The Healthcare Quality Strategy for NHS Scotland 2010
Disability Discrimination Act 2005
Children (Scotland) Act 1995
Social Work (Scotland) Act 1968
Adult Support and Protection (Scotland) Act 2007
Chronically Sick and Disabled Persons(Scotland) Act 1972
Education (Scotland) Act 1980
Mental Health (Scotland) Act 1984
Mental Health (Care and Treatment) (Scotland) Act 2003
Mental Health Strategy 2012 - 2015
Disabled Persons (Services, Consultation and Representation) Act 1986
Housing (Scotland) Act 1987
Further and Higher Education (Scotland) Act 1992
Carers (Recognition and Services) Act 1995
Criminal Procedure (Scotland) Act 1995
Standards in Scotland's Schools Act (2000)
Education (Additional Support for Learning Act) (2004; amended 2009)

Children and Young People's (Scotland) Act 2014
Equality Act (2010)
Adults with Incapacity (Scotland) Act 2000

Glasgow Policy Frameworks
ASD Working Group
Review of the Autism Resource Centre (ARC)
NHS NES skills and competency framework for assessment and interventions
Adult autism team – development of expert patient courses
Online autism specific training (GOLD) for all Council staff
Equality and diversity training for NHS and Council staff
Vulnerable Adults Training
Glasgow Strategic Planning Group (Disability)
Glasgow Strategic Planning Group (Carers)
Commissioning Services for People with Autism - Policy and Practice Guidance
Parent and Carer Pathway
Young People in transition protocol
Housing strategies
Employment initiatives
Glasgow City Council Service Map (National Autism Services Mapping Project)
Towards the Nurturing City
Language and Communication Friendly Establishment Standard for Education Establishments
Every Child is Included Education Policy (the Staged Intervention Framework)
Glasgow Guidance in ASD for all education establishments; including the training framework
Glasgow City Hate Crime Working Group
Improving Children's Services Group. Glasgow's GIRFEC guidance (2014) and

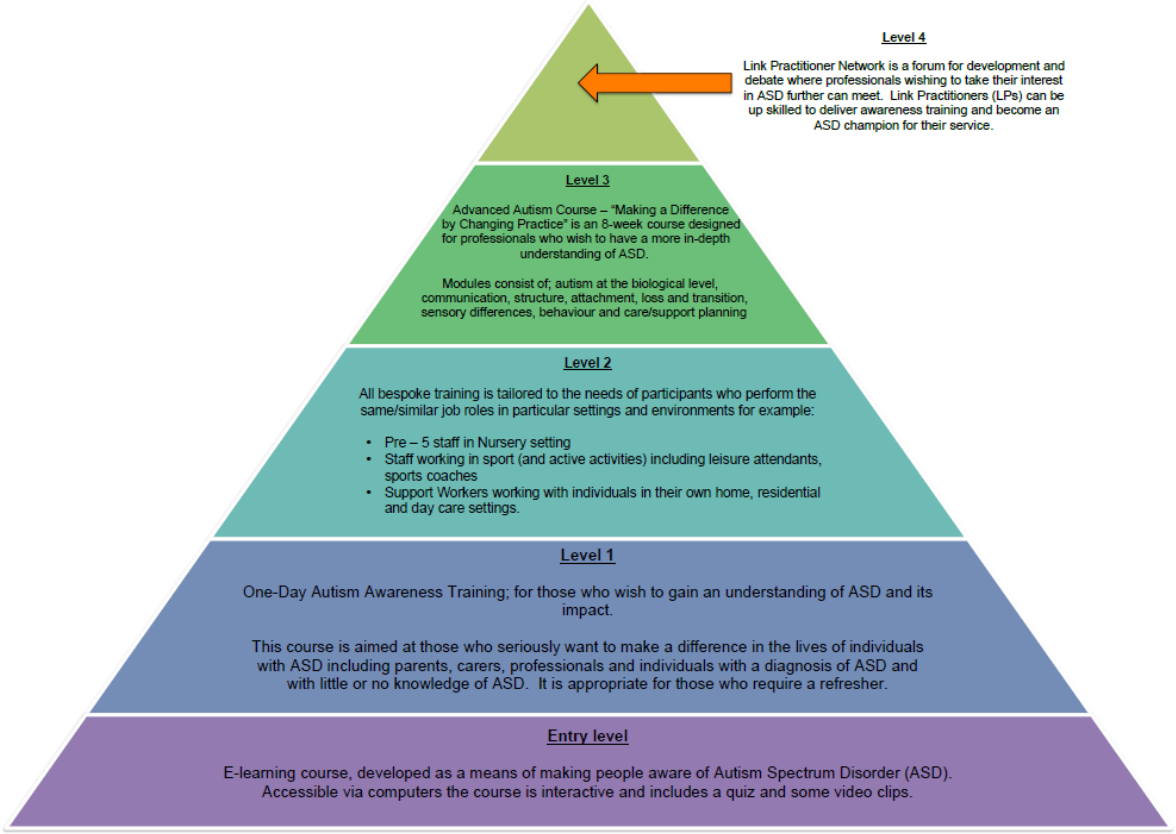
GIRFEC Implementation Action plan (2015)

Appendix ii

SLCN strategy

Appendix iii

Autism Resource Centre's Learning and Development Pyramid



Speech, Language and Communication Needs

A strategy to meet the needs of Glasgow's children and young people

Education Services 2011

Rationale

The ability to communicate is an increasingly essential life skill for all children and young people in the twenty-first century. Communication is a fundamental human skill as recognised by the formal, public and multilateral declaration by UNICEF, UNESCO and the World Health Organisation, which lists communication as one of the ten core life skills.

It is emphasised within Curriculum for Excellence that

> 'language and literacy are of personal, social and economic importance. Our ability to use language lies at the centre of the development and expression of our emotions, our thinking, our learning and our sense of personal identity. Language is itself a key aspect of our culture... children and young people encounter, enjoy and learn from the diversity of language used in their homes, their communities, by the media and by their peers.'

Literacy underpins all areas of learning, as it unlocks access to the wider curriculum. Being literate increases opportunities for the individual in all aspects of life, lays the foundations for lifelong learning and work, and contributes to the development of all four capacities of Curriculum for Excellence.

Effective communication skills support children to engage positively with the world around them. They are at the core of all social interaction and are central to successful learning. Without robust speech, language and communication skills children will struggle to learn, achieve, make friends, develop the skills for work and take their place in the world.

Our Vision

It is Glasgow's aspiration that all children and young people should have age appropriate language skills for entry into school.

We recognise that for some children this will be challenging to achieve. Therefore, we will work with colleagues in Health Services to ensure that those children highlighted at the 30 month assessment as having language and communication support needs are encouraged to take up a place in an early years' establishment. Health Visitors will pass all relevant assessment information to the head of the establishment to allow staff to focus on the development of the child's language skills as early as possible.

All children and young people with language and communication support needs should have a presumption of mainstream education. This should be the starting point for every child. Children and young people who need an alternative to mainstream placement will be considered for this through the staged approach to assessment and intervention.

We want to:

- develop the language and communication skills of all children and young people to allow them to achieve their potential regardless of the context in which their education takes place.
- establish standards of good practice in speech, language and communication in all education provisions.

To achieve this vision we will:

- plan carefully to meet each child's learning needs reflecting their different contexts and individual strengths.
- successfully deliver education for those children and young people with Speech, Language and Communication Needs (SLCN). This includes those children and young people with Language Impairment (LI), Autism Spectrum Disorder (ASD) and various phonological and speech production difficulties.
- ensure there is a holistic, multi-agency approach to meeting the needs of every learner with SLCN. A multi-agency approach recognises that social factors surrounding a child and young person with SLCN can have a significant impact on their ability to interact successfully with others and to access language and literacy aspects of the curriculum.
- develop, implement and regularly update a multi-agency action plan, that will build capacity and support staff through continuing professional development and the production of guidance, protocols and policies.

Policy and Practice

The underlying causes of SLCN are complex and diverse. A range of factors including specific physical illness or disorder, socio-economic and environmental circumstances may account for individual needs. Evidence suggests that SLCN are associated with disadvantage across the lifespan and are implicated in poorer outcomes in education, physical and mental health and employment.

Between 22,000 and 37,000 children within NHS Greater Glasgow & Clyde have SLCN. The unique social, environmental and economic factors present in Glasgow would suggest that impoverished language development is a major contributory factor for many children and young people who experience SLCN. A small proportion of these children may be supported within specialist provision. However, the majority of these children and young people will be supported appropriately in mainstream establishments.

In Glasgow, we plan to meet all children and young people's additional support needs through the staged intervention process underpinned by robust quality assurance. Additional supports will be accessed in line with Glasgow's staged intervention model. Support and resources external to the establishment will only be considered when there is evidence that all of the strategies and resources appropriate at Stages 1 and 2 of intervention have been exhausted as specified by Glasgow's **Every Child is Included** Policy.

Education Services is committed to working in partnership with a range of agencies to raise attainment and achievement of all children and young people. We do this through focusing collectively on the principles of **Getting It Right for Every Child**.

In Glasgow, provision of additional support in language and communication will include provision for children with speech, language and communication needs, including autism. To date, specialist provision has existed separately, i.e. for ASD and LI. Recently, the model of provision for LI was developed to reflect current legislative requirements for the support and inclusion of children with language needs more effectively, i.e. a greater continuum of provision to meet the continuum of needs. This has included enrolment in zoned mainstream establishment, shared placement and an outreach service. Intensive support in the early stages has proved successful in progressing language development and in building more effective liaison with schools. These outcomes have helped to inform the research and planning for similar inclusive strategies for children and young people with ASD.

Glasgow already has a wide range of provision and practice to develop children's language and communication skills.

Early years

Staff in early years' establishments across the city have been trained by educational psychologists and speech and language therapists in ICAN's[1] **Early Talk**. Early Talk is a training programme which aims to improve the skills and knowledge of early years practitioners in developing children's language and communication skills. Participants are supported to make changes in the learning environment which will benefit the language and communication skills of all learners including those with additional support needs. We have provided Early Talk training for all nurseries in Glasgow and changes in practice are evaluated through a process of accreditation which is supported through mentoring. So far five nurseries have achieved accreditation at the first level, earning the status of a **Language and Communication-Friendly Establishment**. In the short term this has led to increased awareness of the importance of language and communication needs; the development of a city wide strategy; a multi-agency focus on the importance of robust language and communication skills; and structured planning to support establishments to meet needs.

For children who require further intervention we have two pre-5 Assessment Centres that work intensively with children to identify and assess specific needs. This information can then help to inform future placement for these children and where best to meet their needs, whether in mainstream or specialist provision.

Four of our family learning centres also offer specialised support for children with ASD. This includes the support of a dedicated worker whose role is to facilitate learning and inclusion within this setting and to plan for transitions. This provision will be extended to include children with SLCN in general, in alignment with the rest of the service.

[1] Communications Trust/ICAN (2008): Speech Language and Communication Framework, London: Communications Trust /ICAN

Primary and secondary

Staff in primary and secondary schools work in partnership with educational psychologists and speech and language therapists to maximise children's language and communication skills. Where support needs have been identified, staff, parents and children are involved in developing plans which aim to address those needs and remove barriers to learning.

For the small number of children whose needs cannot be met full time in mainstream education, there are co-located bases for LI and ASD.

Speech and language therapy

Education Services has a service level agreement with NHS for speech and language therapy. Throughout 2010-11, the delivery model was reviewed and a more outcome-focused approach was developed that is transparent and proportionate. The new delivery model will allow schools to understand more clearly their entitlement and to contribute to the negotiation of entitlement based on self evaluation of their current needs and context. Joint planning will be based on both agencies' compatible models of staged intervention. This will mean a more flexible delivery of service targeted on a shared identification of need arising from within individual learning communities.

The Strategy

In Glasgow we need a flexible continuum of support that promotes inclusion and maximises opportunities for children with SLCN, both within mainstream and specialist contexts.

Parents[2] are the greatest influence on their children. They are central to children's life chances and, as such, are key partners. We recognise that it is vital to maximise the involvement that parents can have in their child's education and the work of our service. The strategy will ensure that a coherent approach exists to engage, consult and involve children and young people. This will include the continued development of a strong parental and children's voice. We will continue to consult with parents, health, social work, education staff, children and young people, where appropriate, as well as the Council's Autism Working group in order to implement the strategy.

For the vision to be realised, it requires concerted and shared action by all partners. This strategy identifies the key elements of such an undertaking and sees individuals, families and carers as partners in planning and decision making to guarantee best value. This strategy will set out a framework for action over the next three years which identifies priority tasks and longer-term goals to improve services and support for children and young people with SLCN within Glasgow.

We will:

- rename all the specialist SLCN (including Autism Units) provision to extend the available flexibility within Glasgow. They will be configured under the generic categorisation of 'Language and Communication Resource'. These will achieve a more flexible approach to the delivery of specialist SLCN services by extending the range of available supports from the early years through to the secondary stage.
- continue to build capacity within our mainstream establishments through improved staff development and the development of a management model that supports inclusion across the broad continuum of speech, language and communication needs.
- develop a more flexible, integrated range of supports across our specialist Language and Communication provision that promotes the presumption of mainstreaming.
- extend the SLI Outreach Service to include children and young people with ASD and rename it the 'Language and Communication Outreach Service' thereby enhancing the capacity and inclusion of mainstream provision.
- develop 'language and communication-friendly' awards linked to Glasgow standards leading to public recognition of the standard that an establishment has reached.

[2] When we use the term 'parents' we also mean 'carers'.

Consultation Questions

We welcome the views of stakeholders to help us to shape policy and provision.

1. We intend to progress a model based on an early intervention approach, how do you think this will help to improve outcomes for children and young people with SLCN in Glasgow?

   Comments

2. The new strategy suggests that young people will be educated within their local community wherever possible. If you agree, which approaches would the education authority need to take to facilitate this aim e.g. provision of a range of placement options such as part-time placements, full-time placements and outreach support?

   Comments

3. Do you agree that specialist provision should be seen more as a support for an inclusive system rather than as an alternative for it?

Comments

4. Do you agree with that we need to link effectively with Health Visitors to use the outcomes from the 30 month assessment?

Yes ◉ No ○ Don't know ○

5. Do you agree that we should extend the outreach service to include children and young people with ASD?

Yes ◉ No ○ Don't know ○

Comments

6. What staff development is needed to build the capacity of mainstream staff to understand and address language and communication support needs?

Comments

7. What additional staff development is needed within our specialist provision to better meet children and young people's support needs in language and communication needs?

Comments

8. We intend to develop a 'language and communication-friendly' award, what should establishments have to demonstrate in order to secure this type of accreditation?

Comments

9. Please make any other comment that you wish us to consider about the future education of children with SLCN in Glasgow.

Use the buttons below to save this copy of the document to your hard drive and also to email your completed Consultation Questions to the email address **schoolconsultations@education.glasgow.gov.uk**

Save form to disk... Email document...

Education Services, Education Improvement Service (EdIS), Wheatley House, 25 Cochrane Street, Glasgow G1 1HL. 0141 287 2000. www.glasgow.gov.uk

Item No. 12

Meeting Date 1st December 2015

Shadow Integration Joint Board

Report By: **Chief Officer, Operations**

Contact: **Alex MacKenzie**

Tel: **0141 287 0386**

UNSCHEDULED CARE AND WINTER PLANNING

Purpose of Report:	To update the Shadow Board on the winter planning arrangements for 2015/16, and unscheduled care.

Recommendations:	That the Shadow Board note: • the winter plan attached; • the work underway to ensure the IJB fulfils its strategic planning responsibilities for unscheduled care; and, • that a further update will be provided at the next Board meeting.

Implications for IJB:

Financial:	The financial implications of the winter plan have been assessed, including the resources required by the Partnership to support HSCP actions.

Personnel:	The implementation of the winter plan might have personnel implications in that staff rotas and leave might be affected should additional capacity be needed over the winter period.

Legal:	None
Economic Impact:	None

Sustainability:	None

Sustainable Procurement and Article 19:	None

Equalities:	In preparing the winter plan the equalities implications have been taken into account 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 update the Shadow Board on progress in preparing the Partnership's winter plan for 2015/16, and the work underway to ensure the IJB fulfils its responsibilities for the strategic planning of unscheduled care.

2. Background

2.1 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 e.g. accident and emergency services. Guidance on unscheduled care, including preparations for winter 2015/16 was issued by the Scottish Government in August 2015. A report was presented to the last Shadow Board meeting that advised the Board on these requirements, and the work underway to prepare a winter plan for health and social care services.

3. Progress to date

3.1 Attached to this report is the proposed winter plan for the Health and Social Care Partnership for 2015/16 that outlines the arrangements to be put in place in order to minimise any potential disruption to the provision of health and social care services to patients, service users and carers.

3.2 The plan focuses on supporting the acute hospital system by helping to avoid unnecessary admissions, managing reductions in delays, and ensuring there is sufficient health and social care staff available to respond to increased demand. Specific measures in plan include actions to:

- maintain our performance on reducing delayed discharges (current performance is reported elsewhere on the Shadow Board's agenda);

- reduce avoidable admissions to hospital, including GPs identifying patients at risk of admission through anticipatory care planning;
- assess the need for additional intermediate care capacity to support any potential additional acute "surge" capacity that might be required;
- provide a rapid response for vulnerable older people at risk of hospital readmission over the winter period via community rehabilitation teams;
- ensure community nursing and other services staffing levels are sufficient over periods of peak activity; and,
- develop a set of indicators to monitor performance, including an alert system.

3.3 A detailed action plan has been put in place to ensure implementation of the actions in the winter plan, and progress is overseen on a weekly basis. Reporting and escalation arrangements have also been agreed with acute hospital services and the NHS Board.

3.4 The HSCP's winter plan forms part of the NHS Board's suite of winter plans covering acute hospital services and all Health and Social Care Partnerships in NHS GG&C as published on the Board's web site.

4. Unscheduled care – strategic planning

4.1 The preparation of this year's winter plan is seen as a precursor to the IJB assuming lead responsibility for the strategic planning for unscheduled care (as described within the Integration Scheme) from 2016/17 and onwards. The Partnership will build on the winter plan and evaluate the plan's impact on unscheduled care activity in Glasgow to inform future strategic planning. The Shadow Board has been apprised of the NHS Board's Clinical Services Strategy, published earlier this year, and that sets the strategic direction for acute hospital services to 2020. The IJB will be framing its unscheduled care plan within this context, and the national unscheduled care programme.

4.2 Planning arrangements are currently being put in place to ensure the IJB fulfills its responsibilities in respect of unscheduled care, and a further report will be presented to the next Shadow Board meeting.

5. Recommendations

5.1 That the Shadow Board note:

- the winter plan attached;
- the work underway to ensure the IJB fulfils its strategic planning responsibilities for unscheduled care; and,
- that a further update will be provided at the next Board meeting.

Glasgow City
Health & Social Care Partnership

Winter Plan

2015/16

November 2015

1. INTRODUCTION

1.1 This plan outlines Glasgow City Health & Social Care Partnership's (HSCP) preparations for winter 2015/16 in order to minimise any potential disruption to the provision of health and social care services to patients, service users and carers. This is first such plan for Glasgow City, and therefore the plan will be subject to ongoing review in the light of experience, with regular reports made to the (shadow) Integration Joint Board (IJB).

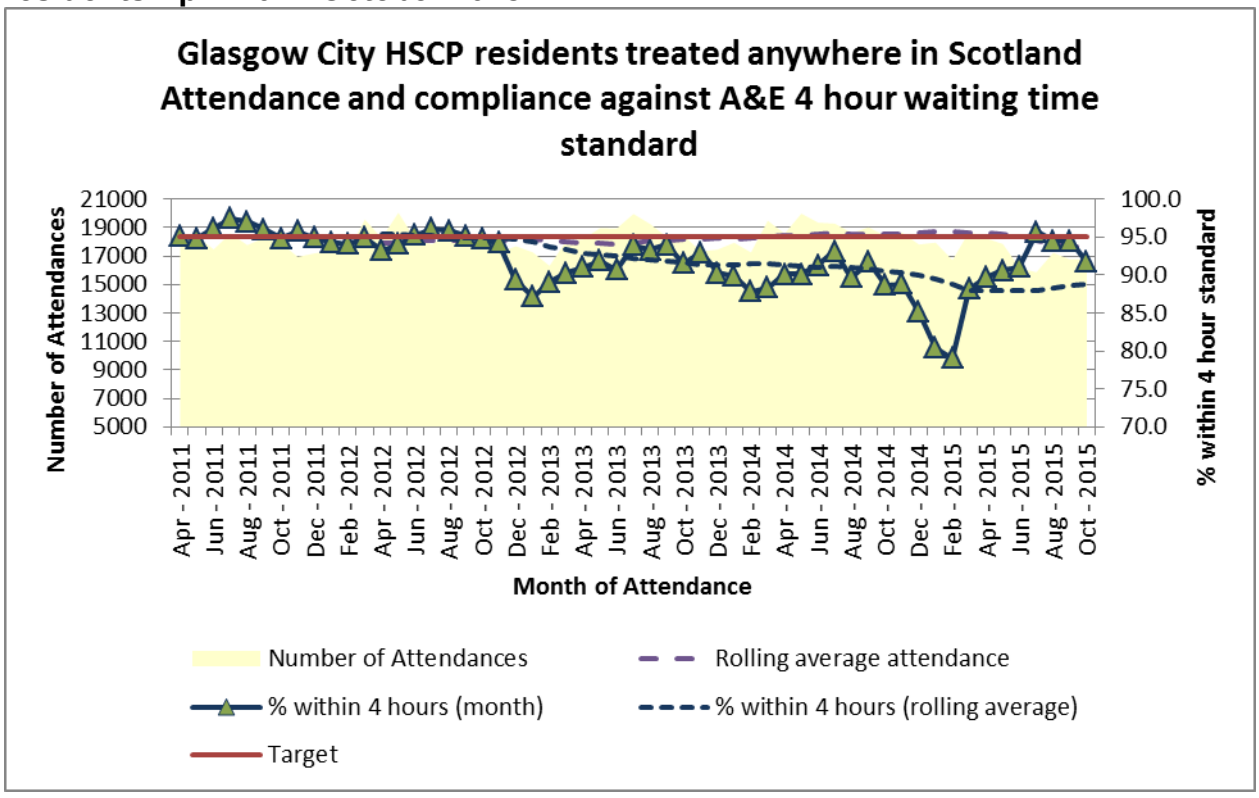
1.2 The plan has been prepared in the context of national guidance from the Scottish Government on unscheduled care, and local guidance from both NHS Greater Glasgow & Clyde and Glasgow City Council. The plan also forms part of the NHS Board's and Glasgow City Council's wider plans to prepare for this winter.

1.3 The plan should been seen as a precursor to the IJB's overall plan to enable delivery of effective unscheduled care from April 2016 onwards. The unscheduled care plan will also describe how the IJB proposes to fulfil its responsibilities for strategic planning of these services, as described in the Integration Scheme for Glasgow City. A draft of this plan will be produced in early 2016 for discussion with clinicians, key partners including secondary care, housing and the third and independent sectors.

2. UNSCHEDULED CARE CONTEXT

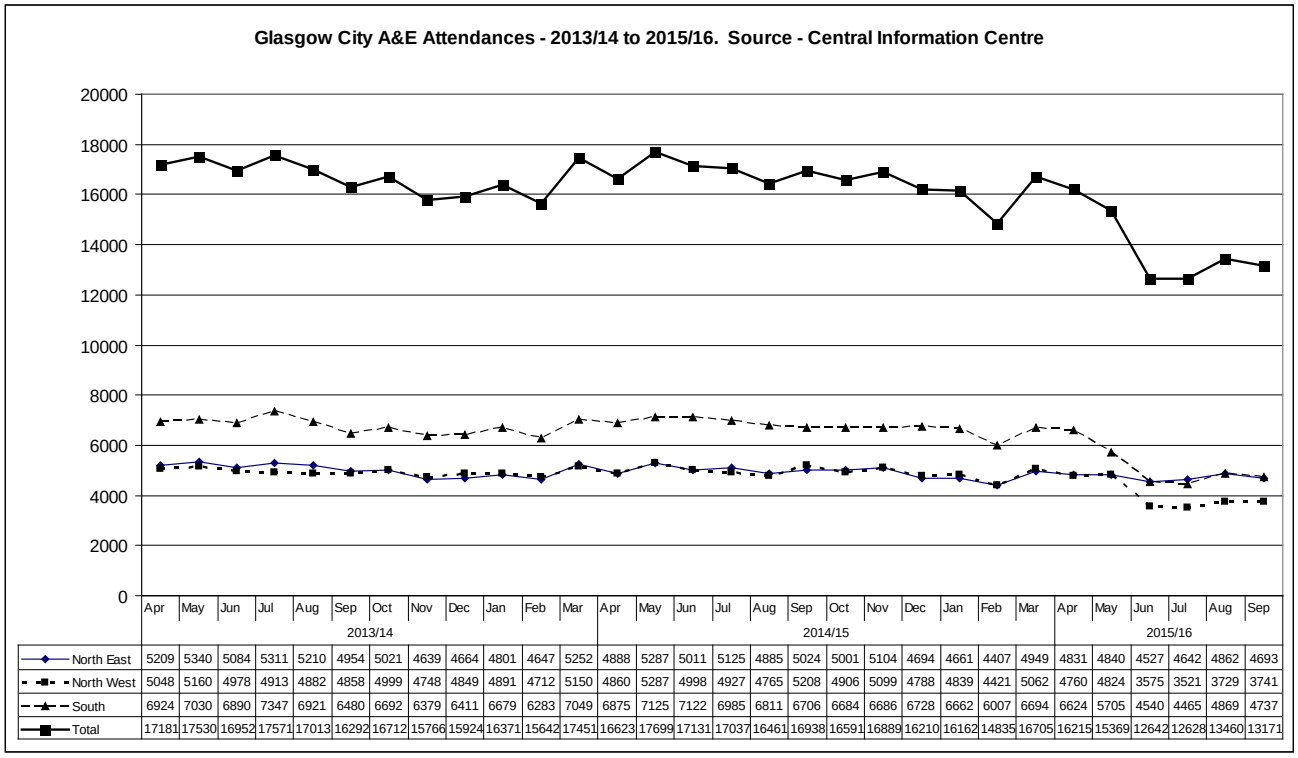
2.1 The health and social care system in Glasgow has faced considerable pressures in recent years. In particular there has been considerable pressure in delivering the national target to delivery care to 95% of accident and emergency attendees within four hours. The recent trends for Glasgow City residents are shown in figure 1 below.

Figure 1 – Accident & Emergency Attendees – 4 hour target – Glasgow City residents April 2011-October 2015



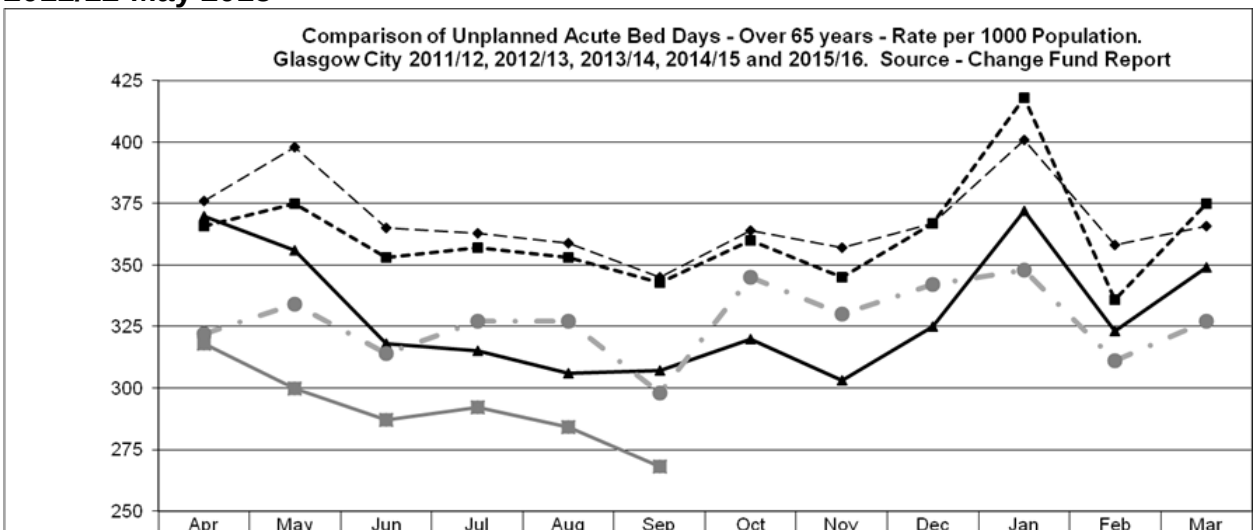
2.2 Further analysis of Glasgow City A&E attendances shows that since April 2012, with the exception of seasonal variations, there has been a gradual downward trend in attendances that has increased since May 2015 (see figure 2). There is also a similar pattern in the emergency admissions rate per 1,000 head of population for people aged over 65 and 75 (see figures 3 and 4).

Figure 2 – Glasgow City A&E attendances 2013/14-2014/15



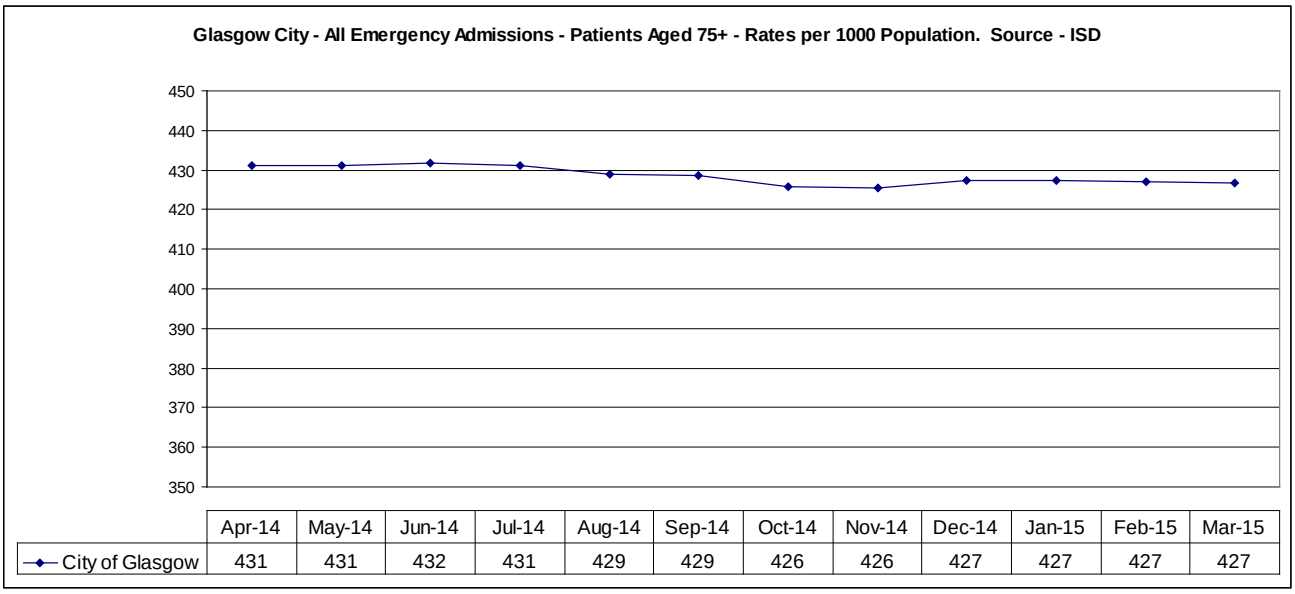
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
	2013/14												2014/15												2015/16					
North East	5209	5340	5084	5311	5210	4954	5021	4639	4664	4801	4647	5252	4888	5287	5011	5125	4885	5024	5001	5104	4694	4661	4407	4949	4831	4840	4527	4642	4862	4693
North West	5048	5160	4978	4913	4882	4858	4999	4748	4849	4891	4712	5150	4860	5287	4998	4927	4765	5208	4906	5099	4788	4839	4421	5062	4760	4824	3575	3521	3729	3741
South	6924	7030	6890	7347	6921	6480	6692	6379	6411	6679	6283	7049	6875	7125	7122	6985	6811	6706	6684	6686	6728	6662	6007	6694	6624	5705	4540	4465	4869	4737
Total	17181	17530	16952	17571	17013	16292	16712	15766	15924	16371	15642	17451	16623	17699	17131	17037	16461	16938	16591	16889	16210	16162	14835	16705	16215	15369	12642	12628	13460	13171

Figure 3 – Glasgow City emergency admissions rate per 1,000 population 65+ - 2011/12-May 2015



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
2011/12	376	398	365	363	359	345	364	357	367	401	358	366
2012/13	366	375	353	357	353	343	360	345	367	418	336	375
2013/14	370	356	318	315	306	307	320	303	325	372	323	349
2014/15	322	334	314	327	327	298	345	330	342	348	311	327
2015/16	318	300	287	292	284	268						

Figure 4 – Glasgow City emergency admissions rate per 1,000 population 75+ - 2014/15



	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
City of Glasgow	431	431	432	431	429	429	426	426	427	427	427	427

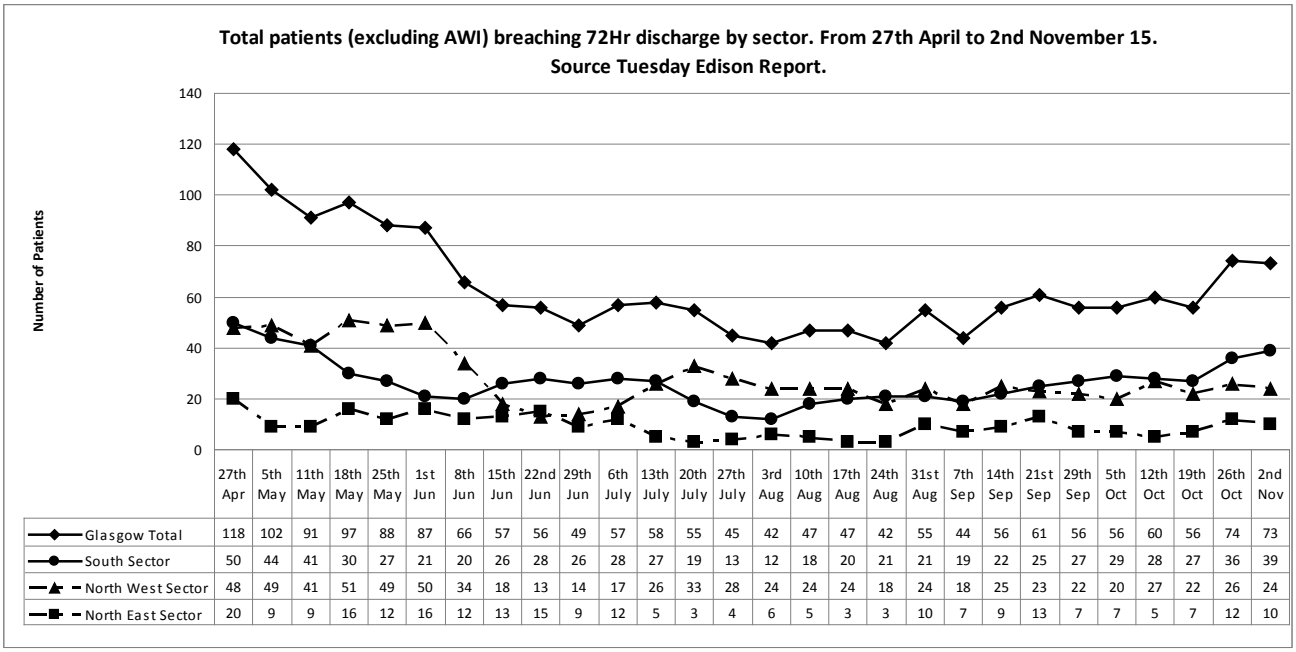
2.3 Further analysis shows that these attendances are influenced by deprivation with a greater rate of attendance from SIMD 1 areas as shown in table 1.

Table 1 – Glasgow City unplanned admissions by SIMD 2011/12-2015/16

	2009/10	2011/12	2012/13	2013/14	2014/15	2015/16 (to August)
Quintile 1	9,771	8,607	8,871	8,808	9,252	4,051
Quintile 2	7,292	8,439	8,228	7,757	7,096	3,010
Quintile 3	4,742	5,341	5,438	4,912	4,844	2,055
Quintile 4	2,954	3,494	3,637	3,459	3,345	1,471
Quintile 5	1,443	1,440	1,466	1,366	1,700	699

2.4 There are a number of actions in our plan outlined below designed to prevent avoidable admissions to hospital. There trends in A&E attendance and emergency admissions will therefore be closely monitored over the winter period to ensure we continue to deliver safe and effective patient care. In addition to work to mitigate avoidable attendances and admissions, the HSCP has a programme of work to improve discharge (outlined below). Delayed discharges has been a pressure in recent years but significant improvements have been made which the HSCP is committed to maintain during the winter period (see figure 6).

Figure 6 – Glasgow City delayed discharges – number of patients breaching 72 hour target January 2015-current



	27th Apr	5th May	11th May	18th May	25th May	1st Jun	8th Jun	15th Jun	22nd Jun	29th Jun	6th July	13th July	20th July	27th July	3rd Aug	10th Aug	17th Aug	24th Aug	31st Aug	7th Sep	14th Sep	21st Sep	29th Sep	5th Oct	12th Oct	19th Oct	26th Oct	2nd Nov
Glasgow Total	118	102	91	97	88	87	66	57	56	49	57	58	55	45	42	47	47	42	55	44	56	61	56	56	60	56	74	73
South Sector	50	44	41	30	27	21	20	26	28	26	28	27	19	13	12	18	20	21	21	19	22	25	27	29	28	27	36	39
North West Sector	48	49	41	51	49	50	34	18	13	14	17	26	33	28	24	24	24	18	24	18	25	23	22	20	27	22	26	24
North East Sector	20	9	9	16	12	16	12	13	15	9	12	5	3	4	6	5	3	3	10	7	9	13	7	7	5	7	12	10

3. PREPARATIONS FOR WINTER 2015/16

3.1 This rest of this plan focuses on the HSCP's actions to manage the potential additional pressures in the health and social care system, including adult mental health services that arise over the winter period. As part of this process the HSCP will be working with partner agencies, including housing and the third sector to maximise their contribution over the winter period.

3.2 The plan also articulates the HSCP's actions to contribute towards the mitigating of pressure on the acute hospital system in Glasgow City, and with a particular focus on actions under the twelve key themes in the Scottish Government's winter planning guidance DA (2015) 20, including measures to avoid admissions and manage delayed discharges.

3.3 To manage the delivery of this plan, co-ordinate our activity and initiate appropriate HSCP responses when required, the HSCP has set up a winter planning group. The HSCP winter planning group will meet weekly until the end of the financial year and will report to the Operations Executive Group, and the (shadow) IJB.

3.4 Development of this winter plan for 2015/16 is seen as key stepping stone in developing the planning process for 2016/17 and onwards when the IJB formally takes on responsibility for the strategic planning of acute services associated with the unscheduled care pathway as outlined in the integration scheme. The terms of reference and membership of the winter planning group will be revised and expanded in early 2016 to reflect this broader remit, and include input from primary and secondary care, the housing sector and third and independent sectors.

4. CRITICAL AREAS – KEY ACTIONS

4.1 This section of the plan describes the measures being put in place by the HSCP in line with the twelve key themes described in the national winter planning guidance DA (2015) 20. In addition, the actions outlined below have taken into account the health and social care aspects of the *Six Essential Actions to Improving Unscheduled Care Performance*.

i) Safe & effective admission / discharge continue in the lead-up to and over the festive period and also in to January.

4.2 In this winter plan the HSCP has placed a particular focus on preventing admission to hospital. Across all health and social care services in Glasgow City we have systems in place to predict or identify vulnerable patients at risk so that the necessary support can be given to avoid unnecessary admission to hospital, and help people remain in their own homes. Specific elements of this programme include:

(a) Anticipatory Care Planning

- GP completed anticipatory care plans are uploaded onto the electronic information system, eKIS;
- All patients with palliative and end of life care needs have an advanced care plan and electronic palliative care summary completed within eKIS;
- The introduction of the Glasgow Community Respiratory Service (£600k from the integrated care fund) to support patients with COPD. The service was tested and evaluated in the North West and is now being introduced across the city. The roll out has been accelerated to ensure that full coverage is achieved by December 2015. Based on activity data from the test site, it is anticipated that initially the service will support between 75-100 referrals per month. These typically comprise 50% referrals related to urgent intervention (either GP rapid response to avoid admission or Early Supported Discharge to reduce acute bed days), and 50% COPD patients who are stable but at risk of deterioration. The service will work with this cohort of patients to develop self-management strategies and the development of Anticipatory Care Plans.
- A programme is in place in the North West to pilot anticipatory care plans for people in Intermediate Care beds and subject to evaluation will be extended to other units in the city; and,
- We will also develop a wider programme to extend anticipatory care plans to all care home settings, including residential care homes, working with the independent sector, Cordia and others.

b) Admission Avoidance

Specific measures in place to prevent admission in addition to those above include:

- Community nursing teams working collaboratively with GPs and third sector providers (e.g. Marie Curie Cancer Care) to manage vulnerable patients with nursing needs and those with palliative care needs. Those at greatest risk are subject to frequent clinical monitoring and case review to ensure all measures are in place to avoid admission to hospital. District Nurses will check if other services are attending and if any issues will contact relevant agency;
- The Rapid Response Link within community rehabilitation teams offer the same day access for patients referred by a GP and who are at risk of admission;

- The Older Adults Mental Health Team has an in-hours duty system in place to provide urgent advice and input as appropriate. Out of hours referrals are directed to the Crisis Team;
- Social Work Services will review all vulnerable elderly people, known to them in the community, though the use of professional supervision. Resource Allocations Groups will continue to prioritise care home allocation to those in most needs including vulnerable people living in the community;
- For those at risk of falling, we will develop a Glasgow wide falls prevention programme, with a focus on frequent fallers and assessing the need for a responders service;
- We will also work with the SAS and acute hospitals to explore the efficiencies in the process of patient arrival at A&E; and,
- Community Mental Health Crisis Services will provide 24 hour 7 day week provision which will assess patients for admission and discharge. These services will be in place over the festive period. The services covering the Glasgow City & Clyde area include social care support. The Crisis Teams will provide public holiday cover during the festive period.

c) Expediting Discharge from Hospital

4.3 The HSCP has established a Hospital Discharge Operations Group (HDOG) charged with improving hospital discharge performance and consistency across the three localities in Glasgow. From November 2015 to March 2016 this group will meet on a weekly basis to accelerate the improvement programme, and ensure regular scrutiny of discharge performance and individual case management. We will aim to maintain our current performance (see figure 6 and the indicators in annex A) over the winter period with a particular focus on the city's two A&E departments.

The work programme includes the following actions:

- development of a detailed action plan for under 65s including patients with complex physical health care needs, mental health and homelessness;
- actions to improve adult mental health Edison recording and improve discharge performance;
- deliver improved performance management for AWI patients delayed due to guardianship applications and correspondingly reduce the number of AWI delays;
- improved hospital interface arrangements including:
    - community team discharges;
    - appropriate completion of specialist multi-disciplinary assessment tool (SMAT);
    - timing of SMAT availability; and,
    - appropriate recording on Edison
- develop palliative care and end of life hospital discharge pathway;
- implement an accommodation-based strategy that seeks to divert demand away from acute care at both admission and discharge ends of the system;
- implement choice protocol for patients refusing to move to intermediate care and ensure appropriately recorded on Edison;
- development of arrangements to facilitate improved discharge to Council managed residential care units;
- agree notification arrangements from homeless liaison team initiated discharges;
- establish focused rehabilitation team input to Intermediate Care units to facilitate patient discharge; and,

- strategically manage care home placement allocations across the three localities to alleviate the areas of greatest pressure and maintain throughput in our intermediate care units.

4.4 Other actions to expedite acute hospital discharge include:

- the Marie Curie fast track service which represents a £250k investment via Glasgow's Integrated Care Fund to support people with palliative care needs to get out of hospital as quickly as possible. The service covers the whole city and is projected to support almost 500 patients in 2015/16, equating to around 4,600 visits and almost 15,000 unplanned bed days. In addition, the NHSGGC contract with Marie Curie for Managed Care augments mainstream community nursing services for people with palliative care needs and avoids unscheduled admissions; and,
- EquipU out of hours service for urgent referrals to avoid potential delays as a result of equipment issues. EquipU will communicate information to all partners in early November, advising store closure dates and order cut-off points. This is supported further by partnership discussion at the Operational Development Group which reviews plans and ensures all services have made provision for public holidays.

d) Other actions:

- GPs will ensure that people are reminded to order and collect their medications, including repeat prescriptions, in advance of the festive period; and,
- in adult mental health Out of Hours services receive referrals from the GP OOH service which triages calls from NHS 24. These services will be in place over the festive period. It is not anticipated that there would be an unusual pattern of referrals to psychiatry based on previous year's information.

ii) <u>Workforce capacity plans & rotas for winter / festive period agreed by October.</u>

4.5 Service managers will be responsible for determining that planned leave and duty rotas are effectively managed to ensure an adequate workforce capacity over the holiday period. Community services such as district nursing will operate as normal over the bank holiday weekends supported by out of hours services. Social work stand by will also be in place.

4.6 In mental health inpatients, staff leave is planned for the full festive period to ensure appropriate staff cover. In addition, there is in place review and attendance plans to monitor absence. In the event of staff shortages access is available to the nurse bank. In exceptional circumstances community psychiatric nursing staff may be requested to work in inpatient services.

iii) <u>Whole system activity plans for winter: post-festive surge.</u>

4.7 The HSCP will contribute to the whole system activity planning and ensure representation in Board-wide winter planning arrangements. The HSCP Chief Officer links closely with acute and other HSCP Chief Officers to maintain a collective perspective on performance issues and escalation arrangements which require action. Acute situation reports (SITREPs) will be regularly reviewed at the HDOG, and shared across community services to monitor performance and inform appropriate actions that might be required.

iv) <u>Strategies for additional winter beds and surge capacity.</u>

4.8 The HSCP has introduced an intermediate care model and capacity in the city. An intermediate care improvement plan is in place. A commissioning strategy is also being implemented with a view to establishing core and flexible arrangements. Over the winter period there is the potential to spot purchase additional intermediate care placements to relieve any surge in appropriate referrals from the acute system.

4.9 In mental health inpatients, the admission and discharge data has been assessed over the past five years, and daily reports on bed occupancy and availability are assessed. These reports also report on any projected ward closures should this be necessary in exceptional circumstances e.g. Norovirus, influenza etc. Annual leave will be managed across the winter and festive period to ensure sufficient staffing to manage demand. The pattern of admissions and discharges over the winter period is similar to the pattern throughout the rest of the year. No special arrangements need to be put in place relating to psychiatric admissions and discharges.

v) The risk of patients being delayed on their pathway is minimised

4.10 Arrangements will be put in place to ensure that areas where there is a potential for delays are reduced, particularly in respect of the adults with incapacity. There is also ongoing work at the primary / secondary care interface within rehabilitation services to improve the sharing of information, and reduce the need for reassessment at points of transition that could lead to a delay in the patient's pathway.

vi) Discharges at weekend & bank holiday.

4.11 The HSCP will put in place a skeleton integrated response team, with access to home care, over the Sunday and Monday of the two holiday weekends to respond to particular pressures that might arise, and with a view to easing pressure as services get back to normal after the holiday weekends.

4.12 The HSCP will work with acute hospitals to anticipate discharges that may require home care services during the two holiday weekends. There are well established arrangements with Cordia for cover over public holidays and this is well communicated to community teams.

4.13 Red Cross will be working throughout festive period, supporting admission avoidance from A&E from the main acute hospital sites in Glasgow including supporting transport of patients' discharge to home and to and from Intermediate Care.

4.14 Community rehabilitation teams will work every day other than Christmas Day and New Year's Day, and will support A&E admission avoidance and Intermediate care.

4.15 In mental health, Liaison Psychiatry Services are provided Monday to Friday to acute hospitals and Psychiatric Liaison Nurse services for deliberate self-harm over weekends and public holidays. The Deliberate Self Harm community psychiatric nursing service will receive referrals directly from acute medical wards over the public holiday and weekend for the festive period. This is in addition to direct referrals to the on-call psychiatry staff in psychiatric hospitals which is available to acute services.

vii) Escalation plans tested with partners.

4.16 The HSCP will monitor performance of the health and social care system over the winter period, including the actions in this plan, through a robust set of arrangements that include:

- monitoring of delayed discharges through weekly meetings of the HDOG;
- weekly meetings of the winter planning group that produced this plan to ensure its implementation;
- reports on winter planning performance to the weekly HSCP Executive Team;
- regular review of locality performance at Locality Management Team meetings;
- a rota of senior management cover over the winter period to ensure an appropriate management response when required;
- Clinical Director liaison with a network of GP "spotter" practices to monitor levels of flu within primary care; and,
- Care Homes and Intermediate Care Units will identify any issues that require to be escalated.

viii) Business continuity plans tested with partners.

4.17 We are currently working on an integrated HSCP emergency plan that will link to the business continuity arrangements in each service. The current business continuity arrangements for each service area will remain in place and will be revised in relation to responsible people and accommodation e.g. the development of the new 120 bedded care homes and the subsequent buddy arrangements.

4.18 GP Practices and Pharmacies have business continuity plans in place that include a 'buddy system' should there be any failure in their ability to deliver essential services. These are currently being updated to ensure they are robust.

ix) Preparing effectively for norovirus.

4.19 The NHSGGC Norovirus Escalation plan will be followed across all HSCP services including inpatient areas and care home settings. Staff will be reminded of the need to remain absent for 48 hours post last symptom of Diarrhoea and vomiting.

x) Delivering Seasonal Flu Vaccination to Public and Staff

4.20 All health and social work staff, including home care staff, will be reminded to encourage elderly and vulnerable people to attend their GP flu vaccination sessions. The Community Nursing service will vaccinate housebound patients on their current caseloads, and who give consent to receiving the flu vaccination.

4.21 Health staff are actively encouraged to be vaccinated and local peer vaccination sessions will be provided across the city.

4.22 Home care staff will be advised as to how they can receive the vaccination if they so choose.

xi) Communication to Staff & Primary Care Colleagues

4.23 To ensure that all HSCP staff, primary care and partner agencies are kept informed, the HSCP will:

- ensure information and key messages are available to staff through communication briefs, specific newsletters and communications, team meetings and electronic links;

- circulate information on available community services and clinics during the festive period, including pharmacy open times, to GP practices;
- collate a range of information regarding staff rotas, service operating hours and lead contact details, and make available to staff throughout HSCP, Primary Care colleagues, acute and NHSGG&C Board;
- information regarding GP availability throughout the festive period will be provided through the NHSGG&C Winter Booklet. Posters will also be provided and will be available to the public through public facing websites and by being displayed in GP Practices;
- other arrangements to provide simple access to services include Social Care Direct for all GCC enquiries and service specific access points for NHS provision;
- based on previous work on developing a single point of access to NHS services, it was agreed that many of the systems currently in place provide quick and easy access to services. Examples include the community rehabilitation and mental health duty system. The District Nursing service is currently the subject of a project to develop a single point of access for Glasgow. The infrastructure for this system will be complete by December and will begin operating in 2016. It is expected this will provide faster access to District Nurses and also free up professional time that will be re-invested in anticipatory care; and,
- public information which directs people to appropriate services will be made available to direct them to appropriate services through website links on the HSCP and Glasgow City Council.

xii) <u>Effective analysis to plan for and monitor winter capacity, activity, pressures and performance</u>

4.24 The HSCP will put in place a robust performance management system to under pin the arrangements described in vii above the key features of which will be to:

- monitor system and service performance / demand across the city and in localities;
- inform our capacity planning and the need for any surge capacity; and,
- report on performance against agreed targets / KPIs.

4.25 Attached at annex A is a set of metrics to be used as part of our performance regime which will be further developed and refined.

5. CONCLUSION

5.1 This plan outlines the actions the HSCP is taking in preparation for winter 2015/16 in line with national guidance, and guidance from NHSGGC and Glasgow City Council. The HSCP has robust monitoring and performance management arrangements in place to minimise any potential disruption to health and social care services, patients, service users and carers over the winter period. An action plan has also been developed identifying key leads for each action, reporting arrangements and key performance indicators. Regular reports and updates will be made to the shadow Integration Joint Board.

ANNEX A

GLASGOW CITY WINTER PLANNING
PERFORMANCE MANAGEMENT FRAMEWORK

Measure	Data Source	Current Position	Level	Comment
Performance - DELAYED DISCHARGE				
Total numbers delayed discharge excluding AWI	Edison	60	City / Locality	Notes reason for delay such as funding or assessment etc as possible trigger for action
Total numbers delayed discharge excluding AWI breaching 72 hours	Edison	54	City / Locality	Reviewed by Locality service Manager / delegated manager and escalated.
Number of delayed discharge patients 65+ years excluding AWI & MH	Edison	30	City / Locality	
Number of delayed discharge patients 65+ years excluding AWI & MH breaching 72 hours	Edison	24	City / Locality	
Number of delayed discharges patients aged under 65 excluding AWI & MH	Edison	13	City / Locality	
Number of delayed discharges patients aged under 65 excluding AWI & MH breaching 72 hours	Edison	13	City / Locality	
Total number of delayed discharge mental health patients over and under 65 years	Edison	17 (13 over 65 / 4 under 65)	City / Locality	
Total number AWI delayed discharge patients (including and excluding MH)	Edison	52 (including MH) 43 (excluding MH)	City / Locality	
Capacity - INTERMEDIATE CARE				
Step Down				

Measure	Data Source	Current Position	Level	Comment
Percentage occupancy	GCC Data	89%	City / Locality / Care Home	Would also need to include reporting of any loss of capacity such as closure of beds for norovirus / repairs etc
Number of Admissions	GCC Data	12	City / Locality / Care Home	
Number of discharges	GCC Data	3	City / Locality / Care Home	
Length of stay - average / min / max	GCC Data	Weekly	City / Locality / Care Home	
Vacancies	Care Homes	Daily	City / Locality / Care Home	Reviewed by Locality service Manager / delegated manager and escalated.
System Demand Indicators - UNSCHEDULED CARE ACTIVITY				
TBC				
Service Demand - HOME CARE				
Referrals to Cordia	Cordia	Weekly	Hospital / Locality	To include weekend and public holiday monitoring