GLASGOW CITY HEALTH & SOCIAL CARE PARTNERSHIP

Shadow Integration Board

Wednesday, 27th May 2015 at 9.30am
in the City Chambers, George Square, Glasgow

AGENDA

		Enclosure
1.	**GP Out of Hours Service Review**	
	Presentation – Sir Lewis Ritchie OBE	
2.	**Apologies for Absence**	
3.	**Minutes**	
	To approve as an accurate record the Minutes of the meeting of the Shadow Board held on 30th March 2015.	Minutes
4.	**Matters Arising** (not otherwise on the Agenda)	
5.	**Integration Scheme – Update**	
	David Williams, Chief Officer Designate	Papers
6.	**Glasgow City Health & Social Care Partnership Brand Identity**	
	David Williams, Chief Officer Designate	Paper
7.	**Performance Management**	
	David Williams, Chief Officer Designate	Paper
8.	**Care Inspectorate Reports July 2014-March 2015 –** Directly Provided Older People and Physical Disability, Residential Services; Older People's Day Care Services; and Children's Care Centres	
	David Williams, Chief Officer Designate	Paper
9.	**Future Meetings of Shadow Board**	
	A programme of future meetings in August and October is being developed, with further dates to be agreed for the Integration Board when established. Details will be notified as soon as possible.	

ITEM 3

27 May 2015

SHADOW HEALTH AND SOCIAL CARE INTEGRATION JOINT BOARD.

Minutes of Joint Board Meeting (DRAFT).

Glasgow, 30th March 2015.

Present: Peter Daniels, NHS GGC (Chair); Councillor Archie Graham (Joint Chair) and Councillors James Adams, Malcolm Cunning, Marie Garrity, and Russell Robertson, Glasgow City Council; Trisha McAuley, Robin Reid, Andrew Robertson, Rev Norman Shanks and Donald Sime, Board Members NHS GGC.

Also present: David Williams, Chief Officer Designate; Mari Brannigan, Director of Nursing, NHS GGC; Ian Leech (staff representative SWS GCC); John McVicar (carers representative); Peter Millar (independent sector representative); Ann Souter (patient representative); and Sharon Wearing, SWS Glasgow City Council.

Apologies: Bailie Mohammed Razaq and Councillor Emma Gillan, Glasgow City Council; Ros Micklem, Richard Groden and Ken Winter, NHS GGC; Alex McKenzie, Director, Glasgow CHP; Shona Stephen (third sector provider organisations representative); and Dorothy McErlean (staff representative NHS GGC).

Attending: Anna Castelvecchi (Clerk); Mike Burns, Sybil Canavan, Mark Feinmann, Susannah McCorry-Rice, Fiona Moss and David Walker (Glasgow CHP); J Middleton, NHS GGC; and A Eccles, SWS GGC.

1 Minutes of 23rd February 2015 approved.

The minutes of 23rd February 2015 were submitted and approved, subject to the inclusion at page 2, after paragraph (c), "(d) agreed that the public consultation process be undertaken in line with nationally agreed standards".

Development of Integration Scheme – Progress noted.

2 With reference to the minutes of 23rd February 2015 (page 3, paragraph 4) noting progress on the development of the Integration Scheme, there was submitted a further report thereon by the Chief Officer Designate, advising that

(1) the 20th version of the draft scheme had been submitted to civil servants and included further comments made by the Health Board at its meeting on 20th January 2015, the Health Board's Director of Corporate Planning and further meetings with civil servants and the Council's legal officer, as detailed in the report; and

(2) there had also been continuing dialogue and negotiation between the Health Board and the Council and while version 20 had been submitted to civil

servants, there remained one issue outstanding which required to be resolved by 31st March 2015 in order to enable it to be submitted to Scottish Ministers;

David Williams then advised that the issue which remained outstanding was in relation to hosted services, specifically Forensic and Child Adolescent Mental Health Services and he reported that

(a) the view of the Chief Executive of the NHS GGC was that these services should be managed by the Chief Officer and accountable to the CEO rather than the Integration Joint Board, and that if this was not accepted, the services should not be included within the draft integration scheme;

(b) the view of the Chief Executive of Glasgow City Council was that the services should be managed by the Chief Officer and accountable to the Integration Joint Board and that delegating responsibility to the Chief Officer was an unacceptable compromise; and

(c) discussions were still ongoing to try and resolve the matter.

There then ensued a full discussion during which Councillor Graham and Peter Daniels expressed the view that they wished the partners to work together to reach a consensus on the matter, however in the absence of full information, it was difficult for the SIJB to provide a view on the issue and it therefore agreed to note the current position.

Financial Governance Arrangements noted.

4 There was submitted and noted a report by the Chief Officer Designate regarding work undertaken to establish a set of procedures and processes to determine the governance arrangements for a range of matters in relation to financial management and accoutability,

(1) advising that a Technical Finance Working Group (TFWG), chaired by the the Executive Director of Financial Services GCC, had been established and included representation from each of the 6 local authorites within the NHS GGC area, to co-ordinate the task of producing various papers which would form the basis of a set of guidance notes to assist the Partnerships in financial management arrangements;

(2) detailing the work undertaken by 3 workstreams and including in an appendix to the report the results of worksteam 2, which had been approved by the TFWG; and

(3) confirming that a number of issues, as set out in the report remained outstanding and were subject to the receipt of national guidance.

Financial Plans 2015/2016 noted.

5 There was submitted and noted a report by the Chief Officer Designate outlining the draft budget available to the IJB for 2015/16 fron NHS GGC and GCC resources,

(1) advising that the Council's budget had been approved on 19th February 2015 and the Social Work element of that budget, excluding central support costs, amounted to direct departmental net expenditure of £395.88m;

(2) detailing the most significant changes from the 2014/15 Social Work budget and highlighting the elements within the Service Reform Programme which had reduced net expenditure by £8.1m;

(3) advising that in respect of the Community Health Partnership (CHP) work was nearing completion to finalise the CHP 2015/16 budget in line with the overall NHS GGC financial plan and final adjustments would be actioned in June 2015 in respect of 2015/16 uplifts, however the indicative CHP budget amounted to net expenditure of £614.4m; and

(4) detailing significant changes from the 2014/15 CHP budget and advising that in addition the CHP was required to finalise savings adjustments as part of its financial planning process and draft plans were currently being finalised within the Partnership's collective service redesign programme to reduce net expenditure by £15m which included a CHP local savings target of £3.2m.

Development of Participation and Engagement Strategy noted.

6 There was submitted and noted a report by the Chief Officer Designate regarding the development of a participation and engagement strategy for the Glagow Health and Social Care Partnership

(1) detailing the backgroud and policy context within which the participation and engagement strategy was being developed;

(2) setting out the current engagement arrangements and structures which were utilised to engage with service users, carers, communities and the third sector both in localities and city-wide;

(3) advising that a review of current engagement structure arrangements was underway and setting out its scope and methodology and confirming that this activity would inform and ensure a co-production approach which would produce proposals for an engagement framework which would meet legislative requirements and the Partnership's expectations for locality planning; and

(4) advising that it was anticipated that the review and consultation would be concluded in late autumn 2015 and a report thereon submitted to the IJB by the end of 2015 with its proposals to take effect from April 2016.

Membership of Integration Joint Board – Appointment arrangements noted. noted.

7 There was submitted and noted a report by the Chief Executive Designate regarding the statutory requirements for membership of the Integration Joint Board and the process for the appointment of members.

Proposed Management Development Programme noted.

8 There was submitted a report by the Chief Officer Designate outlilning a management development programme for the new leadership group of the Glasgow Health and Social Care Partnership.

Having heard from David Williams that members of the SIJB were welcome to attend any of the stage 1, 3 or 4 sessions described in the report, the SIJB noted the report.

Children's Services Developments – "Getting it Right for Every Child" – Presentation noted.

9 There was heard and noted a presentation by Mike Burns on the "Getting it Right for Every Child" (GIRFEC) approach to services for children

(1) detailing the background to the development of the GIRFEC approach;

(2) setting out its principles and key elements; and

(3) describing the case for change, the next steps and its impact on service reviews.

Presentation on Community Addiction Team Review noted.

10 There was heard and noted a presentation be Susannah McCorry- Rice regarding the key outcomes of the recent review of community addiction services which highlighted that

(1) the key emphasis of services would be on recovery, harm reduction and exit strategies;

(2) services would adopt national eligibility standards for treatment and practise;

(3) there would be revised arrangements for children affected by parental substance abuse, using a shared care model; and

(4) the service would be renamed Community Alcohol and Drugs recovery with branding in line with HSCP changes.

Next meeting date noted.

11 The SIJB noted that the next meeting would take place on 27th May 2015 at 0930 hours in the City Chambers, Glasgow.

Valedictory.

12 The Board noted that Peter Daniels' term of office with the Health Board ended this week and consequently this was his last meeting of the SIJB. Councillor Graham, on behalf of the SIJB thanked him for his contribution to the work of the SIJB and its predecessors, and wished him a long and happy retirement.

Item 5

27th May 2015

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

Report By:	Chief Officer Designate
Contact:	David Williams
Tel:	0141 287 8853

UPDATE ON GLASGOW CITY INTEGRATION SCHEME

Purpose of Report:	To update the Shadow Integration Joint Board on the development of Glasgow's Integration Scheme

Recommendations:	Shadow Integration Joint board is asked to consider and note this report

Implications for IJB	
Financial:	Budgets for delegated functions remain with the parent bodies until establishment of the IJB and approval of its Strategic Plan
Personnel:	A formal appointment to the post of Chief Officer must be made by the IJB when established
Legal:	A second rejection of the Integration Scheme by the Cabinet Secretary may result in the parties being directed by the Scottish Ministers as to the form and nature of integration in Glasgow
Economic Impact:	None
Sustainability:	None
Sustainable Procurement and Article 19:	None
Equalities:	An Equalities Impact Assessment was carried out on The Integration Scheme before presentation to the Council and Health Board in January and February 2015. Officers have reviewed the amended scheme and advise of no changes to the findings of the original EQIA.

Implications for Glasgow City Council	Glasgow City Council retains responsibility for those services to be delegated to the IJB until the IJB is established and has approved a Strategic Plan.
Implications for NHS Greater Glasgow & Clyde	NHS GGC retains responsibility for those services to be delegated to the IJB until the IJB is established and has approved a Strategic Plan.

1. Purpose of this report

1.1 The purpose of this report is to update the Shadow Integration Joint Board on the development of Glasgow's Integration Scheme

2. Background

2.1 Shadow Board have previously been advised of the submission to Scottish Ministers of version 20 of the Scheme on 31st March.

2.2 On 29th April, feedback was formally received from the civil servants on the content of the Glasgow Scheme. This feedback is attached as appendix 1.

2.3 The tenet of much of the feedback is that minor re-wording and re-phrasing is required in order to strongly evidence the nature and intent of joint working and integration within Glasgow.

2.4 The technical position in relation to this feedback is that it reflects a formal rejection by the Cabinet Secretary of the Glasgow City submission.

2.5 The legislation allows for a resubmission to be made by the two Parties, however, if this resubmission is rejected again, the Parties will be directed by Scottish Ministers about the form and nature of integration within Glasgow.

2.6 As such, it is imperative that the resubmission is completely fit for purpose at the point of submission.

2.7 This will require a tripartite agreement between Council, Health Board and civil servants prior to submission.

3. Process for re-submission

3.1 Work has been undertaken on the re-wording requirement

3.2 At the time of writing, dialogue and agreement between the Chief Officer Designate and the NHS Director of Corporate Planning and Performance is scheduled to take place prior to shadow Board meeting.

3.3 Further consultation with the civil servants will be required thereafter.

3.4 The expectation of the Council is that the final version requires to be presented to Executive Committee prior to re-submission to Scottish Ministers. This is in recognition of the fact that version 15 is what was consulted on in November and December, and the version that was presented to the Health Board on 20th January and Executive Committee on 5th February had been amended to take account of consultation feedback. Both bodies were advised that the version presented would require further amendment

prior to submission and this resulted in version 20 submitted on 31st March and rejected.

3.5 It is anticipated that presentation at the final Executive Committee of the session will be effected on 25th June.

3.6 This will result in the Scheme being presented to Scottish Ministers after the parliamentary recess, and a likely start date for the IJB of late September.

4. Recommendation

4.1 Shadow Integration Joint board is asked to consider and note this report

Section	page	Scheme wording	Non-Compliance issues	General comments
3.1 – Definitions	6	"outcomes" means the **requirements** of the Public Bodies (Joint Working) (National Health and Wellbeing Outcomes) (Scotland) Regulations 2014	It is not accurate to say that these regulations set out "requirements". The definition should state ""outcomes" means the outcomes set out in the Public Bodies (Joint Working) (National Health and Wellbeing Outcomes) (Scotland) Regulations 2014"	Typing point – a line space is missing between the first 2 definitions .
5 – Delegation of Functions	8	5.1 "the functions that **are to** be delegated…" 5.2 "the functions that **are to** be delegated…"		It is confusing to say that annexes 1 and 2 contain a list of functions that *are to* be delegated, as this implies these are exhaustive lists.. Given the use of separate annex 4 to set out additional functions, annexes 1 and 2 are not exhaustive. It would be better to say that annexes 1 and 2 list the functions that **must be** delegated. This is consistent with an additional list of extra functions being provided in annex 4.
6. Local operational delivery arrangements Section 6.1	8	The Integration Joint Board will through its members be responsible for monitoring and reporting to the parties and the Scottish Government on the delivery of those services	How will the IJB have oversight of the carrying out of the integrated functions? Do the reports come from members or the IJB as an	

		delegated to it by the Council and the Health Board, and will issue directions to the parties in response to the information it receives to ensure performance is maintained and improved.	entity? What are the governance arrangements? Who is operationally managing the services. More information is required to be set out in the scheme	
	9	The Integration Joint Board will be responsible for planning the delegated acute services working with the Health Board but the latter will have operational oversight of acute services and through the Board Chief Executive, will be responsible for operational delivery of acute. The Health Board will provide information on a regular basis to the Chief Officer and the Integration Joint Board on the operational delivery of these services.	What is the interaction between the person responsible for the operational management of acute services and the chief officer?	
6.2.2	9	…a list of these targets, measures or arrangements will be made available to the integration joint board	The scheme must set out the process to be used to prepare this list.	

			upon its formal establishment		
7. Clinical and Care Governance **7.1**	13		Quality, clinical, care and professional governance **in** the integration joint board…	This should refer to "in relation to services provided in pursuance of the functions delegated to the integration joint board" or "in relation to services directed by the integration joint board". This is closer to the requirement of the regulations. It's about governance of the services, not just the board.	
Section 7.4	13		The Health Board's Chief Executive is responsible for clinical governance, quality, patient safety and engagement, supported by the Health Board's professional advisers. This responsibility is delegated to each Chief	How will the chief officer carry out this role? What support is to be in place for the chief officer to carry out this responsibility?	You need to clarify whether the chief officer does certain things on behalf of the HB and LA, as a member of their staff, as well as acting on behalf of the IJB, and the distinction needs to be clear throughout the scheme. Here, for example, why is the chief officer of the IJB responsible for the HB's internal clinical governance responsibilities. But if they are acting in the separate role of HB operational manager, then that might make more sense, but it needs to be clear.

		Officer.		
7.7		The Integration Joint Board will establish a Governance Framework comprising relevant professional interests and management representation.	The regulations require the scheme to set out the detail of the how the clinical and care governance arrangements are to provide oversight of, and advice to the IJB. How will the IJB do this? Will the parties provide the support to do so? Is the Governance Framework a document or a group of people? This is confusing.	
7.10	15	The Integration Joint Board will demonstrate through its Clinical and Care Governance structure that it is compliant and can provide demonstrable assurance to the Health Board's Clinical	As above. How will the IJB do this? There is a lack of integrated structures/forums for this demonstration/assurance.	Will a group/committee provide this assurance? Maybe describe the Clinical and Care Governance structure and it's interaction with the IJB.

7.11		Governance Forum. 7.11 The Health Board wide patient safety programme will be operationally delivered by Chief Officer and scrutinised by the Integration Joint Board with assurance provided to the Health Board Clinical Governance Committee	Does this only refer to integrated services? In what capacity is the chief officer acting here? How can the IJB scrutinise these arrangements if this is delegated to the chief officer in their operational capacity? What support would the IJB have in any case to carry this out.	
This section			There is no reference to the role of the Chief Social Work Officer.	You may wish to refer to the intention to submit the report of the Chief Social Work Office to the IJB
8 – Chief officer **8.1 – 4th and 5th bullet points**	16	• The chief officer will have **delegated responsibility ….for operational delivery** of those functions delegated to the IJB • The chief officer will have	These say 2 different things which cannot both be true. Does the chief officer have delegated operational delivery responsibility for all delegated functions, or for all delegated functions except as they are	

		delegated operational responsibility for delivery of integrated services, **except acute services.**	exercised to provide acute services?	
8.1	17	Final bullet point of paragraph 8.1	The scheme regulations require that the arrangements that the *constituent authorities* will make, on the request of the IJB, are set out. The way the interim chief officer is to be identified is very clearly described, but relates only to action taken by the IJB members. The role of the HB and LA also needs to be set out. It should say that (for example) once a person is identified, on the request of the IJB, the constituent authorities will make such arrangements as are needed to allow for any interim secondment or release of the identified person, to take up the role	

			of interim chief officer.	
9 – Workforce *9.1*	17	… These will be developed during the first year of establishment of the Integration Joint Board and subject to regular review by the integration joint board.	These documents are prepared for the parties (as per the 1st bullet point under 9.1, and in accordance with the regulations). Why is the IJB, not the parties (or the chief officer on the parties behalf) reviewing them? The parties should retain control of the plans that relate to their workforce. For full clarity that this completely complies with the regulations, you should add in "developed and put in place"	The IJB can be party to such reviews but the parties own the plans.
9.1	17	The integration scheme recognises that **employees of the parties will remain employed** by their respective organisations	This may imply some on-going effect on employment contracts, which the scheme should not purport to do. It is not true that all employees will always remain employed come what may. It is true, however, that the scheme will not directly change the employment status. Suggested additional text to	

			clarify this - "The employment status of staff does not change **as a result of this scheme** – employees of the parties will remain employed by their respective organisations…"	
Section 10 - Finance **10.7** **10.8**		The projected hospital capacity targets will be calculated as a cost value using a costing methodology to be agreed between the Council and Health ration Joint Board. In the event that the recovery plan does not succeed, the Council and Health Board will consider either utilising reserves	*Amend to:* *….methodology to be agreed between the Local Authority, NHS Board and IJB*	It is the IBs decision whether to use its reserves-not the HB or LA. So change to: In the event that the recovery plan does not succeed, the Chief Officer, Chief Financial Officer of the Integration Joint Board will consider utilising Integration Joint

				Board reserves…
10.9		…The exception to this general principle relates to exceptional circumstances as defined by local arrangements.	This is too vague. It needs to be clear how the exceptional circs will be defined and what role will the IJB have in this.	
10.10		Neither party may reduce the payment in-year		Include a paragraph on HB and LA making supplementary allocations to the IJB.
10.15 & 10.16		Periodic financial monitoring reports will be issued to the Chief Officer/ budget holders in line with timescales agreed by the Council and Health Board. In advance of each financial year a timetable of reporting will be submitted to the Integration Joint Board for approval.	This needs to also set out the conditions/process to apply for an increase in payment (other than as a result of an overspend.). This doesn't set out a clear frequency (or at least a minimum frequency) for these reports. It doesn't set out the agreed content of financial monitoring reports.	So include a minimum content and frequency and a process for agreeing the content and frequency when the IJB is established.

Section 11 Participation and Engagement **Section 11.2**	*23*		The stakeholders consulted in the development of this Scheme were: □ All stakeholder groups as prescribed in the Public Bodies (Joint Working) (Prescribed Consultees) (Scotland) Regulations 2014 □ The Shadow Integration Joint Board □ Staff of the Health Board and Council	The scheme must set out the means by which the consultation was undertaken. 11.3 helpfully sets out that the responses received were taken into account. But there is no information on how those responses were obtained, the tools used to contact specific groups, etc. The regulations require the scheme to include 'a list of persons consulted' – this should include those that are prescribed consultees and any persons over and above this.	
Section 11.4	23		A 'Participation and Engagement Strategy' for the Integration Joint Board will be developed by officers of the Council and the Health Board, under the direction of the	It is for the IJB to prepare the engagement strategy	You will wish to say that the officers are provided to support the IJB develop its engagement strategy.

		Chief Officer,		
12. Information sharing and data handling	24	The Parties agree to be bound by the Information Sharing Protocol already in place between the Health Board and the Council and will recommend that the Integration Joint Board also becomes a signatory to this protocol. This protocol will be subject to regular review by the Parties and the Integration Joint Board.	The scheme must set out the process followed to agree an information sharing accord and the process for amending it. The scheme must also set out the process to agree procedures for sharing information between the HB, LA and IJB and for amending these procedures. A timescale must also be included.	It would be helpful to make reference to SAPSI. The protocol referred to could contain the information sharing procedures – you would need to make this clear.
13. Complaints	24		The scheme needs to set out process by which a service user may make a complaint.	
14 – claims handling, liability and Indemnity	25		The wording of the regulations requires any indemnity arrangements between the parties to be set out. This does not oblige	

			them to have such arrangements but where such arrangements do exist these should be included. • If it is the parties' intention to establish a system of indemnities, should be worked out in advance and published in the scheme – this gives everyone clarity and certainty.	
16. Dispute resolution mechanism	27		The dispute resolution mechanism is between the HB and LA. The regulations do not provide for the involvement of the IJB. Given the above, in what capacity is the chief officer involved?	
Annexe 1 part 1 (and annex 4))		Set out below is the list of functions that **are proposed to be delegated** by the health board […]	This is not accurate – it is only part of the list (the rest of the list is in annex 4). The 2 lists also make contradictory provision about the delegation of, for example, sections 38 and 39 of the 1978 Act (annex 1 excludes these from delegation and annex 4	

			provides for them to be delegated. This should either be changed to “set out below is the list of functions that **must** be delegated”, or the list in annex 4 should be added in to annex 1 s. A statement is also needed that these functions are delegated only to the extent that they relate to the services described in part 2 and the additional services listed in annex 4. Annex 4 states that health visiting services will be included in integration. There is no delegation of section 38A which relates to breastfeeding support services. Are these services being excluded from integration, and are they provided separately from health visiting services ?	
Annex 1 part 2		These services relate to	At present you are delegating most health services (A&E, general	

		• Persons of at least 18 years of age	inpatients, allied health professionals, GPs, dental services , etc) only in relation to adults. But you are also delegating specialist children's services. What about general acute and community children's services, the aspects of GP/dental services that relate to children? Should the functions in annex 1 also be delegated in relation to persons under 18?	
		• Care and treatment provided by health professionals	You must delegate functions in relation to community services (at least), *in full,* and not only to the extent that they relate to care and treatment provided by health professionals. The reference to care and treatment by health professionals in the regulations, relates to the	

			mandatory delegation of functions in relation to acute services, and is to avoid requiring the fragmentation of the support/ancillary services provided in a hospital setting which may relate to a number of non-integrated, as well as integrated services.	
Annex 2 Part 1		Extensive text in footnotes		The footnotes in the regulations, which have been replicated in the annex 2, meet the requirements for drafting secondary legislation. The detail does not need to be replicated in the scheme and is likely to be of limited value to a reader of the scheme (especially as no equivalent information is given about the health functions in annex 1) .

Item 6

27 May 2015

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

Report By:	David Williams, Chief Officer Designate
Contact:	Jason Mokrovich, Service Modernisation Manager (GCC) Gary Dover, Head of Planning and Performance (NHSGGC) Lynn Dalgleish, Marketing Manager (GCC)
Tel:	287 0929

CREATIVE SOLUTION FOR BRAND IDENTITY

Purpose of Report:	To update the Shadow Integration Joint Board on the development of a creative solution for the Glasgow City Health and Social Care Partnership's brand identity.

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

Implications for IJB	
Financial:	The costs of developing the creative solution for the brand identity and logo was funded by the Scottish Government organisational development budget and were minimised through commissioning Glasgow City Council's Corporate Graphics Team to complete the work.
Personnel:	None
Legal:	None
Economic Impact:	None
Sustainability:	None
Sustainable Procurement and Article 19:	None
Equalities:	The recommended creative solution is level AA compliant for colour contrast and colour blindness accessibility.

Implications for Glasgow City Council	None
Implications for NHS Greater Glasgow & Clyde	None

1.0 Purpose

1.1 To update the Shadow Integration Joint Board on the development of a creative solution for the Glasgow City Health and Social Care Partnership's brand identity.

2.0 Background

2.1 A creative solution, which included a logo, was previously developed for Glasgow City's Community Health and Care Partnerships (CHCPs) in 2006, and it was applied across a 'brand identity system' (that is, letterhead stationery, presentation templates, leaflets and staff identity badges). Identity guidelines for the application of the creative solution were also developed to support implementation and ensure consistency and compliance.

2.2 There are a number of positive benefits for the Glasgow City Health and Social Care Partnership (HSCP) having a brand identity. The main ones include:

- assists in articulating and achieving a shared and consistent vision, values and objectives—a shared culture;
- assists in emphasising and reinforcing the 'jointness' of the partnership and commitment to it, as opposed to two separate organisations and
- assists in signposting staff and other stakeholders to sources of information/updates about integration and the Partnership.

2.3 The Integration Communications Workstream was remitted to take forward work on the development of a creative solution for the Glasgow City HSCP's brand identity. Glasgow City Council's Corporate Graphics Team was identified in the PID to develop the creative solution.

2.4 A subgroup of the workstream was then established to take forward this work, led by Glasgow City Council's Corporate Communications Team, with representation from communications staff from Glasgow City Council Social Work Services and NHS Greater Glasgow and Clyde (NHSGGC).

3.0 Development of Brand Identity System

3.1 Draft creative solutions with a logo were developed for the Glasgow City HSCP's brand identity in March 2015, with different fonts, colours and layouts. The draft solutions were reviewed by the Glasgow City HSCP's Joint Executive Team and staff from Glasgow City Council and NHSGGC, including corporate, health and social work communications staff. Consideration was given to accessibility in respect of colour contrast and colour blindness.

3.2 A typographic creative solution (in colour and greyscale) for the brand identity is being recommended as follows:

3.3 Appendix A and Appendix B demonstrate how the creative solution can be applied to a letterhead and report cover (these are examples; they do not represent recommended layouts, fonts and content). Both the Glasgow City Council and NHSGGC logos can also be incorporated to reflect that the Glasgow City HSCP is a partnership between the Council and the Health Board.

3.4 The recommended typographic creative solution is level AA compliant for colour contrast and colour blindness accessibility.

3.5 Approval of the creative solution for the brand identity will follow with the development of the brand identity system, where the solution will be applied across the development of a range of communication channels including:

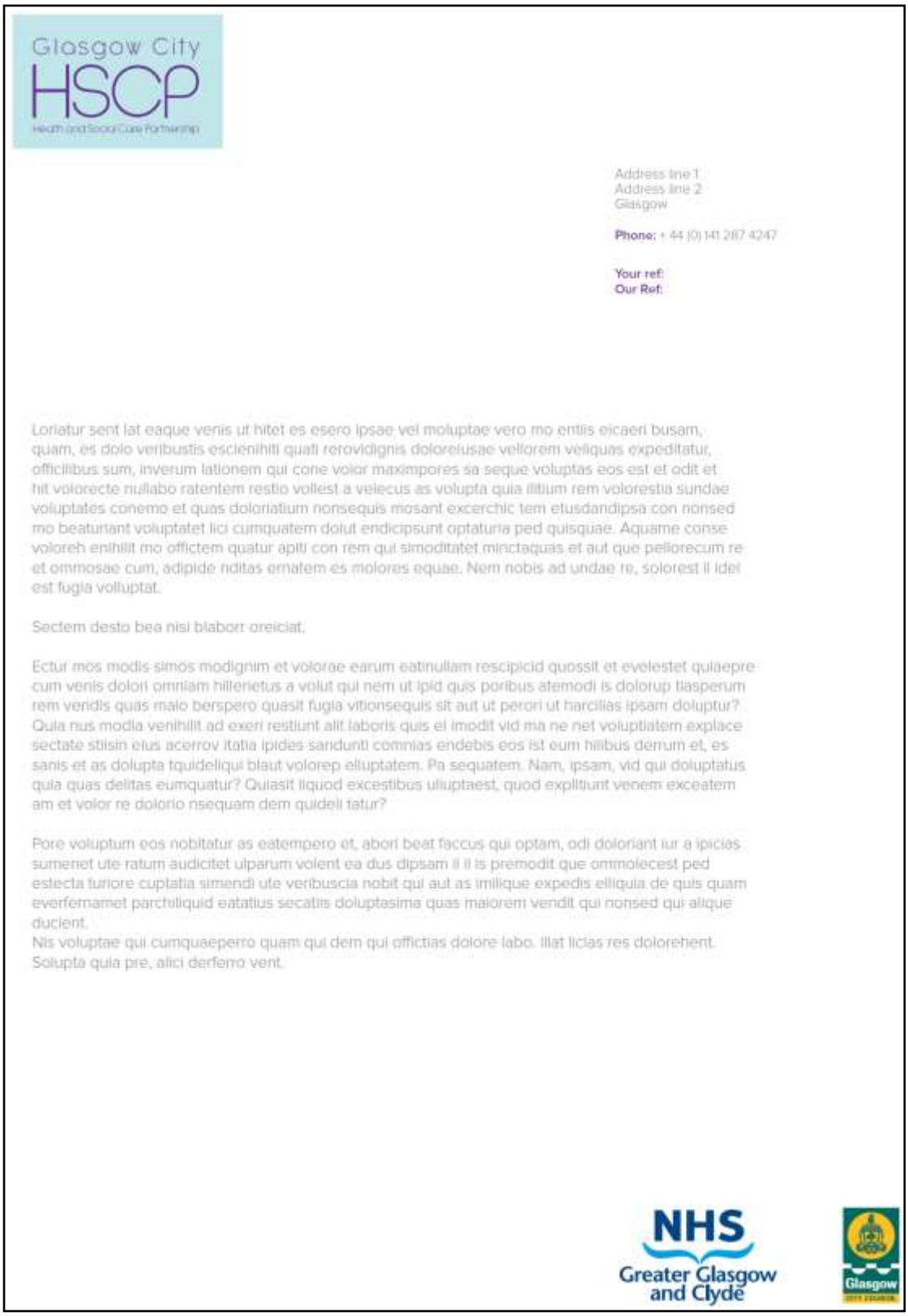
- letterhead stationery;
- report templates;
- Internet and Intranet websites;
- Chief Officer briefing;
- manager and staff briefings;
- newsletters;
- PowerPoint presentation template and
- various marketing materials (for example, pens, lanyards and leaflets).

3.6 As part of the brand identity system, guidelines will be developed to ensure consistency and compliance of the application of the creative solution. The guidelines will also take into account existing identity guidelines for Glasgow City Council and NHSGGC.

4.0 Recommendations

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

Appendix A: Letterhead Stationery Example



Appendix B: Report Cover Example

Item 7

27 May 2015

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

Report By:	Chief Officer Designate
Contact:	Allison Eccles, Head of Business Development
Tel:	0141 287 8751

PERFORMANCE MANAGEMENT

Purpose of Report:	The purpose of this report is to update the Shadow Integration Joint Board on development of a joint performance management process

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

Implications for IJB	No current implications for Shadow IJB; implications for full IJB once established are as noted below:
Financial:	Statutory annual performance report must contain financial information as outlined in Regulations
Personnel:	Staffing resource requirements to develop necessary suite of performance reports
Legal:	The Integration Joint Board has statutory responsibility for delivery on the National Health and Wellbeing Outcomes
Economic Impact:	None
Sustainability:	None
Sustainable Procurement and Article 19:	None
Equalities:	None
Implications for Glasgow City Council	Current reporting arrangements between Social Work Services and Glasgow City Council to be reviewed in development of integrated performance management arrangements
Implications for NHS Greater Glasgow & Clyde	Current reporting arrangements between Glasgow CHP and NHS Greater Glasgow and Clyde to be reviewed in development of integrated performance management arrangements

1. Purpose

1.1 The purpose of this report is to update the Shadow Integration Joint Board on development of a joint performance management process.

2. Background

2.1 The Shadow Integration Joint Board has been kept regularly updated on the development of Glasgow's Strategic Plan.

2.2 Work is ongoing via the established Strategic Planning Groups and Planning Forum to develop the Plan ready for review by the Integration Joint Board when legally established. An event has also been scheduled for Thursday 4th June 2015, 09.00 – 12.30 in the Banqueting Hall, Glasgow City Chambers to bring together all Strategic Planning Groups. This event will consider the draft Strategic Plan in its entirety, and all members of the Shadow Board have also been invited to this event.

2.3 To facilitate effective monitoring of delivery of the Strategic Plan, a performance management framework is being developed linked to the nine National Health and Wellbeing Outcomes.

3. Performance Management

3.1 Alongside development of the Strategic Plan, work is ongoing to develop an integrated Performance Management structure which can robustly evidence achievement of the statutory National Health and Wellbeing Outcomes by the Partnership.

3.2 Ahead of publication of any statutory guidance, officers have reviewed existing performance processes and indicators utilised by Social Work Services and the Glasgow Community Health Partnership and mapped these to the National Outcomes. Discussions have also been held with Heads of Localities as to the performance information required to support operational management at a local level.

3.3 The 'As Is' performance management arrangements utilised by both partners are detailed in Appendix 1 and 2. Examples of performance reports at service and care group levels are available at Appendix 3, 4 and 5. These appendices provide detail on the range of performance reporting that exist at Health Board/CHP/Corporate/Council, service, and locality levels. The Integration Joint Board, when established, will receive summary performance reports on a number of high level key indicators, in the form of a 'corporate scorecard'.

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

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

3.6 A sample of the logic model related to one of the nine National Health and Wellbeing Outcomes is available at Appendix 6. This appendix provides a description of the Outcome; high level core indicators adopted by the Scottish Government; a range of Health and Social Care Indicators that feed into the Scottish Government core indicators; example of operational workload activity from North East locality that feeds into the Social Care Indicators; and an example of Health Homelessness referrals that feeds into Health Indicators.

3.7 A paper outlining detailed proposals for Glasgow's performance management structure, including full detail of the logic model linked to all National Outcomes, will be presented to a future meeting of the Shadow Integration Joint Board for information and to the Integration Joint Board proper, once established, for approval.

3.8 It is recognised that as integration develops there may be gaps that come apparent in the performance management framework and logic model. The process will be kept under regular review and any proposed developments presented to the Integration Joint Board for information or approval as necessary.

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

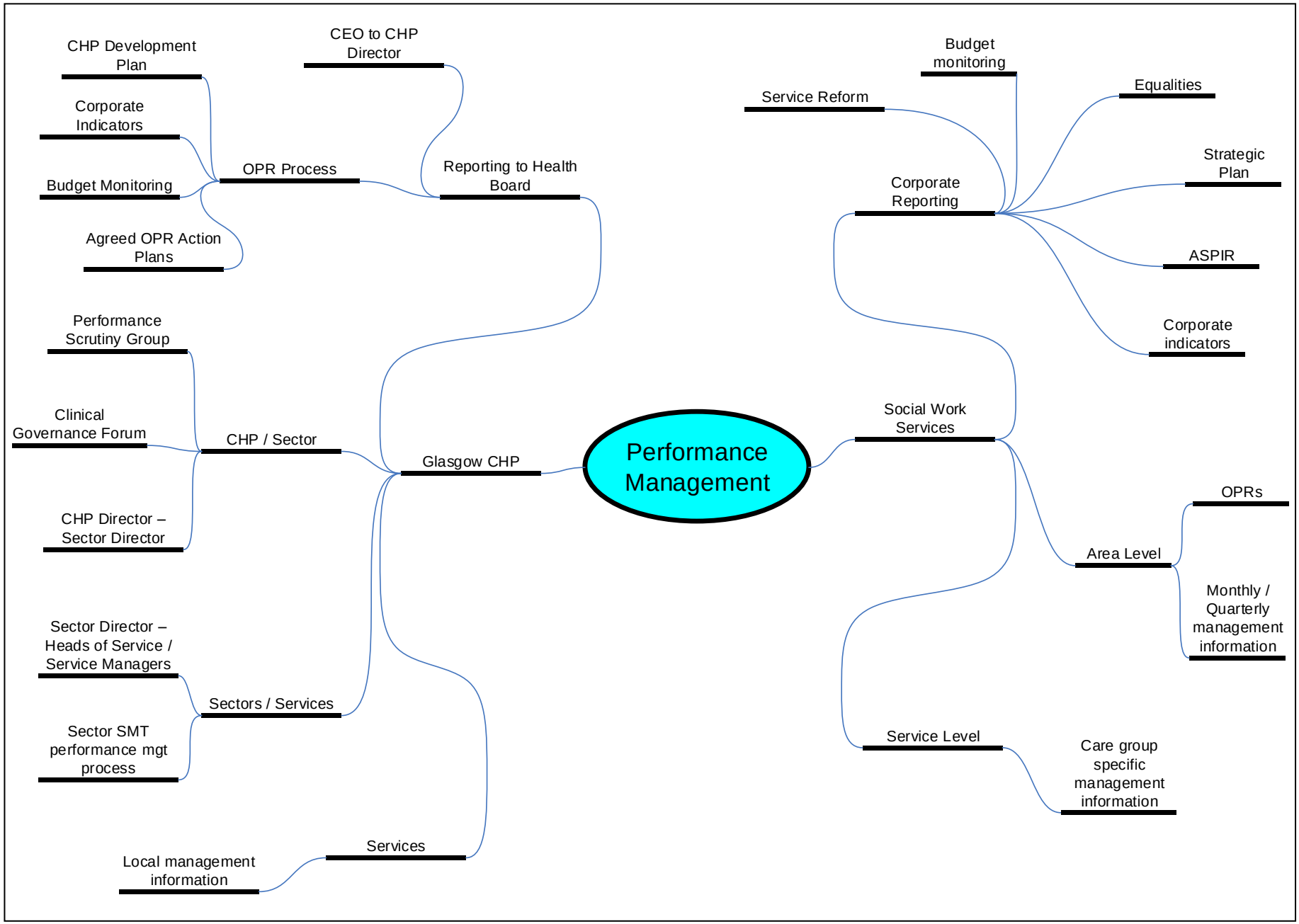
3.10 The Public Bodies (Joint Working) (Scotland) Act 2014 requires partnerships to produce an annual performance report within four months of the end of each reporting year. Statutory Guidance on the form and content of partnerships' annual performance reports is expected from Scottish Government later in 2015.

3.11 Upon publication of this guidance, Glasgow's emerging performance management framework will be reviewed to ensure that the statutory report can be produced in the format required by the Scottish Government.

4. Recommendations

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

Appendix 1 – 'As Is' Performance Management Structure



Appendix 2 – 'As Is' Performance Management Arrangements

GLASGOW HEALTH AND SOCIAL CARE PARTNERSHIP

CURRENT PERFORMANCE REVIEW ARRANGEMENTS - GLASGOW CHP

1. Health Board-CHP

At present the Health Board undertakes a six monthly Organisational Review of CH(C)Ps within Greater Glasgow and Clyde, after which it formally writes to them setting out the key actions agreed at the meeting.

The OPR meeting examines performance in relation to the following three components, relating to which the CHP is required to submit a template in advance of the meeting:

1. A review of performance in relation to a range of Performance Indicators. These include HEAT targets; KPIs set by the Board; and locally specified KPIs identified by the CHP within their Development Plan.

2. A review of evidence presented by the CHP to demonstrate that they are taking actions which are impacting upon a set of outcomes agreed at Board level. A number of such outcomes have been agreed for each of the Health Board's 6 Strategic Priorities; early intervention and preventing ill health; shifting the balance of care; reshaping care for older people; improving quality, efficiency and effectiveness; tackling inequalities; and effective organisation.

3. Progress against the actions agreed at the previous OPR meeting.

2. CHP-Sector

Performance is reviewed corporately within the CHP through the Performance Scrutiny Group. This meets two monthly. This reviews performance in relation to the following:

1. Corporate performance (using PIs which feature in OPR).

2. Financial performance

3. Development Plan delivery

4. Progress against the actions agreed at the previous OPR

5. Staff governance

6. Organisational development

7. Service improvement and quality

Clinical governance is reviewed separately through the CHP's Clinical Governance Forum.

Regular individual meetings also take place between the CHP Director and the respective sector directors.

3. Sectors-Services

Local arrangements are also in place within each sector to enable their management teams to review performance across services using the corporate performance report produced for the Performance Scrutiny Group. To complement this, a sector variation report is also produced corporately which highlights those indicators where there are the most significant variations between sectors. These may be supplemented by locally produced information from each sector.

4. Services

Services within each sector also have arrangements in place to scrutinise their performance in more detail. This varies across services and in addition to the corporate reports, may rely upon more detailed management and workforce information produced locally.

This information may also support the cross-sectoral liaison arrangements which have been established for each of the services by Directors and/or Heads of Service. These are intended to ensure effective linkages across sectors, and that the services are being delivered across the city in a consistent and co-ordinated manner.

CURRENT PERFORMANCE REVIEW ARRANGEMENTS - SOCIAL WORK SERVICES

1) Corporate / Council-wide reporting

All council services produce an Annual Service Performance and Improvement Report (ASPIR) which provides a progress report on the delivery of the Council Strategic Plan, Single Outcome Agreement (SOA) and major service priorities. The aim of the ASPIR is to review targets set for the previous year and provide contextual and statistical evidence about how well we have performed in meeting our objectives. The ASPIR also looks ahead to the next year and where necessary sets out our refreshed targets and milestones for the period. In addition, the report sets out the service's approved budget changes and savings requirements for the upcoming year.

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

As leads on the council strategic plan theme 'A City That Looks After Its Vulnerable People', Social Work reports twice per year to the Operational Delivery and Scrutiny Committee on progress towards delivery of this strategy. Other groups, such as the

Tomorrow's Glasgow Governance Group request periodic updates on delivery of this theme.

Social Work provides performance information on key areas included within the Council's 'Corporate Scorecard' on a quarterly basis.

Social Work provides input to corporate reports on other areas such as:

Attendance management
Budget monitoring
Complaints

Progress on delivery of the Social Work element of Glasgow City Council's service reform programme is reported four-weekly to the Council Management Group.

Other corporate-level performance reports are produced on an as-required basis.

2) Area / Service Level Reporting

The Organisational Performance Review (OPR) process is a 'whole systems' approach to assess how we are performing in each Social Work local area. It aims to focus on each Area's contribution to the achievement of the Social Work Services' overall objectives as set out in the ASPIR, the Service Reform programme, the Council Strategic Plan and other City-wide strategic plans.

OPRs are held for each of the three Social Work areas and Direct Services twice yearly: a mid-year OPR held in November / December and a year-end OPR held in June / July. The OPR aims to highlight good performance or progress, share good practice, and identify variations in performance and areas of concern. Where performance is below what is expected, the OPR process allows for discussion and identification of possible causes (both local and City-wide) and agreement on improvement action where necessary.

Areas, teams and care groups also receive a regular suite of reports focussing on priority issues, to support ongoing management of service delivery. These include a monthly Child Protection and Children Looked After report, reports on the last review date of individuals receiving residential and homecare, reablement performance reports etc.

Appendix 3 - Performance Report (Service Level - Social Work Services to Operational Delivery and Scrutiny Committee)

Social Work Services
Operational Delivery Scrutiny Committee
Report by Executive Director of Social Care Services Quarter 1 April to June 2014

Contact: Allison Eccles Ext: 78744

Performance Report

Social Work Services Operational Delivery Scrutiny Committee Report presents an overview of Social Work Services performance between year-end 2013/14 and the first quarter of 2014/15.

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

Green Where performance is within 2.49% of the target

Amber Where performance misses the target by between 2.5% and 4.99%

Red Where performance misses the target by 5% or more

The following key reflects the 'Golden Thread', local and national policy and performance setting out where our Performance Framework features in other frameworks:

CSI Corporate Scorecard Indicator

SPC Strategic Plan Commitment

EOI Equality Outcomes Indicator

SPI Statutory Performance Indicator

Health **A**ccess to Services and **T**reatment. This is an **HEAT Target** Improvement, **E**fficiency, internal NHS performance management system

The tables below represent the performance of areas of Social Work Services across Glasgow in relation to the service's key performance indicators:

Staffing

Measures & Links	2010-11	2011-12	2012-13	2013-14	2014-15 Q1	2014-15 Target	What this means
Sickness Absence Rate	5.65%	5.25%	5.09%	4.7%	**5.3%**	**5%**	Although we did not meet the 5% target at Q1, the long term trajectory is a decrease in absence rates as robust absence management procedures continue to have an impact.

Customer Focus

Measures & Links	2010-11	2011-12	2012-13	2013-14	2014-15 Q1	2014-15 Target	What this means
Complaints							We exceeded all our targets for handling and responding to customer comments, complaints and enquiries in Q1.
Number of comments & enquiries received	243	228	246	208	**55**	**n/a**	
Number of complaints received	446	478	516	601	**172**	**n/a**	
Total	689	706	762	809	**227**	**n/a**	
% of the total handled within 15 working days	81%	79%	84%	76%	**89%**	**70%**	
% of complaints responded to within 15 working days	73%	74%	80%	69%	**85%**	**65%**	
% of complaints responded to within 28 calendar days (statutory deadline)	89%	90%	90%	87%	**96%**	**85%**	
Elected Member Enquiries							In Q1 we provided responses to 95% of elected member enquiries within 10 days of receipt.
Number received	1,163	1,233	1,393	1,432	**416**	**n/a**	
% handled within 10 days	89%	93%	96%	95%	**95%**	**80%**	
Freedom Of Information (FOI) Requests							We met our target for FOI requests, providing responses to 95% within the statutory timescale of 20 working days.
Number of requests received	170	194	190	192	**44**	**n/a**	
% responded to within 20 working	96%	95%	96%	95%	**95%**	**90%**	
days of receipt							
DP Subject Access Requests							In Q1 we failed to meet the 80%

Measures & Links	2010-11	2011-12	2012-13	2013-14	2014-15 Q1	2014-15 Target	What this means
Number of DP Subject Access Requests received	-	-	57	125	**15**	**n/a**	target for DP Subject Access Requests.
% responded to within 40 calendar days of receipt	-	-	91%	85%	**73%**	**80%**	

Employability – Care Leavers

Measures & Links	2010-11	2011-12	2012-13	2013-14	2014-15 Q1	2014-15 Target	What this means
Percentage of young people receiving a leaving care service known to be in employment, education or training. **SPC EOI**	35%	51%	58%	65%	**63%**	**75%**	At Q1 our performance fell slightly from the position at year end however the long term trend remains in an upward trajectory.

Adult Services - Older People Reviews and Home Care

Measures & Links	2010-11	2011-12	2012-13	2013-14	2014-15 Q1	2014-15 Target	What this means
Older People Reviews							
% of older people (65+) resident in a **Purchased** Care Home placement reviewed in the last 12 Months. **CSI**	-	-	41%	**37%**	**35%**	**100%**	At the end of Q1 there were 3,091 older people in purchased care home placements. Given the large number of clients in scope for review (i.e. those who have been in care for more than 1 year) we have been developing a review model which, within current resources, offers a range of scrutiny options tailored to the needs and priority of each service user.
% of older people (65+) resident in a **Directly provided** Care Home placement reviewed in the last 6 Months. **CSI**	-	-	97%	87%	**87%**	**100%**	The figure shown is as at Q4 2013/14. Of the 564 older people in Directly provided care home placements (Q4), 72 were overdue. Of these, 66 reviews were held back to avoid duplication once residents transferred to Hawthorn House which opened in June. It is anticipated that improvement will be seen by mid-year.
% of older people (65+) receiving **home care** services reviewed in the past 12 months. **CSI**	-	-	75%	85%	**89%**	85%	In Q1 we exceeded the 85% target for reviews of older people receiving home care services. Home care reviews remain an area of focus for SWS ensuring that people receive the right level and type of service.

Adult Services – Care Homes and Delayed Discharges

11

Measures & Links	2010-11	2011-12	2012-13	2013-14	2014-15 Q1	2014-15 Target	What this means
Care Homes							
Number of Older People 65+ in long stay care home placements (includes purchased, voluntary and directly provided placements).	3,971	3,877	3,907	3,795	**3,684**	**< 4,000**	We have kept within the upper limit set for the number of older people in long stay residential care.
Delayed Discharges Number of people remaining in acute hospitals **4** weeks or more after being assessed as ready for discharge (as at figure). **HEAT Target**	0	2	6	15	9	**0**	Although our Q1 figure is disappointing, this is a reduction in the number of delayed discharges (n=15) at the mid-March census date. Performance in relation to this indicator continues to remain one of the highest priorities in SWS.

Adult Services – Personalisation

Measures & Links	2010-11	2011-12	2012-13	2013-14	2014-15 Q1	2014-15 Target	What this means
Number of *My Support Plan* eforms completed during the period	-	-	-	1,153	**309**	**2014-15 target to be confirmed**	This indicator, introduced at the start of 2013/14, is used as a measure of the roll out of personalisation. There were 39% more *My Support Plans* completed during the first quarter of 2014/15 (309) in comparison with the first quarter of 2013/14 where 223 were completed.
% of service users with personalised services taking support in the form of a Direct Payment	-	-	11%	**11%**	**13%**	**15%**	There is ongoing focus to increase the uptake of Direct Payments and although we failed to meet target in Q1, our performance has increased since year end 2013/14.

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

Measures & Links	2010-11	2011-12	2012-13	2013-14	2014-15 Q1	2014-15 Target	What this means
Carers							
Number of Carer Assessments	-	-	658	1,507	**419**	**1,000**	We are on course to exceed the annual target of 1,000 carer assessments during 2014/15.
Reablement							
Percentage of Service Users referred to Reablement Services. Target is for **all** referrals to be referred to Reablement rather than mainstream home care services.	-	-	-	57%	**52%**	**100%**	From **April 2014/15** the focus of this indicator was narrowed to new Hospital Discharge service users and community referrals only. We did not meet our target at Q1, nevertheless the 52% reablement referral rate represents a significant increase above the baseline rate of 27% (October 2013).
Adult Support and Protection							
Completed Duty to Enquire within 5 working days from referral.	-	-	53%	53%	**27%**	**90%**	We have not met the 5 and 8 day targets set for the completion of the Duty to Enquire and Completion of the ASP investigation respectively. Adult Support and Protection procedures and targets are currently being revised. From ASP referral to completion is likely to be changed to 20 days in line with Child Protection procedures.
Completed ASP Investigations within 8 working days from referral.	-	-	35%	23%	**35%**	**90%**	
Management Information							
No. of ASP referrals received	-	-	3,235	4,300	1,175*	**n/a**	*Please note that these are the Q1 figures rather than the full year figures.
	-	-	175	169	52*	**n/a**	There has been a steady increase

No. of ASP case conferences held

							in the number of ASP referrals received and this has impacted on our ability to delivery. Case conferences and review conferences represent only 4% and 2% respectively of the number of ASP referrals received during the quarter.
No. of ASP review conferences held	-	-	91	107	23*	**n/a**	

Alcohol and Drugs Services

Measures & Links	**2010-11**	**2011-12**	**2012-13**	**2013-14**	**2014-15 Q1**	**2014-15 Target**	**What this means**
Access to treatment							
% of individuals receiving appropriate drug/alcohol treatment within 21 days that supports their recovery **HEAT Target**	-	-	**81%**	**96%**	**95%* (Q4 figure)**	**90%**	**This information is reported 3 months retrospectively to the Scottish Government and as a result this indicator is reported one quarter in arrears.* At Q4 2013/14 we exceeded the National target for this indicator.
Access to treatment Management Information							
Number of individuals entering	-	-	959	907	**226**	**n/a**	These figures indicate that the

community rehabilitation							balance of care for alcohol and drugs service users is correct in that the majority now receive treatment in a community, rather than a residential setting. Complementary indicators, measuring the number of people successfully completing these services will be introduced in future and reports are currently being developed for these.
Number of individuals entering **residential support**	-	-	151	182	**17**	**n/a**	
Number of individuals entering **specialist inpatient services**	-	-	457	474	**121**	**n/a**	
Total	-	-	1,567	1,563	**364**	**n/a**	
Support for Children of parents with a substance misuse problem							
% of Parental Assessments completed (where assessment identified as being required)	-	-	-	61%	**74%**	**50%**	We met and exceeded the target in relation to the completion of parental assessments.

Criminal Justice

Measures & Links	2010-11	2011-12	2012-13	2013-14	2014-15 Q1	2014-15 Target	What this means
Community Payback Orders							
Number of new CPOs per quarter	-	412	576	695	**727**	**n/a**	The number of new CPOs per quarter has increased year on year since they were introduced in 2011.
% of work placements commenced within 7 days of sentence	-	80%	77%	67%	**66%**	**75%**	In Q1 we did not meet the target for the percentage of work placements commenced within 7 days of sentence. The slip in performance which started mid-way through 2013/14 appears to be linked to the migration of Criminal Justice staff to the new careJust database and is believed to relate mainly to data quality.

Measures & Links	2010-11	2011-12	2012-13	2013-14	2014-15 Q1	2014-15 Target	What this means
Case Management Plans							
% of CPOs with a Case Management Plan within 20 days	-	41%	59%	83%	**91%**	**75%**	We exceeded the target in relation to the proportion of clients with a case management plan within timescale.
Reviews							
	-	-	61%	59%	**56%**	**75%**	During 2013/14 performance increased significantly for this indicator. However, at year end and then again at Q1 there was
% of 3 month reviews held within timescale.							significant slippage in performance which appears to be related to the migration of CJ staff to the new careJust module. New review recording processes continue to impact on performance and this is being addressed through monthly performance meetings and briefings to Team Leaders and Service Managers.
Client Attendance Rate at review	-	69%	60%	48%	**24%**	**65%**	This indicator has been impacted in the same way as the one above. At Q2 and Q3 (2013/14) performance increased significantly (Q3, 70%). However post-migration with the accompanying change to recording procedures, performance slipped at year end and again at Q1. Sampling of review contacts identified that staff are under reporting our performance in this area. Guidance has been re-issued and performance is being monitored through monthly performance meetings and the Service

Measures & Links	2010-11	2011-12	2012-13	2013-14	2014-15 Q1	2014-15 Target	What this means
							Managers' Meeting.

Children & Families

Measures & Links	2010-11	2011-12	2012-13	2013-14	2014-15 Q1	2014-15 Target	What this means
Looked After Children							
Total number of looked after children (snapshot at end of quarter)	3,741	3,742	3,634	3,588	**3,533**	**n/a**	At the end of Q1, 2,045 children were looked after at home, and 1,488 children were looked after away from home.
Proportion of the total that are looked after at home or with family and friends.	63%	62%	60%	59%	**58%**	**60%**	We narrowly missed a green rating for this indicator. The long term trend is an increase in the

Measures & Links	2010-11	2011-12	2012-13	2013-14	2014-15 Q1	2014-15 Target	What this means
Proportion of the total that are looked after away from home.	37%	38%	40%	41%	**42%**	**40%**	proportion of children who are looked after away from home, rather than looked after at home.
Allocated (Primary) Worker							
x Looked After Children (LAC)	92%	92%	89%	92%	**93%**	**100%**	While 7% of children looked after at home (LAC) do not have a primary worker, almost all children looked after **away from home** (LAAC) do have a primary worker.
x Looked After & Accommodated Children (LAAC)	100%	100%	99%	98%	**98%**	100%	
Care Plans							
% of LAAC accommodated for 14 days or more with a completed GIRFEC assessment/child plan.	83%	82%	89%	95%	**96%**	**100%**	Although we did not meet target there has been a significant increase in performance since the launch of the GIRFEC assessment in September 2013.
Recruitment of foster carers and adoptive parents							
Number of foster carers approved during 2013/14 (including respite care and shared care)	-	50	57	68	**9**	75	At Q1 we were not on course to meet the annual target of 75, however at end of June there were a further 35 assessments underway. Our new Families for Children Foster Carer recruitment campaign, *A Career Without a Commute* has been launched recently.
Number of foster carers (includes multi-dimensional treatment, respite care and shared care)	466	490	513	612	**598**	490	At Q1 we continued to meet the target in relation to the number of foster carers.

Number of adoptive families approved	46	54	43	45	**10**	50	The annual target increased from 35 to 50 in **April 2014.** At Q1 we are not on course to meet the new annual target at year end, however, it is of note that despite this 17 children were matched during the quarter.
Permanency							
Number of LAAC aged under 5	270	266	229	206	**195**	**n/a**	The number of children under 5 who are looked after and accommodated away from home has continued to decrease.
% who have had a Permanency Review. **CSI**	57%	56%	72%	76%	**78%**	**90%**	Although this indicator remains short of target, there was further improvement since year end. The issues and challenges of this area are being tackled by increasing worker awareness and knowledge, particularly in relation to concurrency planning, and by highlighting to new staff the importance of planning timely reviews.

Children & Families – SCRA Reports

Measures & Links	2010-11	2011-12	2012-13	2013-14	2014-15 Q1	2014-15 Target	What this means
SCRA Reports							
Number of New reports (offence & non-offence based) requested by the Reporter.	1,964	2,276	1,575	608 (only Oct to March figure avail.)	**179**	**n/a**	During the first quarter of 2014/15 we continued to build on the improvement seen in 2013/14. It is anticipated that this performance will be maintained throughout 2014/15 as SCRA reports remain an important priority for Social Work Services.
% of **New** SCRA reports submitted within 20 days/on time.	46%	26%	52%	55%	**67%**	**55%**	

Children & Families – Child Protection

Measures & Links	2010-11	2011-12	2012-13	2013-14	2014-15 Q1	2014-15 Target	What this means
Child Protection Register							
Number of children on the Child Protection Register **CSI**	402 (Aug '10)	372 (Aug '11)	403	500	**455**	n/a	The number of children on the register rose sharply in the six months prior to March 2014 before falling back slightly in June (Q1).
Percentage of children on the Child Protection Register with a primary worker.	99%	100%	100%	98%	**96%**	**100%**	Despite the sharp increase in the number of children on the register, we ensured that almost all these children (96%) had a primary worker.

Homelessness

Measures & Links	2010-11	2011-12	2012-13	2013-14	2014-15 Q1	2014-15 Target	What this means
Assessments							
Number of households assessed as homeless or potentially homeless	7,383	6,297	5,937	4,974	**1,234**	**< 4,500**	Homelessness applications have reduced as a result of the provision of housing options advice and assistance, enabling many households to resolve housing difficulties without having to make an application. As a result, there has been a reduction in the number of cases which require to be assessed. A revised target of <4,500 has been proposed for **2014/15** to build on this success. Extrapolating the Q1 figure, we are not currently on track to meet the proposed new target at year end.

Number of households reassessed as homeless or potentially homeless within 12 months	356	250	153	329	**139**	**<300**	Extrapolating the Q1 figure, we are not currently on track to be below the annual upper limit of 300 at year end. The volume of Cases has been monitored on a quarterly basis, and a pattern of increase has been observed. A case analysis is being undertaken to identify and take action on any policy or practice issues which arise.
Completion of Duty SPI							
% of decision notifications issued within 28 days of initial							The reduction in performance is likely to be a consequence of the
presentation: **SPI CSI**							transition and modernisation of Homelessness Casework Services. This has been identified with local management and remedial actions are now being put in place.
x Permanent accommodation	93%	91%	91%	89%	**85%**	**95%**	
x Temporary accommodation	92%	88%	80%	77%	**52%**	**95%**	

Homelessness

Measures & Links	**2010-11**	**2011-12**	**2012-13**	**2013-14**	**2014-15 Q1**	**2014-15 Target**	**What this means**
Temporary accommodation:							
Households with pregnant women or dependent children in B&B:							
x Average length of tenancies ended	12 days	14 days	16 days	15 days	**16 days**	**10 days**	At Q1 the length of stay remains outwith the target range. A reduction is desirable to ensure that we do not have families in unsuitable accommodation for prolonged periods and it is hoped that the number of days decreases during 2014/15.

Temporary furnished accommodation:							
x Average length of tenancies ended	195 days	215 days	211 days	242 days	**229 days**	**140 days**	In terms of the average length of stay, challenges remain with the complexity of placements and availability of move on accommodation, which means the length of stay, though slightly shorter than year end 2013/14, remains much longer than desired. Support is being put in place for clients prior to securing permanent accommodation, which has an impact on the longevity of the temporary placement.

Appendix 4 – Performance Report (Care Group Level – Residential Care Reviews)

Service users aged 65+ with a current Residential care/Supported Living placement, by area, when last reviewed, as at 22nd Dec 2014.

Purchased (incl Voluntary, Other LA)

		Has review activity Completed in last year	%	Over 1 year since last Completed review activity	%	No Completed review activity	%	Sum
In residential care/supported living for 1 year or more	**North East Area**	238	**31.9 %**	495	66.4 %	12	1.6 %	**745**
	North West Area	341	**42.7 %**	450	56.4 %	7	0.9 %	**798**
	South Area	270	**33.2 %**	522	64.2 %	21	2.6 %	**813**
	Homeless	15	33.3 %	23	51.1 %	7	15.6 %	**45**
	Hospitals	12	66.7 %	6	33.3 %			**18**
	Centre	2	66.7 %			1	33.3 %	**3**
	Sum:	**878**	**36.3 %**	**1,496**	**61.8 %**	**48**	**2.0 %**	**2,422**
In residential care/supported living less than 1 year	**North East Area**	196	90.7 %	10	4.6 %	10	4.6 %	**216**
	North West Area	243	98.4 %	2	0.8 %	2	0.8 %	**247**
	South Area	228	93.4 %	8	3.3 %	8	3.3 %	**244**
	Homeless	2	33.3 %	2	33.3 %	2	33.3 %	**6**
	Hospitals	17	94.4 %	1	5.6 %			**18**
	Centre					2	100.0 %	**2**
	Sum:	**686**	**93.6 %**	**23**	**3.1 %**	**24**	**3.3 %**	**733**
	Sum:	**1,564**		**1,519**		**72**		**3,155**

Local Authority

		Has review activity Completed in last year	%	Over 1 year since last Completed review activity	%	No Completed review activity	%	Sum
In residential care/supported living for 1 year or more	North East Area	42	26.9 %	106	67.9 %	8	5.1 %	**156**
	North West Area	40	36.0 %	67	60.4 %	4	3.6 %	**111**
	South Area	45	33.6 %	87	64.9 %	2	1.5 %	**134**
	Homeless	1	50.0 %	1	50.0 %			**2**
	Hospitals	1	16.7 %	5	83.3 %			**6**
	Centre	1	100.0 %					**1**
	Sum:	**130**	**31.7 %**	**266**	**64.9 %**	**14**	**3.4 %**	**410**
In residential care/supported living less than 1 year	North East Area	58	93.5 %	2	3.2 %	2	3.2 %	**62**
	North West Area	38	95.0 %	2	5.0 %			**40**
	South Area	36	92.3 %	1	2.6 %	2	5.1 %	**39**
	Hospitals	5	100.0 %					**5**
	Sum:	**137**	**93.8 %**	**5**	**3.4 %**	**4**	**2.7 %**	**146**
	Sum:	**267**		**271**		**18**		**556**

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Appendix 5 - Performance Report, Service Level – (extract of Glasgow CHP report to CHP Committee)

1. PURPOSE OF THE REPORT
The purpose of this report is to present the latest performance information available for the CHP and/or its Sectors.

2. BACKGROUND
The latest available performance information is shown in Appendix 1 in relation to a number of performance targets and indicators. These include the current 14/15 HEAT targets and standards; targets identified at Health Board level; and other local performance indicators specified by the CHP in its wider Development Plan.

3. STRUCTURE
In Appendix 1, data when available is shown at CHP, Sector 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 the HEAT and 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:

HEAT Targets/ Key Performance Indicators
In the first section, performance is shown graphically for the HEAT targets and for those indicators which have been identified by the CHP's Performance Scrutiny Group as being areas requiring particular attention i.e. Key Performance Indicators (KPIs). This section is split into three parts based upon the classifications used within the Health Board's performance management system. 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 Other Performance Indicators (O), which have been identified locally by the CHP in its Development Plan, or specified by the Health Board. Within this section, where targets exist, performance is classified in accordance with the Health Board's performance management 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 (HEAT/KPI/Other) is summarised at the start of Appendix 1. A total of 56 indicators are included. Of these 56, 28 are GREEN, 7 are AMBER and 21 are RED.

18 of the indicators are either HEAT targets or KPIs. Of these, currently 7 are GREEN, 3 are AMBER, and 8 are RED, compared to 8 GREEN, 2 AMBER, and 8 RED in the last report to Committee. While there have been movements within categories, the only change in status is in respect to antenatal care (HT7), which moved from GREEN to AMBER and has fluctuated between these two categories over the course of the year. Performance in relation to those HEAT targets or KPIs classed as either GREEN or

RED, and actions being progressed in relation to them are summarised in sections 5 and 6 below. Full details in respect to these and all of the other performance indicators are provided in Appendix 1.

5. WHERE WE ARE DOING WELL (HEAT/KPIs)

KPI5 - To meet target of less than 20% of women smoking in pregnancy – most deprived quintile
Rates for the CHP remain GREEN and all sectors are below the Board wide average.

HT 8 - Psychological Therapies: % of people waiting over 18 weeks Referral to Treatment (RTT)
The CHP and all sectors are now GREEN. 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.

HT 9 - Rate of Emergency Admission (Unplanned) Acute Bed Days for Ages 75+
Performance against this indicator has remained GREEN and improved consistently over the course of the last year. Performance is being supported by Implementation Groups which have been established within each sector to address primary/secondary interface issues; by actions being taken to reduce length of stay and improve discharge management; and by a number of Change Fund projects aimed at reducing emergency admissions.

HT 10 - Child and Adolescent Mental Health Services
Performance against this indicator has improved over the course of the last year and all sectors remain GREEN. CAMHS is complimented in GCHP by the school based Place2be service and the Lifelink contract for 12-18 year olds. These provide resilience, talking and youth counselling components.

HT 11 - Alcohol and Drugs Waiting Times
Performance remains GREEN for alcohol and drugs individually and combined.

HT 12 - Dementia Register
Performance continues to exceed the target for the CHP as a whole, based upon the information from primary care and the nursing home practice. 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 was formally launched in June 2014, and it is expected that as awareness of the service improves, there will be a greater incentive for earlier referrals for diagnosis.

KPI 6 - Smoking in Pregnancy
Targets continuing to be met for the CHP as a whole and for the North West and South. North East remains below target.

6. KEY AREAS IN NEED OF IMPROVEMENT (HEAT/KPIs)
HT 1 - Alcohol Brief Interventions (ABIs)

Despite improvements in performance over the last two financial years, performance has deteriorated in 2014/15. It is believed that there are two main reasons for this. Firstly, the Camglen boundary change, which led to practices and associated ABI activity being attributed to Lanarkshire, without the targets being correspondingly adjusted by the Scottish Government for 2014/15. Secondly, the development of the 17c contract, which means practices are no longer required to formally report on their alcohol related activity.

Going forward, negotiations are ongoing with the national ABI team in regards to adjusting the GGC target in future years. It is likely that it will be amended to reflect the Camglen boundary changes, but to date there has been no acceptance of a shift based on the move to the 17c model. Last year 17c practices (26) contributed 15% of our overall performance. Work continues including training undertaken in November for police custody suite staff to enable them to begin to deliver ABIs to clients who enter into police custody. Glasgow Council for Alcohol has also commenced delivery of ABIs within pharmacies and are rolling this out across the city.

HT 2 and KPI 1 - Delayed Discharges and Beds Days Lost
Numbers have fluctuated throughout the year and remain above target. Senior management from Acute, Social Work, and the CHP are continuing to focus efforts upon improving performance. Actions being taken include addressing the specific issues associated with AWI delays; accelerating referral processes and pathways within the hospital; and increasing the provision of and referrals to intermediate step down care through the implementation of the Integrated Care Pathway.

HT 3 - Sickness Absence
There is an ongoing focus on absence management within the CHP. 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 in place regarding the management of their absence

KPI 2 - Bowel Screening
While remaining RED, there has been an approximate 7% increase in male screening rates since the last round, though there has been a 3% decrease for females. Locally, the CHP is continuing to implement the telephone outreach pilot to patients in SIMD 1 areas being offered bowel cancer screening for the first time. In addition, a two year national sGMS bowel screening GP Practice initiative continues, with 112 of the 152 practices (73%) in the city submitting action plans.

KPI 3 - Cervical Screening
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. The CHP also continues to input to the Board Wide Screening Group led by Emilia Crichton and respond to its recommendations.

HT4 - % able to book an appointment with a GP in advance (HEAT Standard).
As part of QOF 2014/15, 25 points are now 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. It is hoped that this will result in improvements once new data becomes available.
HT5 - **Achieve agreed Quit Rates at 3 months from the 40% most deprived areas**

This is the new HEAT target set for 2014/15 by the Scottish Government based on smoking status at 12 rather than 6 weeks post quit. At present, the data is incomplete as all data on follow ups is not yet available, given the window for follow up appointments to determine status is 12 to 16 weeks.

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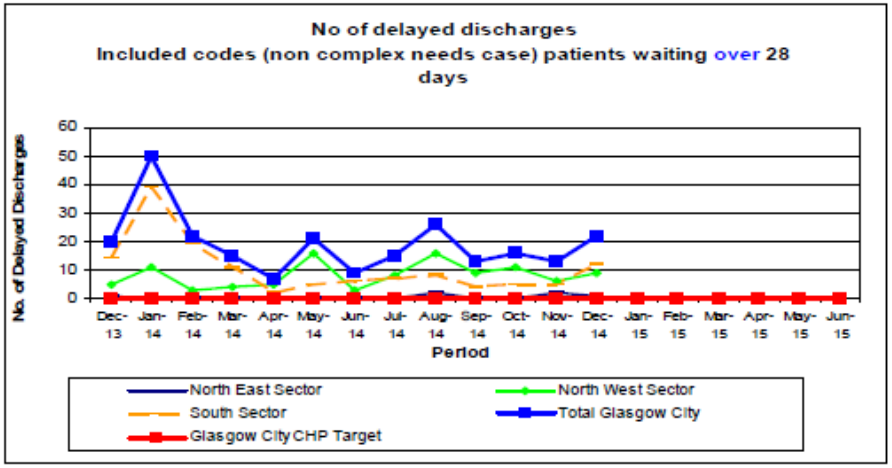
Target/Ref (HT2)	**2. No people will wait more than 4 weeks from March 2013 to be discharged from hospital into a more appropriate care setting (includes codes) (HEAT Target).**
Performance	Performance fluctuates but remains above target and classified as RED for the CHP. Variation evident across Sectors with the North East continuing to experience a significantly lower number of delayed discharges.



Delayed Discharges - Included codes (non complex needs case) patients waiting over 4 weeks

CHP	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Status
North East Sector	0 (G)	2 (R)	0 (G)	0 (G)	2 (G)	1	Red
North West	8 (R)	16 (R)	9 (R)	11 (R)	6 (R)	9	Red
South Sector	7 (R)	8 (R)	4 (R)	5 (R)	5 (R)	12	Red
Glasgow City	**15 (R)**	**26 (R)**	**13 (R)**	**16 (R)**	**13 (R)**	**22**	**Red**
Target	0	0	0				

Commentary
Senior management from Acute, Social Work, and the CHP are continuing to focus efforts upon improving the management of delayed discharges. Actions being taken include addressing the specific issues associated with AWI delays; accelerating referral processes and pathways within the hospital; and increasing the provision of and referrals to intermediate step down care through the implementation of the Integrated Care Pathway.

Appendix 6
Logic Model Thread of Outcome – Scottish Government Core Indicators – Health & Social Care Indictors – Example Operational Performance Information

People, including those with disabilities, 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.

Scottish Government Core indicators

2. Percentage of adults supported at home who agree that they are supported to live as independently as possible http://www.healthcareexperienceresults.org/

12. Emergency admission rate http://www.isdscotland.org/Health-Topics/Hospital-Care/Inpatient-and-Day-Case-Activity/

14. Percentage of adults with intensive care needs receiving care at home http://www.gov.scot/Topics/Statistics/Browse/Health/Data/CommunityCareOutcomes

15. End of Life Care http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/End-of-Life-Care/

19. Delayed discharge bed days http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Delayed- Discharges/

21. Percentage of people admitted to hospital from home during the year, who are discharged to a care home

22. Percentage of people discharged from hospital within 72 hours of being ready

National data sources with data for partnership areas

Spreadsheet containing a range of information relating to community care outcomes including Reshaping Care for Older	http://www.gov.scot/Topics/Statistics/Browse/Health/Data/CommunityCareOutcomes
Data about Free Personal and Nursing Care	http://www.gov.scot/Topics/Statistics/Browse/Health/Data/FPNC
People with Learning Disabilities	http://www.scld.org.uk/scld-projects/esay
Data about home care and direct payments	http://www.gov.scot/Topics/Statistics/Browse/Health/Data/HomeCare
Housing for Older People, those with Disabilities and those with Supported Tenancies	http://www.gov.scot/Topics/Statistics/Browse/Housing-Regeneration/HSfS/SpecialNeedsHousing
Social work eligibility criteria and waiting times	http://www.gov.scot/Topics/Statistics/Browse/Health/Data/QuarterlySurvey
Scottish House Condition Survey Local Authority tables	http://www.gov.scot/Topics/Statistics/SHCS/keyanalyses

Local data to consider

Partnerships will wish to understand many aspects of processes such as single shared assessments and use of anticipatory care including e.g. SPARRA data (http://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/SPARRA/), and discharge planning processes.

Information and improvement resources

Anticipatory Care Planning	http://www.qihub.scot.nhs.uk/quality-and-efficiency/outpatient-primary-and-community-care/primary-and-community-care-.aspx
Integrated Community Ward / Virtual Ward case studies and	http://www.knowledge.scot.nhs.uk/chin/intermediate-care.aspx
Joint Improvement Team Action Areas	http://www.jitscotland.org.uk/action-areas/
Technology Enabled Care case studies and resources	www.knowledge.scot.nhs.uk/telehealthcare.aspx

Health and Social Care Indicators

	Indicator	Area
Social Care	Percentage of service users who felt able to resume their usual activities following reablement.	Older People
Social Care	Percentage of service users who felt able to do more for themselves following reablement.	Older People
Social Care	Number of patients remaining in acute hospitals 4 weeks or more after being assessed as ready for discharge	Adult Services/ Older People
Social Care	Number of patients remaining in acute hospitals 72 hours or more after being assessed as ready for discharge	Adult Services/ Older People
Social Care	Number of service users referred to reablement service.	Adult Services/ Older People
Social Care	Number of service users completing a reablement service.	Adult Services/ Older People
Social Care	Percentage of service users completing a reablement service requiring no home care/reduced hours.	Adult Services/ Older People
Health O31	Delayed Discharge Adult Mental Health >2/4 weeks	Mental Health
Health O33	Delayed Discharge Adult Mental Health > 2/4 weeks – exception codes	Mental Health
Health O39	COPD Discharge Rates (per 100,000)	Adult Services/ Older People/PCare
Health O40	Asthma (per 100,000)	Adult Services/ Older People/PCare
Health O41	Diabetes (per 100,000)	Adult Services/ Older People/PCare
Health O42	CHD (per 100,000)	Adult Services/ Older People/PCare

	Indicator	Area
Health O43	All (per 100,000)	Adult Services/ Older People/PCare
Health HT 2 (HEAT)	Number of delayed discharges over four weeks in acute beds	Older People
Health KPI1	Number of acute bed days lost to delayed discharge (65+)	Older People
Health O44	Number of acute bed days lost to delayed discharge for adults with incapacity NB Also add in OPMH figs (65+)	Older People
Health HT 7	Rate of unplanned acute bed days (75+) - per 1,000 population	Older People
Health O45	Unplanned acute bed days (65+) - numbers and rates per 1,000 population	Older People
Health O47	Emergency admission (65+) - numbers and rates per 1,000 population	Older People
Health O48	Emergency Admissions (75+) - numbers and rates per 1,000 population	Older People
Health O49	Hospital – average length of stay	Older People
Health O50	Number of older people on anticipatory care plans	Primary Care

SOCIAL CARE OPERATIONAL PERFORMANCE MANAGEMENT

NORTH EAST: worker workload (adult services)

ABEF

summary	no.	ave. per 4 weeks
total E-FORMS completed in 2013	1	0.1
all types of E-FORMS completed in 2014 to-date	31	2.1
all types of review ACTIVITIES completed to-date in 2014	7	0.5
ot ACTIVITIES (assess, prov + pause) completed to-date in 2014		
mh ACTIVITIES (specific activities only) completed to-date in 2014		
current client to primary relationships	34	na

adult services E-FORMS	completed 2014 to-date	currently open
adult screening form		
screening/duty to enquire		
asp - investigation		
seq		
my support plan		
ssa		
risk assessment		
personalisation baseline		
personalisation est budget		
short term intervention (sti)		
review of sti		
obsp peer review		
rasg minute		
ot assessment		
ot review/closure summary		
review form		
homecare asess - generic		
homecare review (generic)		
add'tion assess (+smr25a)	14	9
impact parental sub'ce use		1
smr25b	17	3
referral		
other	0	0
total	**31**	**13**

review ACTIVITIES	completed to-date 2014	currently open
care plan	6	1
service agreement		
placement agreement		
hc emerg'cy non-assess		
hosp discharge home sup	1	
assessment		
weekly review hospital		
other	0	0
total	**7**	**1**

ot ACTIVITIES	completed to-date 2014	currently open
assess ot need		
housing assessment		
self assessment		
adaptation (other)		
adaptation (private)		
adaptation (rsl/lho)		
equip (arrange recovery)		
equip (follow up)		
structured rehab		
hold awaiting funding		
total		

mhp & awi ACTIVITIES	completed to-date 2014	currently open
renewal of guardianship		
sheriff (app w'fare guard)		
apply for cto		
cto scr		
compul'n order no restricts		
compul'n order + restricts		
transfer for treatment		
cto extension variation		
emergency detention		
short term request		
awi app la g'ship (prop...)		
awi supervise guardian		
awi welfare guardian		
total		

asp ACTIVITIES	completed to-date 2014	currently open
investigation		
implement protection plan		
review protection plan		
total		

open EVENTS	currently
open total	

north east

adult services E-FORMS	completed 2014 to-date	currently open	currently open	currently open assigned	currently open months
adult screening form		76	37	39	33
screening/duty to enquire		70	69	1	1
asp - investigation		10	9	1	2
seq		76	70	6	72
my support plan		64	61	3	61
ssa		89	68	21	69
risk assessment		189	178	11	161
personalisation baseline		66	66		66
personalisation est budget		174	167	7	173
short term intervention (sti)		18	18		9
review of sti		30	30		2
obsp peer review					
rasg minute					
ot assessment		452	452		212
ot review/closure summary		301	301		134
review form		93	89	4	88
homecare asess - generic		9	9		3
homecare review (generic)		2	2		1
add'tion assess (+smr25a)		460	344	116	118
impact parental sub'ce use		53	53		9
smr25b		105	105		41
referral		203	140	63	189
other		651	597	54	185
total		**3,191**	**2,865**	**326**	**1,629**

north east

review ACTIVITIES	completed to-date 2014	currently open	currently open and assigned	currently opened not assigned	currently open for over 12 months
care plan		907	430	477	437
service agreement		1,623	1,563	60	127
placement agreement		517	182	335	220
hc emerg'cy non-assess		22	14	8	3
hosp discharge home sup		156	148	8	3
assessment		132	100	32	5
weekly review hospital		1	1		
other		507	220	287	246
total		**3,865**	**2,658**	**1,207**	**1,041**

ot ACTIVITIES	completed to-date 2014	currently open	currently open and assigned	currently opened not assigned	currently open for over 12 months
assess ot need		811	295	516	31
housing assessment		5	4	1	
self assessment					
adaptation (other)		69	69		9
adaptation (private)		247	246	1	33
adaptation (rsl/lho)		391	391		65
equip (arrange recovery)		5	4	1	
equip (follow up)		207	206	1	27
structured rehab		1	1		
hold awaiting funding		45	45		4
total		**1,781**	**1,261**	**520**	**169**

mho & awi ACTIVITIES	completed to-date 2014	currently open	currently open and assigned	currently opened not assigned	currently open for over 12 months
renewal of guardianship		3	3		1
sheriff (app w'fare guard)		5	4	1	
apply for cto		5	5		
cto scr		3	3		
compul'n order no restricts		1		1	1
compul'n order + restricts		1	1		1
transfer for treatment		2	2		
cto extension variation		2	2		
emergency detention		1	1		
short term request		3	3		1
awi app la g'ship (prop...)		8	7	1	2
awi supervise guardian		115	94	21	31
awi welfare guardian		19	13	6	7
total		**168**	**138**	**30**	**44**

asp ACTIVITIES	completed to-date 2014	currently open	currently open and assigned	currently opened not assigned	currently open for over 12 months
investigation		3	3		
implement protection plan		7	7		4
review protection plan		4	4		
total		**14**	**14**		**4**

all ACTIVITIES	completed to-date 2014	currently open
completed to-date 2014		12,056

Health Operational Performance Management – Homelessness Referrals, discharges and contacts during quarter 3 2013-14 compared with quarter 3 2012/13

Summary Q3 2013/14	GP	HAT	HFHCT	HMHS	OT	HHN	Total
Number of unique/individual patients seen	N/A	315	N/A	206	153	160	**N/A**
New referrals by quarter	35	108	242	68	74	56	**583**
Discharges	52	78	181	84	70	118	**583**
Contacts successful	1,071	1,457	319	1,014	458	500	**4,819**
Contacts failed	0	153	172	262	100	86	**773**
Contacts cancelled	0	3	0	40	72	0	**115**
Average caseload	346	323	213	166	135	47	**1,230**
Waiting Times Urgent Routine	0	2 days 14 days	2 days 14 days	2 days 5-7 days	0 days 26 days	0	

Summary Q3 2012/2013	GP	HAT	HFHCT	HMHS	OT	HHN	Total
Number of unique/individual patients seen	**N/A**	**277**	**N/A**	**210**	**177**	**262**	**N/A**
New referrals by quarter	**55**	**116**	**266**	**75**	**57**	**216**	**785**
Discharges	**31**	**118**	**294**	**61**	**75**	**231**	**810**
Contacts successful	**980**	**2,006**	**388**	**1,180**	**642**	**1,011**	**6,207**
Contacts failed	**0**	**252**	**191**	**288**	**178**	**227**	**1,136**
Contacts cancelled	**0**	**14**	**0**	**61**	**145**	**1**	**221**
Average caseload	**283**	**434**	**148**	**172**	**163**	**94**	**1,294**
Waiting Times Urgent Routine	**0**	**2 days 14 days**	**2 days 14 days**	**2 days 5-7 days**	**2 days 36 days**	**0**	