South Glasgow

Locality Plan 2018/19

FOREWORD

This is the third Locality Plan for the South since the establishment of the Health and Social Care Partnership (HSCP) in 2016. The aim of the plan is to provide a review of the progress made in 2017/18 and to identify our priorities for 2018/19.

There are challenging times ahead both in financial terms and also in delivering improvements in our performance. As well as progressing on-going work, within the plan you will see ambitious and exciting new projects which we plan to implement in the year ahead which will improve lives and to further reduce inequalities. These include:

- completion of the £17m New Gorbals Health & Care Centre replacing the old health centre, South Bank Centre and the Two Max building. The development as well as improving services is a major contribution to the on-going regeneration of the Gorbals area;
- introducing new integrated neighbourhood teams to better support older people in the community and work more closely with GPs, third sector partners and others;
- continue to support the implementation of the Thriving Places agenda with community planning partners and local communities in Gorbals, Govan, Priesthill/Househillwood and Govanhill to improve health and well-being;
- implementing a "test of change" approach to community support where all services pull together and attend "Early Help" meetings with a solution focused approach to helping families;
- developing a community immunisation model across the South to improve childhood immunisation rates;
- implementing new alcohol and drug access team arrangements in line with the realignment of team locations across the South; and,
- review links between Primary Care Mental Health Teams, Community Mental Health Teams and GP practices to identify a link with each cluster.

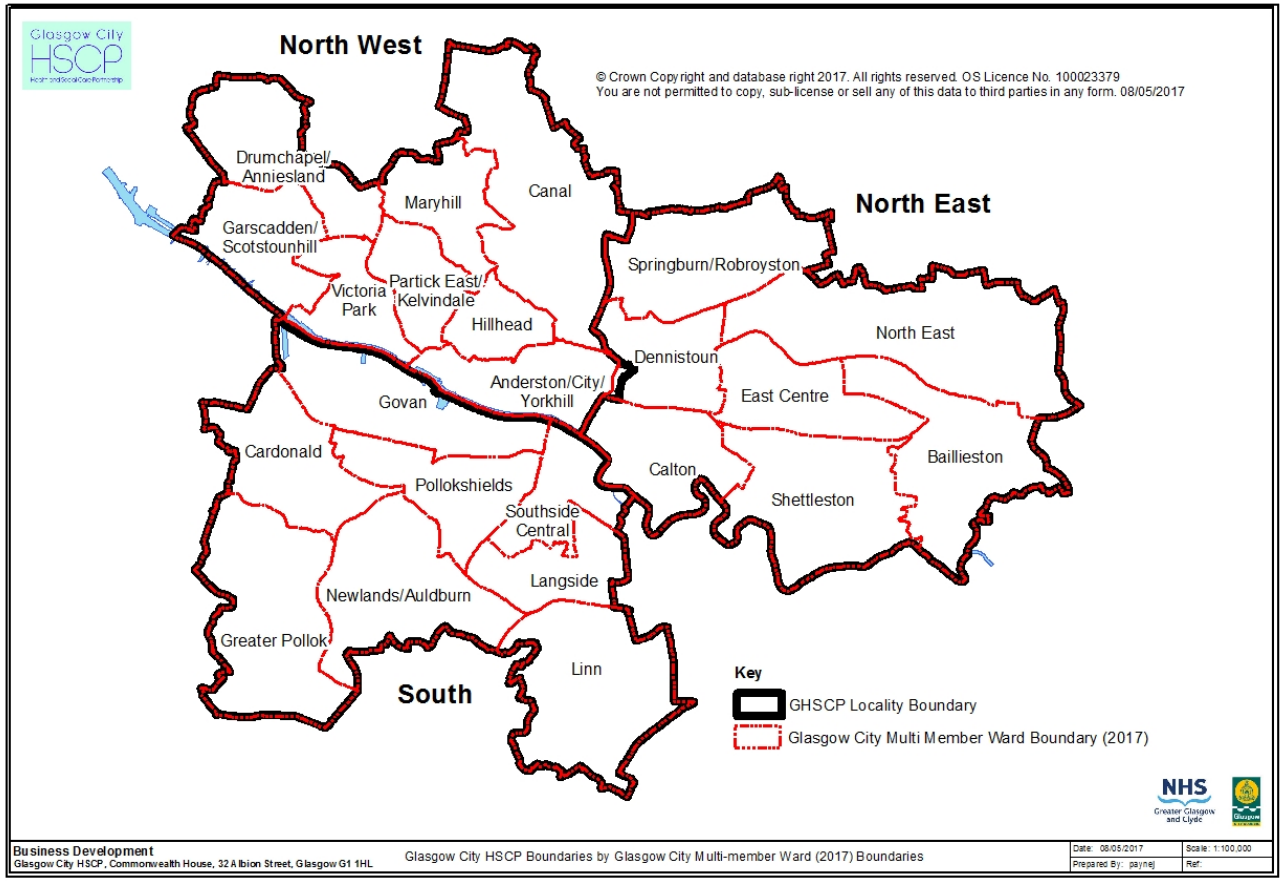
This plan for 2018/19 highlights the challenges we face in the South in taking forward this agenda, the key issues for users and carers, and the actions we are going to take over the course of the year to implement the HSCP's Strategic Plan and respond to local needs. We are keen to build on the first year of our status as an integrated organisation, working closely with our partners, local communities and organisations.

Stephen Fitzpatrick
Assistant Chief Officer (Older People & South Locality)
Glasgow City HSCP

1. INTRODUCTION

Health & Social Care Partnership Strategic Plan 2016-19

Glasgow City Integration Joint Board (IJB) came into being in February 2016 and in March that year the Board endorsed a three year Strategic Plan for the period up to 2019 (see https://www.glasgow.gov.uk/index.aspx?articleid=19044). In that Plan the IJB set out its vision for health and social care services - that the City's people can flourish, with access to health and social care support when they need it. The IJB envisaged that this would be achieved by transforming health and social care services for better lives. This Locality Plan shows how we intend to implement that plan in the South of the City. The figure below shows the three localities in Glasgow, and the areas covered.



2. OUR KEY PRIORITIES

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

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

In the HSCP localities are an important part of our integration arrangements to improve the delivery of health and social care services for the people of Glasgow. We have agreed three localities in Glasgow as shown above. A key responsibility of localities is to produce a locality plan for the area they serve. This document is the locality plan for South Glasgow for 2017/18. In last year's plan we gave a profile of the locality and the services we provide. Similar plans are also available for the North East and the North West.

The purpose of this plan is to:

- show how we will implement the HSCP's Strategic Plan 2016-2019 in the South of the city, and what this will mean for service users, patients and local communities; and
- how we will respond to local needs and issues.

The plan is a one year plan covering the period April 2018 to March 2019. The plan is based on:

- what we know about health and social care needs and demands and any changes from the 2017/18 plan;
- our current performance against key targets;
- the key service priorities as defined in the HSCP's Strategic Plan, including health improvement and what we are doing to tackle inequalities; and,
- the resources we have available including staff and accommodation.

We will report later in the year on how we are doing in implementing the plan and identify further areas of improvement for next year's plan. If you have any comments on this plan, let us know.

3. COMMUNITY ENGAGEMENT – LOCALITY ENGAGEMENT FORUM

Glasgow City Health and Social Care Partnership has a Participation and Engagement Strategy that sets out the principles and approach to engaging individuals, groups and communities in service planning and development for community health and social care services. Each locality has its' own arrangements to meet this commitment. South locality launched its' Locality Engagement Model in April 2017 at an event attended by 60 local groups, organisations and community representatives. The model consists of three key strands:

1. A Locality Engagement Network of individuals, community representatives, groups and organisations with an interest in local health and care services. The Network has produced three Locality Engagement Bulletins sharing news and information about health and social care services in the South and wider HSCP. The bulletin also highlights services provided by local groups and projects. It is circulated to 350 Network members in South Locality and is also available on the HSCP website.

2. A programme of feedback and engagement activities that enable people using HSCP services to share their experience at the point of access. This includes support for citywide consultation and engagement opportunities. Support is provided to frontline staff to enable them to develop feedback opportunities, consultations and user involvement activities.

3. A series of Locality Engagement Forum meetings bringing together users, carers and community organisations with experience of particular care groups or HSCP services. The forums have helped plan and deliver four public engagement sessions and over 180 people participated in one or more of these session in 2017/2018. Participants gave feedback on a range of health and social care issues including;

    - Treatment Room services
    - Occupational Therapy Services
    - Palliative and end of life care
    - Access to interpreting and translation services
    - Pathways into health and social care
    - Community views on the new Gorbals Health and Social Care Centre
    - Support services for older people in the community
    - A new neighbourhood model for Older People's Services
    - Creation of a Suicide Safer Community in South Glasgow
    - A new model for adult mental health services in Glasgow

    Key messages from these sessions included;

- An understanding amongst the wider public of why we need to review how we deliver services and make them fit for the future
- HSCP must communicate better and at the earliest opportunity with patients, users, carers and third sector partners
- HSCP should work more closely with community planning partners to ensure better communication and joined up decision making
- Person centred care needs to remain at the heart of all decision making in spite of the financial and other challenges facing public services

The HSCP is committed to listening to a wide range of user, carer and public views and feedback, comments, concerns, ideas and suggestions are used to inform future service planning and delivery. Key locality engagement priorities for 2018 include:

- Continue to grow the Locality Engagement Network
- Deliver a further three public engagement sessions in partnership with members of the Locality Engagement Forums
- Create opportunities for people to share their views on key HSCP plans and priorities including:

    - review of Out of Hours services
    - primary Care Improvement Plan
    - Moving Forward Together Programme
    - HSCP Strategic Plan, and,
    - HSCP Locality Plan

To find out more about our South locality engagement arrangements please contact: Lisa Martin, Community Engagement officer (South Locality) on 0141 427 8300.

4. PERFORMANCE INFORMATION

This section summaries our performance against key targets and indicators. There are a number where we need to make improvements in 2018/19 and these are included in the action plans that follow.

Where We Are Performing Well
Percentage of Older People who go home after a stay in Intermediate Care
Compliance with Older People - Prescribing Costs: Compliance with Formulary Preferred List.
Older People - Prescribing Costs: Annualised cost per weighted list size.
Number of new carers identified that have gone on to receive a carers support plan or young carer statement
Percentage of Health Plan Indicators allocated by Health Visitors within 24 weeks
Number of referrals being made to Healthier, Wealthier Children Service
Percentage of children and young people who accessed specialist Child and Adolescent Mental Health Services within 18 weeks of referral
Percentage of people who started treatment within 18 weeks of referral to Psychological Therapies:
Percentage of people commencing alcohol or drug treatment within 3 weeks of referral.
Percentage of Parental Assessments for people accessing alcohol or drug services completed within 30 days of referral.
Percentage of people who initiated a drug or alcohol recovery plan following assessment
Percentage of criminal justice community placement orders (CPO) with a 3 month review within agreed timescale
Percentage of Unpaid Work (UPW) requirements completed within timescale.
Percentage of post sentence interviews held within one day of release from prison.
Number of women smoking in pregnancy.
Number of women exclusively breastfeeding at 6-8 weeks.

Where improvement is required
Percentage of older people (65+) within care homes reviewed in the last 12 months.
Percentage of service users leaving the service following re-ablement with no further period of homecare
Meeting delayed discharge targets for people (i.e. discharge within 72 hours of being assessed as ready for discharge)
Primary Care - Flu Immunisation Rates
Percentage of children receiving ready to learn assessment (27 to 33 months assessment)
Percentage of looked after and accommodated children aged under 5 who have had a permanency review (who have been looked after for 6 months or more).
Percentage of new SCRA reports submitted within 20 days/on time.
Percentage of young people receiving an aftercare service who are known to be in employment, education or training.

Where improvement is required
Length of Stay within Short Stay Adult Mental Health wards
Meeting the target timescales for assessing all unintentionally homeless applications
Percentage of Community Payback Order (CPO) unpaid work placements commenced within 7 days of sentence.
Percentage of Community Payback Orders (CPO) with a Case Management Plan within 20 days.
Percentage of Criminal Justice Social Work Reports (CJSWR) submitted to court within the timeframe
Alcohol Brief Interventions undertaken
Smoking Quit Rates at 3 months in our most deprived areas .
Women exclusively breastfeeding: 6-8 weeks in the most deprived area.

SERVICE PRIORITIES – Review of 2017/18 and Targets for 2018/19

Primary Care

Priority	Key Actions	Progress 2017/18	Target 2018/19
Improving GP Premises All GP surgery premises assessed as being compliant with agreed standards.	• Work with the GP practices concerned to agree plans for improvement.	New premises for Arden still to be identified. Butterbiggins MC applying for funding to upgrade premises	Continue to support
New GP Contract Taking forward the formation of GP clusters using a "bottom up" approach, and identifying GP Practice Quality Leads and GP Cluster Quality Leads.	• Continued support and facilitation to agree GP clusters and quality leads	7 GP Clusters identified with a CQL identified for each cluster 1 PQL for each practice identified (51)	Engagement sessions planned for key stakeholders for information and comment for Primary care Improvement Plan (PCIP). 1st July 2018
	• Development sessions set up with CQLs and LET to discuss services in clusters and training and development for CQLs	3 CQL development sessions taken place QI training taken place with additional available as required	CQL/LET sessions to continue. Now to be held monthly while working on the PCIP
Anticipatory Care Plans Introduction of anticipatory care plans within GP practices to support management of patients at risk of admission.	• Work with practices to support continual improvement of anticipatory care plans	ACPs are identified as a priority for clusters	Continue to work with practices to increase the number of ACPs.
Primary/Secondary Care Interface Develop a local clinical interface between primary and secondary care to support the HSCP's plans for unscheduled care and implementation of the Clinical Services Strategy.	• Discuss with clinical leads, to further develop the interface • Monitor rates of new A&E attendances by GP referral to improve management of unscheduled care	Acute/ primary care interface group created to link with QEUH. Acute rep identified for GP committee – as required	Meetings now set up with CDs in QEUH and GPs that use their services.

Priority	Key Actions	Progress 2017/18	Target 2018/19
Improved Healthy Life Expectancy for Men & Women Support the delivery and development of Community Orientated Primary Care within East Pollokshields.	• COPC to be introduced in East Pollokshields • Improve health of the population by encouraging more social prescribing using Sole Riders, Walking Groups and Urban roots.	COPC is in place, group meet 6 weekly to discuss areas of concern Diabetes collaborative established 18 families identified. Work underway to co-produce a culturally appropriate self-management & prevention plan GPs now using green care prescribing with a case study approach adopted	To further develop the social care and green care prescribing agenda. Progress the development of the Diabetes Collaborative in conjunction with local families, HSCP and third sector organisations. Continue to work with partners to address oral health agenda within Govanhill.
EU Care and Support to Govanhill GP Practices Continue to support GPs in Govanhill, and other areas, in registering patients where there is a need for specific support such as interpreting services through agreed action plan	• Continued discussion with GPs and others to address issues as they arise, and implement the agreed action plan	Govanhill Primary Care Action Plan has improved access to Roma/Slovak interpreters. Govanhill practices meet regularly with interpreting services and attend their management reference group.	Continue working to support GPs in Govanhill
	• Community Orientated Primary Care model established within Govanhill	COPC established and meeting on a 6 weekly basis, priorities identified	Continuing with 3 Community Link Workers agreed, 1 for each of the Govanhill GP practices.
Govan SHIP The HSCP will continue to support sharing the learning form the SHIP project, subject to available resources.	• Continue to monitor and evaluate outcomes and disseminate learning. • Explore how the components of the model can be implemented in line with HSCP and the new GP contract developments.	Tested inclusion of Pharmacist and MSK physio in MDT. Funding secured for first 6 months of 2018/19. Alternative plan is being developed in line with existing funding. All 2017/18 targets delivered Mental Health work stream is now underway	Continued delivery across key areas including Additional GP time, structured MDT working, including social work and effective utilisation of new MSK Physiotherapy and Pharmacy resources Complete communications plan, evaluation and exit plan including transition into the primary care implementation plan. Finalise and implement action plans for the newer mental health work stream

Priority	Key Actions	Progress 2017/18	Target 2018/19
New Residential Care Unit Building good links and communication with new unit Orchard Grove. Building similar links for Leithland.	• Set up group to look at opportunities to improve service delivery • Share learning from Orchard Grove	Completed for Orchard Grove. Leithland Unit has been delayed; estimated date of completion Mar 19	Continue to build links between the unit and services and identify opportunities for service improvement.
Screening We will work with GPs to improve screening uptake rates for cervical screening and bowel screening	• Cervical and bowel screening sessions delivered within GP practices with low uptake by HI team	Included in Practice Activity Reports. Raised at locality meetings and PLT Learning from delivery within practices to inform a community based approach to screening promotion and awareness.	Focusing on GP practices with low uptake rates as well as those practices with high SIMD 1& 2 patients.
Improving Access	• Promote greater use of Community Pharmacy Minor Ailment service	Community Pharmacy information leaflets developed and translated into alternative languages commonly used within Govanhill	Review and monitor
	• Optometrist as first point of contact for eye problems being promoted.	Poster developed and distributed to all GP practices and pharmacies	Review and monitor
	• Promote use of other services before accessing GP	Know Who to Turn To Posters displayed in all practices, dentists and local libraries Peer learning event has taken place around redirection to the most appropriate service.	Redirection/signposting training to be delivered to reception staff, GPs and practice managers.
Support Sustainable General Practice	• Better use of all members of the primary care teams	Smaller, vulnerable practices identified, resilience sessions undertaken. Making the most of your practice leaflets distributed and displayed in practices	Build on work to support smaller practices.
Prescribing We will continue to work with Prescribers and local community Pharmacists to deliver the safe, cost effective patient centred use of medicines in Primary Care.	• Delivery of Prescribing action plan in conjunction with GP Clusters, the prescribing forum and individual GP practices	As of end November 2017 Glasgow South shows an overspend of 1.8%. This is being driven by price increase of specific medicines that have been subject to shortages or delayed patent expiry issues. For 17/18 a risk sharing agreement exists between GG&C HSPCs and HB to cover associated	Core themes to be progressed in 2018/19 as part of South Prescribing Action Plan are: • prescribing budget spend; • prescribing indicator improvement

Priority	Key Actions	Progress 2017/18	Target 2018/19
		overspend South continues to show overall progress with key prescribing indicators	
Prescribing Lead on the delivery of the GMS 2018 contract pharmacotherapy service as part of the Primary Care Improvement Plan	• Develop the prioritization schedule for implementation across practices in GS • Recruit and develop the workforce to deliver the service • Engage & communicate with all appropriate stakeholders regarding progress	By end of march 2018 GS will have pharmacotherapy service –like enhanced pharmacy input in 16 practices These are implemented under the Primary Care Investment funding for 16/17 and 17/18	Implementation of next phase of pharmacotherapy resources as allocated

Carers

Priority	Key Actions	Progress 2017/18	Target 2018/19
Continue to raise awareness of adult carers and promote the single point of access within the health and social care teams	• Identification of new Carers • Training and awareness raising to staff • Increase in carers referrals from primary care	All targets met, increase in referrals from primary care to 24% in 17/18. Test of change exercise currently underway at QEUH with surgery each Wednesday afternoon.	Continuation of implementation of different parts of carers act, monitor and evaluate compliance levels and effectiveness via locality reporting and operational quarterly and annual carers reporting structure via IJB
Continue to identify and support young carers through a family based approach	• Training around Young Carers • Links with Education partners • 300 new adult carers by March 2017 • Asset and outcome based training to be delivered by September 2016	All training targets for South HSCP staff met during 2017. South YC Education Worker has prepared an information/working pack for Education pathway.	Continue to review and monitor

	• Staff training and awareness raising on-going		

Children & Families

Priority	Key Actions	Progress 2017/18	Target 2018/19
Keeping Children Safe			
Children and young people living in the South of the city should be free from the risk of Child Sexual Exploitation (CSE).	CSE Community Engagement model to increase awareness of CSE amongst our communities and partner agencies.	To be reviewed bi-monthly at the South Child Protection Forum.	March 2019.
Healthy and Resilient Children			
Children's primary immunisations are delivered in a safe, efficient and effective way.	To develop a community immunisation model across the South locality	Phased approach to implementation, enabling a safe transition to complete locality cover.	March 2019
School nursing services are to be reviewed across the city.	South HSCP will contribute to and support review of service.	As per review recommendations.	March 2019
Teenage pregnancy rates across neighbourhoods in the South locality are to be explored.	Analysis of variance in teenage pregnancy rates across South neighbourhoods to be undertaken.	Progress reviewed bi-monthly at South Locality Planning group.	December 2018
Children under the age of 5 years will be offered additional assessments in line with the National Practice Model.	Implementation of the Universal Health Visiting Pathway.	Progress reviewed bi-monthly at South Locality Planning Group.	December 2018
Family Support and Early Intervention			
Early Years Joint Support Teams (EY-JST's) will	Validated self-evaluation exercise to be undertaken with	Progress to be reviewed bi-monthly at South Locality Planning Group.	March 2019.

Priority	Key Actions	Progress 2017/18	Target 2018/19
continue to provide co-ordinated early help for pre-school children living in the most deprived neighbourhoods in the South of the city.	the Pollok and Gorbals EY-JST's (Govan complete 2017).		
Families who do not require statutory support from social care, can access a range of preventative third sector services.	Financial investment to be secured which ensures that families living in the South of the city can access necessary third sector support which is proportionate with families living in other areas of the city.	Progress to be reviewed bi-monthly at South Locality Planning Group.	March 2019.
Services supporting children and families living in the South of the city can accurately signpost families to appropriate support services.	Mapping exercise to determine range of third sector support services both in specific neighbourhoods and across the South locality.	Progress to be reviewed bi-monthly at South Locality Planning Group.	October 2018.
Raise Attainment and Achievement for All			
Children and young people living in the South of the city are supported to overcome barriers which prevent them being able to learn.	Children's services in the South locality will ensure a co-ordinated and planned response to the delivery of supports achieved through the Pupil Equity Fund.	To be reviewed bi-monthly at the South Locality Planning Group.	March 2019
Care Experienced Children and Young People			
Children and young people from the South of the city who require to be looked after and accommodated by the local authority can expect to remain living in the city and maintain	We will further reduce the number of South children living out with the city by 10%.	To be reviewed monthly by Service Manager (Social Care).	March 2019.

Priority	Key Actions	Progress 2017/18	Target 2018/19
connections important to them.			
Transforming Glasgow – prevention through Early help			
Families living in the South of the city will receive services from the HSCP that are located within their communities.	A review of accommodation across the South HSCP will determine opportunities for co-location and effective delivery of HSCP Children's Services.	Progress will be regularly reviewed, with a staged approach to co-location.	December 2018
Families requiring support from social care can expect a service that is prompt, respectful and meets their needs.	Children's social care services in the South locality will replace the current Duty model with an Early Help service designed to work alongside families to meet their support needs.	Progress to be reviewed bi-monthly at the South Locality Planning Group.	Implementation March 2018 – progress update to be completed March 2019.
Families requiring support will receive a co-ordinated response that is tailored to meet their individual needs.	Neighbourhood HSCP will implement a "test of change" approach to community support – where all services pull together and attend "Early Help" meetings with a solution focused approach to helping families.	Test of change will commence after accommodation review and HSCP services are co-located in neighbourhoods.	Test of change not likely to commence until March 2019. Priority for 2019/2020.
Children and families living the in Govan area will receive a community-based Early Help approach to supporting them.	Govan SHIP is a multi-agency Early Help model which considers the needs of vulnerable families registered with 3 GP practices in the Govan area.	Review currently on-going.	October 2018
Children and families living in the Govan area will be meaningfully consulted in relation to disadvantage, and	NSPCC, in partnership with South HSCP will deliver the NSPCC "Together for Childhood" model of community	To be reviewed quarterly at NSPCC Together for Childhood forums chaired by HSCP South Head of Children's Services.	March 2022 – 5 year programme

Priority	Key Actions	Progress 2017/18	Target 2018/19
supports delivered accordingly.	partnership and sustainable change.		
Welcoming Diversity and Tackling Inequality			
Children residing in communities whom did not receive immunisations in their country of origin will be immunised up to the age of 12.	Community immunisation clinics focusing on incomplete childhood vaccinations will deliver a needs-led response.	Progress to be reviewed bi-monthly at the South Locality Planning Group.	December 2018
Children and their families can expect a service that is sensitive and responsive to cultural diversity.	"Cultural competence" training will be delivered to HSCP frontline workers.	Progress to be reviewed bi-monthly at the South Locality Planning Group.	March 2019

Adult Services including addictions, adult mental health and learning disability

Priority	Key Actions	Progress 2017/18	Target 2018/19
Focus on and develop service capacity particularly in relation to prevention and early intervention support Implement the changes to Learning Disability Out of Hours Service in line with GG&C strategy recommendations.	• Progress through the learning disability planning group. • Review changes and adherence to strategy recommendations	Implementation complete – CPN Out of Hours Service now providing this role. Reviewed no issues 345 contacts in 2017	
Review adult mental health	• Review pathway at locality	Updated pathway implemented;	Review the admission/discharge

Priority	Key Actions	Progress 2017/18	Target 2018/19
patient pathway between hospital and community with health and social work interventions to optimise admission and discharge planning, including improving delayed discharge performance for adult mental health and learning disability.	planning groups. • Scrutiny of delayed discharges at operational management level on weekly basis	feedback resulted in amendments (completed April 18) Discharge co-ordinator role created to focus on 3 month plus admissions; early indications are this role in conjunction with the bed manager and updated pathways are positive impact on reducing delays.	pathway to support the aim of ensuring that movement through the pathway is managed as efficiently as possible. Further develop the role of the Discharge co-ordinator to support the admission/discharge pathway work and to support more efficient discharge planning.
Complete a self-assessment against the Adult Mental Health Community Services Framework requirements for all community mental health services across South Glasgow.	• Benchmark against the Mental Health Community Services Framework and identify actions to achieve any unmet standards.	Framework implemented, focus now on monitoring of standards.	On-going and continue to monitor standards
Review links between Primary care Mental Health Teams and Community Mental Health Teams with GP practices	• On-going monitoring and review • Establish links with GP clusters	Initial work has been via Govan SHIP project. Agreement to identify a link CPNs to clusters.	Agreed Primary Care MH team point of contact for each cluster; support and information re referrals to MH network.
Access to psychological therapies	• Maintain patients seen within 18 weeks performance • Improve percentage of first referrals seen within 28 days.	Quarter 3 17/18 achieving 95.9% (target 90%)	Maintain psychological therapies 18 weeks performance, and improve percentage of first referrals seen within 28 days.
Update patient information systems	• EMIS implementation within In-patient Services.	New work for 18/19	As part of the system wide programme of work, commence the roll out of EMIS to in-patient areas.
Implement new alcohol and drug access team arrangements in line with the geographical realignment of	• Implement through addictions management team arrangements	Completed, new arrangements reviewed Jan 18.	Maintain strong links with Community Recovery Hub and South Community Recovery Network (SCRN)

Priority	Key Actions	Progress 2017/18	Target 2018/19
team locations across South Glasgow.			Support SCRN to develop and expand volunteer programme with assistance of Recovery Co-ordinator Continue to provide link worker to South Community Recovery Hub to ensure continued movement between services
Deliver services that are safe, efficient, effective and value for money Increase numbers of staff trained in adult support and protection and strengthen joint approach across health and social care staff.	• Progress through adult services management team meetings. • Review performance information re staff training	Mandatory Learn-pro module for all in-patient staff, good uptake of monthly training targeted at second worker training for NHS staff. Additional sessions developed as required.	On-going as 17/18
Implement the recommendations of the Community Addiction Team review across south Glasgow.	• Implementation taken forward by addictions management team	Staged delivery of the review recommendation, Access and Shared Care concluded and reviewed.	Complete
Participate in the work of the Learning Disability Tier 4 redesign process.	• Taken forward by city-wide learning disability planning group. • Work led by North East Glasgow	Review Group convened to develop options for supported living models and on-going work with local care providers to reduce delayed discharges.	On-going
Consider options for learning disability day care provision for the South.	• Taken forward by city-wide learning disability planning group. • Work led by North East Glasgow	Significant investment in the fabric of day service; business case developed to prioritise a new build in North Glasgow. South LD day services will continue as is for the forthcoming period Work commenced in relation to an integrated service model for CLDT; consultation is commencing 27th March 18.	Continue to link in with city-wide LD Planning Group. Follow up output of consultation
Work with third sector care	• Processed through the adult	Addictions New Community recovery	On-going

Priority	Key Actions	Progress 2017/18	Target 2018/19
providers, Commissioning and Finance to meet the challenges of rising costs of social care particularly in 24 hour services.	services management team	hubs established through commissioning with quarterly monitoring. About to undertake a re-commissioning of residential services	
Planning for the Future Ensure a shared understanding of the approach, process and inputs, delivery and outcomes of the roll out of personalisation within adult services, including increased numbers taking support in form of direct payment.	• Progressed through adult services management team meeting, locality planning groups and forums.	Work in relation to sleepovers due to the implementation the Scottish Living Wage is now complete. Direct payments continue to be consistently static around 15% in line with the rest of the City.	
Develop a contingency response procedure for replacement care if a Provider exits the social care market – all care groups	• Processed through service modernisation and commissioning	Contingency planning continually refreshed and updated as appropriate. This has not been required as the market has held stable and preventative actions have been successful.	On-going
Recovery programme Rebalanced relationship with alcohol and reduced drug use: Support the implementation of the Single Outcome Agreement for Alcohol and the Alcohol & Drug Partnership Strategy	• Contribute to community recovery within South Locality and further develop & deliver South Locality 'Recovery with Rangers' and 'Recovery with the Citizens' programmes. • Implementation of Single Outcome Agreement actions by March 2017	Delivery and evaluation of phase 1 of pilot programme integrating RWR, rowing, photography, cookery and swimming under the banner of South Health Addictions Recovery Programme (SHARP). SVQ3 Placement engaged with Portfolio 1 through Elevate Glasgow	Contribute to community recovery within South Locality, including ELEVATE- Glasgow and further develop & deliver South Health Addictions Recovery Programme (SHARP).
Roll out recovery training for all alcohol and drug service staff to ensure service is recovery orientated in line with review recommendations and ADP outcomes measures.	• Roll out to be overseen by locality addictions group.	South Recovery Matters training concluded. South Alcohol and Drug Service launched 2017, review identified development work with staff re recovery.	Take forward development work identified in review

Priority	Key Actions	Progress 2017/18	Target 2018/19
Improve mental wellbeing and resilience Implement the recommendations in the Mental Health Framework	• Delivery of community based stress service for adults and young people through the Lifelink Contracts.	Adult contract is on course to deliver against its annual targets	Delivery of community based stress service for adults and young people through the Lifelink Contracts.
	• Build capacity for Peer Mentoring approaches through local Mental Health Support networks.	platForum produced a research report on Peer Support. Further developments are dependent on on-going support to platForum and city-wide 5 year strategy	On-going
	• Build capacity of staff and third sector organisations through delivery of MH Training i.e. Seasons for Growth, Assist, Safe Talk and Suicide Prevention.	SMHFA training is planned for second half of financial year.	Continue to work with staff and third sector organisations. Develop Suicide Safer Communities Form for South Locality
	• Consider in depth training for contracted third sector organisations engaging with patients who have severe and enduring mental health issues.	Review outcome of activity and report on proposals for 2017/18	Implement proposals
Improve access to addiction treatment and care	• Introduce 'Access Teams' within existing alcohol and drugs community services to improve assessment and access to appropriate services.	Completed	N/A
	• Focus on more intensive, shorter-term interventions to maximise the opportunities for recovery.	Achieved 90% of clients commencing alcohol or drug treatment within 3 weeks of referral Recovery plans in place within 21 days of commencing treatment	Maintain performance
	• Establish presence of "lived experience" representation along with recovery hubs within Access Teams to support individuals not requiring/eligible for formal Care and Treatment provision.	Peer volunteers spend time within the teams every week	Continue to support peer volunteers

Priority	Key Actions	Progress 2017/18	Target 2018/19
	• Implement eligibility criteria consistently	Review September 2017	
	• Engage with service users and communities over proposals to locate NHSGGC addiction inpatient beds and 'Greater Glasgow' NHS day services at Gartnavel Royal Hospital, with enhanced outreach provision.	Day Services move to single site on hold due to issues with the fabric of the building	Complete review and move to implementation of new day service model. Undertake a suitability study of current premises in Kershaw Unit. Move to ensure single day programme running across both sites initially
	• Development of community based Recovery Clinics • Review of Clinics within Care and Treatment Services	Not commenced	Plan to introduce recovery clinics based within Community Recovery Hub (CRH) to offer safe detoxification from ORT in partnership with CRH

Older People, including older people's mental health

Priority	Key Actions	Progress 2017/18	Target 2018/19
Putting in place the architecture of Integration Establish an Integrated Management Team for OPPC ensuring that there is appropriate time and exposure of all components within OPPC agenda	• Agree TORs for schedule of meetings and arrangements for cascade of information to and from all staff	Integrated Management Team Established March 2017 4 locality engagement events taken place, involving OP teams and other agencies. Team building and understanding other services, relationship building.	Develop integrated teams (health and social work) built around the neighbourhood model. Build working relationships with GP clusters, contractors, third sector, RSLs and others.

Priority	Key Actions	Progress 2017/18	Target 2018/19
including physical disability and long term conditions			
Establish Locality Planning for older people and physical disability services that links to Community Planning and HSCP strategic planning arrangements.	• Implement the older peoples' system of care • Progress planning and implement integrated neighbourhood teams	Older People Locality Planning Group in place. Planning events taken place.	Review and monitor
Establish Locality Governance structures for OPPC that connect to wider HSCP, Health Board and Glasgow City Council arrangements.	• Ensure we have effective governance including for ASP, escalation of concerns, Datix reporting, complaints, outcomes of LMRs and Significant Clinical Incidents and audits. Encourage an increase in NHS input and presence at ASP meetings	Continue to review and evaluate to ensure effective governance arrangements in place. ASP Completed, Established processes in place	Review and monitor
	• Develop training and awareness arrangements for NHS staff on ASP	On-going roll out of training and awareness	Review and monitor
Match local service delivery against agreed priorities Test our service provision against • National priorities (e.g. the 9 Health and Wellbeing Outcomes and HEAT targets) • Outcomes and key actions described in the HSCP Strategic Plan 2016-19 (Strategy Maps).	• Specific local actions to deliver these to feature on the agenda of the OPPC planning group and management group. • Report on progress against agreed outcome measures/targets at the OPPC planning meetings and locality and HSCP management structures	On-going review of progress and performance through agreed action plan. On-going. citywide weekly operational delayed discharge meeting Home is Best Steering Group established working on draft operational procedures with development sessions	Continue to monitor performance against the action plan. On-going
	• Increase the number of people who receive supported living services at home	Progress made towards target including review of collection of performance data Supported living considered in all appropriate cases.	Continue to monitor performance against target
	• Increase in % of intermediate users transferred home (target	Continue to monitor through balance scorecard	Continue to monitor performance against target

Priority	Key Actions	Progress 2017/18	Target 2018/19
	30%)	Average % in previous 12 months is 27%	
	• Increase in % receiving re-ablement following referral for home care (target 75%)	Achieved on on-going basis, Cordia are working to improve enablement outcomes	Continue to monitor performance against target
	• Delayed discharges improve the number of patients over 65 breaching the 72 hour target	Target is a maximum of 20 delays per month. Continue to improve performance in this area to achieve set citywide targets	Continue to monitor performance against target
	• Contribute to a reduction in the percentage of people aged 65+ and 75+ dying in acute hospitals	40% target achieved in quarter 3 (44.2% 65+ & 43.9% 75+)	Continue to monitor performance against target
Focus on and develop service capacity particularly in relation to prevention and early support Develop services that are in line with the National Clinical Strategy (2015) http://www.gov.scot/Resource/0049/00494144.pdf and the NHSGGC Clinical Services Review.	• We will promote anticipatory care approaches throughout our services • We will focus on the prevention of falls across our services • Target residential and nursing care homes to support them to reduce falls	Anticipatory Care Completed for all intermediate care residents to support discharge home Citywide Strategic Group work-plan now concluded moving to locality groups. Work underway to improve falls awareness among staff. LA residential (Orchard Grove) and independent care homes have been engaged with the CAPA (Care about Physical Activity) programme.	Focus on the development of cross sector training, working with partners including the independent sector to remove barriers to accessing joint training. Continue to implement the CAPA programme to increase physical activity within the care home population, working with independent partners to share learning across the different care home settings.
	• Support early discharge from hospital, contributing to the on-going development of Intermediate Care and the accommodation based strategy • Maintain 90% occupancy rate • LOS target of 30 days	Intermediate care units established. Supporting staff to ensure that these areas are considered in the assessment process	On-going
	• Develop, test and evaluate effectiveness of level one and two	Key individuals at locality level are working to develop service based solutions to improve falls awareness.	Build on current work with Scottish Ambulance Service to reduce the number of uninjured

Priority	Key Actions	Progress 2017/18	Target 2018/19
	falls assessment tools	Focus is on increasing level 1 falls conversations and developing proxy measures.	fallers being transported to A&E by improving uptake of the SAS pathway into Community Rehab Services
Support residential and care homes to have easy and appropriate access to primary care services and routes for escalation - Focus on reducing the number of hospital admissions from care homes	• Develop a co-ordinated approach to District Nursing and treatment room services for residential care homes population	Work has not progressed to develop a residential treatment room service Focus on improving Level 1 Falls conversations and implementing the CAPA programme to increase physical activity. Focus on reducing unplanned admissions is progressing via Unscheduled Admissions Group led by Clinical Director	As above
Implement the Dementia Strategy locally	• Work with Acute and care homes re admissions and support provided to Care Homes	Dementia strategy service managers 2017/20 – national and local Glasgow – to be progressed in 2018.	On-going
Deliver on early intervention and person centred approaches to care for those with a mental health diagnosis	• Disseminate information re 8 pillars pilot and contribute to evaluation	All staff trained in person centred approach. 8 Pillars evaluation complete	Completed. Review and monitor
	• Raise awareness and understanding of dementia amongst our staff and the general public and to promote timely access to dementia diagnosis	Sessions carried out with OPMH staff as part of the 8 pillars pilot including key learning from 8 pillars evaluation rolled out across both teams Multi agency approach, RAG is now MDT, SW in attendance at OPMH ref meetings local approach to crisis intervention OPMH & SW	On-going
	• Evaluate the outcomes of the '8 Pillars' approach, centred on a Dementia Practice Co-ordinator role and implement good practise across all services.	On-going review agreed performance targets / progress at OP planning Group	On-going
	• Progress a consistent model of	Agreed measures for waiting times	Continue to monitor

Priority	Key Actions	Progress 2017/18	Target 2018/19
	Dementia Post Diagnosis support and progress to tender and implementation. Monitor and review waiting times	through dashboard measures. Waiting list for PDS Alzheimer's Scotland contracted to employ 2 additional 6 month fixed term contract to reduce waiting list citywide Developed a service pathway for referral to PDS as part of the new contract	performance and waiting times for access to PDS.
	• CMHT Framework to be implemented • Improve hospital environment to meet the needs of people with dementia as described in National Dementia Strategy, 10 Point National Action Plan.	CMHT Operational Framework action plan has been developed and strands on-going. Dementia Demonstrator Site on-gong until 2019 Met all 10 points; Single sex environment improved, access to appropriate garden space, reviewing and improving the furniture to reduce falls.	On-going
	• Glasgow City Dementia Strategy and Integrated Dementia Services Framework for Residential and Day care services and with Commitment 11 of the Strategy.	Commitment 11 action plan completed. Recruiting additional care home liaison nurse residential, stress and distress training is being rolled out in res homes	On-going
	• Deliver access to Psychological Therapies to meet HEAT target.	Continue to meet the target All inpatient staff completed stress and distress training; CBT training underway.	On-going
Palliative Care Take forward in South the HSCP palliative are strategy in South and support individuals with palliative care needs	• Support for individuals with Palliative Care needs • Continue to develop a South Locality Palliative Care plan in partnership with key stakeholders and partners taking account of key priorities outlined in the Palliative and End of life strategy	Continue to progress through the South Locality palliative care group.	On-going

Priority	Key Actions	Progress 2017/18	Target 2018/19
Continue to lead and implement on the polypharmacy / mindful prescribing agenda to ensure safe, effective and patient centred use of medicines in OP as per South Sector Prescribing action plan	• Reshape current prescribing support team commitment to focus on polypharmacy reviews	Prescribing support reviewed, on target to achieve 2017/18 action plan. Focus on continual improvement	On-going
Deliver services that are safe, efficient, effective and value for money Deliver services within budget; identify areas of further efficiency and areas requiring development, investment or disinvestment with reference to the Quality Strategy. Establish mechanisms for monitoring and reviewing performance against agreed KPIs across health and social care	• Ensure close budget monitoring to address any financial challenges • Included on the agenda of the OPPC planning group and Management Team agenda quarterly	On-going – OPMH ward/unit closed as part of the financial target achieved. Continue to identify opportunities for service reform and savings	Support the closure of Mearnskirk Hospital (led by acute) in March 2019 and agree a new model of provision to include a combination of beds and community supports. Link with the on-going review of Out of Hours Community Services to identifying opportunities for service reform and improve the model of OOH community nursing services across the city.
Planning for the Future Ensure that staff within OPPC are well informed about policy, strategy and emerging issues and are given opportunities to contribute to contribute to the shape of future services	• Locality events being planned May/June and autumn 2016 • Organise shared learning events, briefings and developmental opportunities throughout the year • Consider other models of service including for treatment room provision as part of the city wide review	4 engagement sessions and neighbourhood planning sessions targeted at Team Leader and Service Managers	On-going Recruit and train 11 phlebotomists. Ensure that the infrastructure is in place to support this service (IT etc.) Link with the on-going review of Out of Hours Community Services to identifying opportunities for service reform and improve the model of OOH community nursing services across the city.

Homelessness

Priority	Key Actions	Progress 2017/18	Target 2018/19
Putting in place the architecture of Integration Embed the community homeless service in the locality	• Improve the interface with all care groups. • Provide shadowing opportunities for Community Homeless Team	Regularly attend management meetings for all care groups Shadowing on-going	On-going
	• Increase access to preventive services	Housing Options implemented; review resulted in updated paperwork.	Review regularly
	• Undertake a review of the Housing Options approach to include referral numbers to preventative services and service user outcomes	Review report completed; quarterly reporting on-going	Review regularly
Match local service delivery against agreed priorities Homelessness prevention mediation service Improve provision for those leaving prison We are introducing this to the Prison Casework Team, this is a service that is currently available through housing options.	• Examine ways of reducing homelessness on leaving prison. • Work with SPS re measure outcomes. • Prison Casework Team to work more closely with Community Homeless Teams • Reduce the length of time that service users spend in bed and breakfast accommodation. • Aim to resettle people as quickly as possible following a period of homelessness	Prison homeless team are now dealing with all registered sex offenders the prison homeless team now cover duty in the South. Reviewed and no issues identified. Target has been increased from 24 to 30. Issue across the city with a lack of appropriate RSL lets (properties tend to be 2/3 bedroom which is unsuitable for large families or single people)	Work closely with SPS and Criminal Justice Social Work to improve outcomes for prisoners Continue to work to achieve target
Improve the quality of accommodation available to homeless service users.	• Agree a new service user involvement framework to ensure service users views are fed into planning and service delivery • Ensure services to refugees continue to be effective	HHL to carry out 2017/18 Service User Survey and submit to Executive Group	On-going
Improve our arrangements for service user involvement	• Continue to ensure access to cost effective interpreting services	HHL to carry out 2017/18 Service User Survey and submit to Executive	On-going

Priority	Key Actions	Progress 2017/18	Target 2018/19
	• Carry out annual survey on access to health and social care services	Group	
Support the development of services to refugees and new communities	• Ensure staff have access to up to date guidance for homeless applicants with no recourse to public funds • Community Homeless Team to work closely with Children and Families Roma Team to support Roma families • Continue to examine opportunities to develop access to private rented sector.	On-going	Review and monitor
Focus on and develop service capacity particularly in relation to prevention and early support Strengthen the focus on homelessness prevention Mitigate the effects of welfare reform	• Continue to support the Housing Options approach, to prevent homelessness. • Improve links with the private rented service in conjunction with DRS to improve private rented accommodation. • Improve joint work with law centres • Support delivery of the single outcome agreement Housing and Homelessness work stream • Continue to monitor the impact of welfare reform • Continue to ensure staff can signpost	The HSCP continues to support the 18 Housing Options' sites in South Glasgow. Named contacts in every care group; regularly reviewed. Health and Homeless Lead acts as a single point of contact to Housing Options' sites for access to HSCP and other services	On-going
Deliver services that are safe, efficient, effective and value for money Strengthen tenancy sustainment activity Improve outcomes for multiply	• Improve pathways into services • Develop innovative approaches to accessing housing support services • Improve access to homeless prevention services to tenants in	Turning Point Scotland contracted to provide homelessness housing support; this includes prevention of homelessness work	Co-locate both in Council buildings and Turning Point Scotland buildings to improve outcomes for homeless service users in relation to securing a permanent tenancy

Priority	Key Actions	Progress 2017/18	Target 2018/19
excluded homeless service users Ensure effective service pathways for vulnerable people	private rented sector • Review and develop pathways for vulnerable adults and children		
Planning for the future Ensure commissioned services continue to be strategically relevant, meet the needs of service users and the wider community. Access to employment, health and education	• Work with GCC Commissioning Team on a review of commissioned services, including housing support and Bed and Breakfast accommodation.	Continue to work closely with the commissioning team	Work closely with Social Work Services Commissioning Team in relation to the implementation of the homeless alliance.

6. Health Improvement and Inequalities

Priority	Key Actions	Progress 2017/18	Target 2018/19
Less difference in healthy life expectancy between neighbourhoods and groups Thriving Places: Contribute to the development of a place based approach to community capacity building and neighbourhood regeneration through partnership working in Gorbals, Priesthill/Househillwood and Govan.	• Support the Gorbals Regeneration Group develop the Thriving Places agenda, including development of a communications strategy • Community engagement 'creating conversations' activities undertaken in Gorbals and Priesthill/Househillwood thriving places. • Support the selection process to ensure the appointment of anchor organisation for Priesthill/ Househillwood • Continue to work with	Community Events including Community Market, Gorbals Fun, Spirit of the Gorbals, St Francis Com Garden, Community Breakfast, School Holiday Programme, Arts Strategy Group & Community Renewal Continue the development of neighbourhood forum and thematic groups. Anchor organisation &Community connecter appointed Consortium of local organisations	Support the Gorbals Regeneration Group in its delivery of a thriving places agenda, including the development of an engagement strategy which will link to the Gorbals Locality Plan. Build on existing relationships within the Priesthill/Househillwood area, continue to enhance established community resources.

Priority	Key Actions	Progress 2017/18	Target 2018/19
	partners to develop the Thriving Places approach in Govan. • Support the wider community planning agenda and requirements for the development and delivery of Local Outcome Plans.	(Galgael, Plantation Productions & Govan Community Project) are progressing the Community Engagement aspect of Govan Thriving Places; report to be produced by end of financial year Assisted in the development of the 4 CPP Locality Plans (3 thriving places and Govanhill)	Govan: Continue to work with partners to develop thriving places approach.
Govanhill Neighbourhood: Responding to the diverse needs of Govanhill community	• Recruitment of additional peer educators for Roma Peer Education Programme • Implementation of capacity building and training programme for peer educators.	Training needs identified. Update sessions taken place, focus on oral health & GP registration; Antenatal care and pharmacy update session planned. Pilot developed in conjunction with EU Health Visiting Team, Health Improvement, OHD and Childsmile move to whole family approach for newly transferring in families. Staff input delivered Govanhill ESOL classes around specific health themes.	Support current Peer Educators in their delivery of Peer Education sessions and development of their role within a wider context.
Reduced exposure and use of tobacco Smoke: Support the Implementation of the Glasgow Tobacco strategy	• Target our smoke free services to patients in SIMD 1 & 2 to ensure new HEAT Target is reached. • Make use of data to target new partnerships with pharmacies • Improve marketing to support update of services (Govan & Gorbals) • Target BME Groups within Govanhill	83 clients set quit dates at these 2 new services. Data is being used to inform discussions with local community pharmacies; 28 staff attending training session to improve outcomes, data recording and partnership working. Facebook marketing targeted within local areas of high deprivation to promote local stop smoking services, sharing good news stories, etc.	Continue to target our smoke free services to patients in SIMD 1&2 to ensure new LDP target is reached.

Priority	Key Actions	Progress 2017/18	Target 2018/19
		Smoking cessation information and support available at the EU drop in clinic held in Govanhill.	
Rebalanced relationship with alcohol and reduced drug use: Support the implementation of the Single Outcome Agreement for Alcohol and the Alcohol & Drug Partnership Strategy	• Train local partners in Alcohol Brief Intervention. • Community Alcohol campaigns • Increase the number of people participating in 'Recovery with Rangers' and other recovery programmes.	ADP, P & E Contracts Started July 2017: ABI training & delivery. Workforce Development Alcohol & Drug Training. October 2017: Children & Families Multiple Risk Contact, 1:1 service and Prevention & Education programme Community Alcohol Campaigns in Govan and Ibrox delivered 32 people involved over 2 courses. Recovery with Rangers integrated into SHARP	Train staff & partners in Alcohol Brief Intervention's (ABI) and monitor delivery towards the LDP target. Deliver & evaluate the delivery of CRAFFT screening and brief interventions for young people. Develop referral guidelines for youth workers in South Locality and within a wider context. On-going work to support Increase the number of people participating in SHARP and other recovery programmes
Reduce Poverty and Build Aspirations Deliver financial inclusion services including income maximisation, financial capability and debt management.	• Increased referrals to financial inclusion services. • Peer support group established.	Resources secured to deliver the service in 2017/18; on track for referrals and uptake of service. Attendance allowance flyers were produced and distributed to staff and third sector organisations. Continuing to support Money Matters in delivery of the project.	Increased referrals to financial inclusion services.
Employability	• Deliver employability services through the Bridging Service. • Promote the service to improve referral rates	Joint presentation with Momentum at management development group and links made with HI team. Occupational Therapist now operating in South within Pollok Civic Realm.	Continue to deliver employability services through the Bridging Service.
Deliver actions to address	• Deliver food and nutrition	Food for Thought contract awarded to	Continue to deliver food and

Priority	Key Actions	Progress 2017/18	Target 2018/19
poverty including food poverty and the stigma of living in poverty for our patients and communities.	programmes.	Urban Roots to deliver community/family meals in the Thriving Places areas. Cookery courses continue part funded by HI and IGF. HI funding to Urban Roots to pilot a Food Co-op style initiative in the Priesthill/ Househillwood Thriving Place.	nutrition programmes. Implementation, monitoring and evaluating of Food For Thought Contract.
Creating a Culture for health in the city (alcohol drugs smoking and obesity) Promote breast feeding and healthy early years (NHWO 1,2,3,5,7,9) Deliver Oral health Improvement Programmes based on local Population needs targeting BME and Vulnerable communities within Budget; Identify areas for further efficiency and	• Maintain UNICEF baby accreditation awarded. • Welcome award and BFFN to be targeted in localities with lowest breastfeeding rates and highest BME communities • Support exclusive breastfeeding among BME communities. • Support the Child healthy Weight programme.	Unicef Baby Friendly accreditation maintenance programme continues. Annual audit submitted Sept 17. Sector will look to progress to Unicef Achieving Sustainability Gold award in next two years BFFN award on-going. Improved links with education to support uptake of outstanding nurseries Roll out of Welcome Award to Glasgow Life (and other large orgs) in 2018. New breastfeeding Group Launched Pollok Nov 17 to target areas with low breastfeeding rates. Scottish Gov funding up to March 18 for Govanhill Baby Café run by National Childbirth trust (NCT) with HV teams /Health Improvement. Child Healthy Weight programmes continue in Govan and Priesthill/ Househillwood. 30 Starting Solids Sessions delivered across 7 venues in 2017 (Ave 4 per venue).Sessions being reviewed and	Maintain Unicef Baby friendly Standards and progress towards achieving the Unicef BFI Achieving Sustainability (Gold) award Continue breastfeeding public acceptability work (breastfeeding Nursery and breastfeeding welcome awards) in the locality with a focus on manager cascade training to increase roll out. Continue to provide support to baby cafe in Govanhill and new breastfeeding support at Pollok. Look at options to develop further breastfeeding support 2018/19 Delivery of 32 starting solids sessions per year. Number of targeted establishments and age range

Priority	Key Actions	Progress 2017/18	Target 2018/19
areas requiring development, investment or disinvestment with reference to the SHANARI indicators(NHWO 1,2,3,5,7,9)	• Number of programmes/ local residents involved in early years programme	targeted to areas with most need. Fluoride Varnish Programme consent process reviewed, increase in consents noted. Oral Health Training delivered to EYS and key partners. Daisy Chain pilot programme to improve the oral health of local children particularly Roma continues. Working in partnership with Early Years Scotland, Bookbug, Jeely Piece Club and Home-Start Glasgow South. Partners encouraged to offer services in local neighbourhood areas.	of children consented for Fluoride varnish to Increase during 2018/19 Reduce incidence of dental caries in pre fives: On-going delivery of oral health prevention programme in early years establishments. . Method of updating staff training via managers updates being rolled out.
Early intervention, prevention and harm reduction. **Public protection including keeping vulnerable people safe from harm.**	• Child and young people's mental health and wellbeing framework		Implementation of the board child and young people's mental health and wellbeing framework.
Providing greater self-determination and choice Young Parents Programme	• Young Parents Programme		Develop a tailored programme to meet the expressed needs of young parents to provide opportunities for personal and social development.
Providing greater self-determination and choice Health Issues in the Community (HIIC)	• Increase community capacity and participation and supports community development approaches to tackling inequalities in health.		Continue to identify groups of young people to participate in the Health Issues in the Community programme.
Early intervention, prevention and harm	• Weigh to Go - healthy, sustainable and successful weight		Co-ordinate the Weigh to Go programme in the South,

Priority	Key Actions	Progress 2017/18	Target 2018/19
reduction. Weigh to Go	loss for young people who are overweight and want to lose/manage their weight.		refer/sign post young people to the service and continue to raise awareness (with young people and relevant partners) of the supports available.
Focus on and develop service capacity particularly in relation to prevention and early support	• Early notification of dates of generic training for all staff		Wide communication of objectives and benefits of GBV specific Training opportunities to be targeted at Health Visiting staff

7. PROMOTING EQUALITY

The South Locality will contribute to the delivery and actions and priorities set out within Glasgow City HSCP's Equality Plan 2016-18. Key actions and priorities for the South include:

- roll out of ' Checking It Out' Toolkit across services;

- staff awareness raising sessions to improve uptake and referrals to interpreting services and use of accessible information for patients;
- maintaining accessibility audits and Equality Impact Assessments for new buildings;
- participation in Equality Impact Assessments of cost savings, service redesigns, service developments and policies;
- hate crime awareness and reporting;
- routine enquiry money worries, gender based violence (GBV), employability and appropriate onward referral;
- responding to findings of the Fairer NHS staff survey alongside staff training priorities (Asylum seekers & Refugees, Poverty e-learning module, key care groups including Roma and GBV;
- meeting the requirements of the HSCP's participation and engagement strategy including equalities monitoring of community engagement;
- analysing performance monitoring and patient experience by protected characteristics as required; and,
- provision of a programme of equality and diversity training for South staff and local organisations.

Gender Based Violence

Priority	Key Actions	Progress 2017/18	Target 2018/19
Putting in place the architecture of Integration Embed the work of the South GBV Implementation Group in the locality	• Improve liaison with HSCP care groups	Locality Groups including South GBV Implementation Group to be reviewed in March 2018 as part of a citywide cross locality approach. HSCP staff offered multi-agency GBV training on an on-going basis.	On-going training programme
Match local service delivery against agreed priorities	• Concentrate effort in 'hot spots'	Daisy project continues to cover the whole of the South. Police have been active members of both the South Implementation Group and Events Sub Group. A programme of events for 16 days took place; 6 events in the Govan hot spot.	Work with partners such as the Police to target activity where required
Focus on and develop service capacity particularly in relation to prevention and early support	• Early notification of dates • Wide communication of	Training timetable shared with HSCP staff and partner organisations Tailored sessions delivered to housing	Continue to raise awareness of GBV training and the benefits

Priority	Key Actions	Progress 2017/18	Target 2018/19
Promote attendance at multi-agency, multi-disciplinary awareness raising training	objectives and benefits	staff 4 lunchtime drop-in sessions for HSCP and acute sector staff held during 16 days FGM Awareness session took place with a mix of partner Youth staff and HSCP staff.	of training GBV specific training opportunities to be targeted at Health Visiting Staff
Deliver services that are safe, efficient, effective and value for money	• Advertise availability of local and city-wide services • Annual diary of events, particularly 16 Days of Action • Continue to deliver annual programme with £6k IGF and 'in kind' input • Locality staff continue to participate in MARAC	Women Where to Go leaflet shared widely during 16 Days of Action GBV stall at Mental Health Awareness community session Full 16 Days' programme delivered in 2016 Locality staff took part in the review of MARAC and participate	On-going
Planning for the future	• Ensure services in the South are strategically relevant • Work with Community Planning Partners	South GBV Implementation Group and other locality groups to be reviewed in March 2018 as part of a citywide cross locality approach. Hotspots and equity of service for GBV to continue to be discussed with partners; hot spot areas have received extra support during 16 days and International Women's Day events.	On-going
Public Protection – including keeping vulnerable people safe from harm	• Ensure local communities and those who access our services are safe from harm	Offer a range of supports e.g. Youth worker guidelines Providing GBV training Coordination of the Schools Health Relationships drama programme	

8. RESOURCES

Accommodation

Services are delivered across a wide range of locations in the South locality. Our vision is that we will focus our health and social care services around our four main centres in Gorbals, Castlemilk, Govan and Pollok supported by other smaller centres across the south. We will take forward a programme to improve our accommodation and support the delivery of integrated health and social care services to the people of South Glasgow. We have begun a major project to assess the scope for increasing clinical space, making better use of our non-clinical areas through the introduction of agile working, and improving facilities for staff and patients.

Work has commenced on a new health and care centre in the Gorbals to replace the existing Gorbals Health Centre, the Two Max building and the South Bank Centre for Specialist Children's services. This is due to be operational in early 2019. We have also begin to make significant moves in Rowanpark so that this becomes a hub for children's and families services serving the South West, and remodel Govan health centre and Elder Park Clinic as one of four bases in the South for our new integrated teams for older people. We are currently assessing space in both Castlemilk health centre and Castlemilk social work office to better support integration. During 2018/19 we will also be exploring options for a new HQ.

Human Resources

We have a total of 1,841 staff working in the South – 1,288 NHS staff and 553 social work staff. We have undertaken a programme of staff engagement to raise awareness about integration and what it means for staff and teams, and the challenges facing the HSCP. Each care group has also undertaken staff engagement sessions to explore specific issues of relevance to them. Supporting staff through training and other personal development opportunities will be a priority for us going forward. We are also conscious of the current sickness absence rates for NHS and social work staff, are currently above target.

Finance

The indicative budget for the locality in terms of net expenditure for 2018/19 is approximately £236.9m as shown below by care group.

South Locality Budget by care group 2018/19

GCHSCP – South	**2018/19**
Children and Families	15,709,000
Prisons Healthcare and Criminal Justice	2,428,000
Older People	35,641,000
Addictions	3,990,000
Carers	575,000
Elderly Mental Health	7,349,000
Learning Disability	20,780,000
Physical Disability	5,525,000
Mental Health	24,719,000
Homelessness	1,295,000
Prescribing	47,106,000
Family Health Services	61,160,000
Hosted Services	3,951,000
Other Services	6,700,000
Total	**236,928,000**