SOUTH WEST COMMUNITY HEALTH AND CARE PARTNERSHIP

DEVELOPMENT PLAN
2008/2009
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**APPENDICES:** 36
As Chair of the South West Glasgow Health and community Care Partnership, I am very pleased to be welcoming you to our Development Plan for 2008 – 2009.

This Plan is the second phase of our three-year Development Plan (2007 – 2010) and gives examples of the achievements we have made during the last twelve months and what our priorities for 2008/2009 are.

We have tried to capture the work that has been undertaken to improve services for local people and the partnership working that has been carried out across the area to deliver better health and social care services, and wider health improvements.

For the first time, we have included case studies to show examples of good practice and good news stories from areas of our service that I hope you will find helpful and useful in understanding the range and diversity of the work that our staff carry out.

We have once again spoken to our staff, our Committee and key partners and service users to prioritise the work that needs to be done for 2008/09 and these include:

- Improved communication between the CHCP, our service users and local partners
- The role of some of our sub groups and structures and who they represent
- Enhance support for our young people across the area

Should you wish to make any comment or if you require further information, please do not hesitate to contact:

Councillor Stephen Curran,
Chairperson, SW CHCP
1. INTRODUCTION

The South West Glasgow CHCP finalised the first of a three year development plan in May 2007. It was written in partnership with staff, stakeholders and residents and committed us to 128 key developments to reform and improve services. We produced a summary plan and quarterly newsletters throughout the year to enable our staff, residents and stakeholders to engage with us and know what was happening. Both the full plan and summary version are still available at www.chcps.org.uk/southwestglasgow. This document gives a brief outline of progress during last year and the actions we commit to undertake during the second year of this planning cycle.

The plan is intended for a wide readership and is available on our website and can be made available in other formats or languages by contacting us either by telephone or e-mail (0141 276 5239 or southwestinfo@glasgow.gov.uk)

2. PROGRESS LAST YEAR: ACHIEVEMENTS AND CHALLENGES

The South West CHCP operates 47 services, involving 950 health and social work staff from 22 operational bases in South West Glasgow.

2007/8 was a very challenging second year of operation for us, with lots of service moves, the development of new services and trying to make our services more accessible. Milestones during the year included;

- Relocation of staff to shared sites; 218 staff to Rowan Park, closing Govan Town Hall and co-locating Social Work, Health and Culture & Sport staff on site and bringing Children and Families staff into the extended Pollok Health Centre. Similarly the co-location of health and social care staff for community mental health services at Rossdale Resource Centre and Brand Street, and the redevelopment of Elderpark

- Establishing the South West Bridging Service. In partnership with South West Glasgow Regeneration Agency we brought employment, Careers Scotland, Financial and health staff into a single team which CHCP staff refer clients for employability support. In six months the team have received over 450 referrals.

- Worked with learning disability service users and carers around the reform of existing local services. Since January 2008 an independent external consultancy has undertaken consultation with people who use services for people with learning disabilities and their carers. Over 60 service users and carers have engaged in this process and further dialogue is being undertaken to engage young people with learning disabilities and their carers around their future needs and how we best plan for these.

- Public Partnership Forum. A vibrant Executive Group operates with 20+ members, engaging in CHCP and wider NHS/GCC engagement activity. The annual Partnership Matters event attracted over 100 local people and set the agenda for the next steps.

- Commencing the Mental Health Crisis Service, providing 24-hour services to prevent admission and enable early discharge in relation to mental health episodes.
• Establishing an early intervention team for older residents, both those coming to us for the first time and those with care needs being discharged from hospital. The team are already responding faster and providing more appropriate packages of care to this group.

• Securing Keep Well Phase 2 funds to enable Primary Care staff to engage with patients who need these services most.

• Establishing a Clinical Forum in early January 2008 enabling NHS contractors and professionals to engage in the development of clinical services.

• A substantial improvement in Criminal Justice Services has meant that all Probation cases are now allocated, and moving towards co working in sexual and domestic violence situations. Much improved progress in achieving the National Standards of provision. We are now looking forward to the completion of the localised management of services including Prison Throughcare, Community Service and Supervised Attendance Orders staff joining us.

• The staff open day where half of our 950 workforce participated in the day, staff feedback demonstrated the value of this networking event helping staff understand and learn about the wide range of services encompassed in the SW CHCP. “Really useful. I learned such a lot about services I knew nothing about.”

During the year we also managed a range of challenges and pressures, including:

• The implementation of the Health Visiting Review will assist and support the challenges faced by health visitors working across the South West area

• Challenges and demands to meet the service pressures and needs within Children’s Services will begin to be addressed as plans are in place to recruit further qualified social work staff. Plans to look at the broader integration of children’s services will offer a more effective range of services for vulnerable children and their families.

• Recognising the issues that learning disability services have historically faced, a redesign of our day services is being developed. This redesign will address a number of the challenges currently faced by our staff, carers and service users.

• In November 2007 the sickness absence rate for the staff within South West CHCP was 9.75%. We have made considerable progress in developing a number of support systems to ensure we can maximise our staff attendance. Although a significant number of service redesign and staff movement (premises moves) have taken place within the CHCP as well as significant staff shortages, we have put in place a detailed action plan to ensure appropriate and timely management of absence across all service areas.

These key achievements are captured in the timeline on page 6.
3. **LOCAL CONTEXT**

Since our first year of operation in 2006/2007 we have been provided with a new health and well being profile by the Glasgow Centre for Population Health (GCPH). This profile has built upon previous information contained in the 2004 community health profiles and information contained within the ‘Let Glasgow Flourish’ report published by GCPH in 2006.

In terms of the neighbourhoods and population of the South West CHCP, the following table provides a breakdown of the neighbourhoods within the South West Glasgow community and their populations:

<table>
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<tbody>
<tr>
<td>Arden and Carnwadric</td>
<td>9,533</td>
</tr>
<tr>
<td>Bellahouston, Craigton and Mosspark</td>
<td>8,955</td>
</tr>
<tr>
<td>Corkerhill and North Pollok</td>
<td>4,668</td>
</tr>
<tr>
<td>Crookston and South Cardonald</td>
<td>8,031</td>
</tr>
<tr>
<td>Greater Govan</td>
<td>12,114</td>
</tr>
<tr>
<td>Ibrox and Kingston</td>
<td>13,107</td>
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<tr>
<td>Newlands and Cathcart</td>
<td>7,287</td>
</tr>
<tr>
<td>North Cardonald and Penilee</td>
<td>13,772</td>
</tr>
<tr>
<td>Pollok</td>
<td>11,232</td>
</tr>
<tr>
<td>Pollokshaws and Mansewood</td>
<td>12,863</td>
</tr>
<tr>
<td>Priesthill and Househillwood</td>
<td>8,432</td>
</tr>
<tr>
<td>South Nitshill and Darnley</td>
<td>6,586</td>
</tr>
</tbody>
</table>

(Source: A Community Health and Wellbeing Profile for South West Glasgow: Glasgow Centre for Population Health February 2008)

The population of South West Glasgow has remained at approximately 116,000 people. Currently, 18% of the population are children, 66% are young and middle aged adults and over 15% are older people. Almost 5% of our population are from Black and Minority Ethnic Communities making this a very culturally diverse part of the city.

There are a number of sources of information that reflect significant issues for our population;

- 50% of children in Ibrox/Kingston live in a workless household compared to a rate of 35% for the entire South West area
- Almost 6 in every 10 primary 1 school children have dental decay, higher than the Glasgow average
- 1 in every 10 children are in contact with Social Work Services
- There are 232 children Looked After & Accommodated and a further 389 Looked After at Home in the South West.
- There are 55 Children on the Child Protection Register
- Life Expectancy for Men is nearly four years, and for women two years lower than the Scottish average (up to nine years lower in some local neighbourhoods)
- Adults not in employment is 54% above Scottish norm
- High levels alcohol related hospital admission 200% above in Ibrox, 1600 admissions to hospital in the last year from the South West area
- Alcohol related deaths 120% above the norm

This sets a significant service and health improvement agenda for the area. More detailed local health information is presented in Section 6.2.
4. CONSIDERATION FOR 2008/9

4.1 Policy Direction.

There have been a number of significant policy and service developments during 2007/8 that affect our plans for the year ahead. These include:

- Better Health Better Care: In 2007 the Scottish Government produced the Better Health, Better Care document as the overarching health policy to ‘help people to sustain and improve their health, especially in disadvantaged communities, ensuring better, local and faster access to health care’. This, together with updated targets for the NHS, set new challenges in improving access to services, reducing waiting times and involving patients more in the design of health services.

- New Council Plan and Single Outcome Agreement: The Glasgow City Council Plan outlines the aims of the Council over the next three years. The Plan takes account of the Community Planning themes and will assist in the development of an agreed set of outcomes (the Single Outcome Agreement) which both the local and Scottish Government will agree to achieve. Preparations for the Commonwealth Games are also a key consideration.

- Addressing the findings from the Social Work Inspection Agency as well as other audit processes to ensure that we learns lessons and update processes where required. A particular area we will address from the Social Work inspection is the way we communicate with our staff. We will build on what has already been introduced and consider what other steps we require to take to improve two way communications. Changes to learning disability services will also enable us to create more opportunities for this client group, as identified within the inspection.

- Adult Support and Protection (Scotland) Act 2007: This will be implemented in Autumn 2008 and will bring greater rigour to our investigation of concerns around adults and older people at risk. It will sit alongside the Mental Health (Scotland) Act and the Adults with Incapacity Act that consider issues of capacity and the need for guardianship. The new Act investigates the risk of abuse and co-ordinates multi-agency responses to the management or removal or risk.

- The alignment of Education and Social Work Services: Bringing these services together under a single management brings both opportunities and challenges but this change should lead to improvement in outcomes for people of all ages, particularly vulnerable children, families, adults and communities.

- The South West CHCP has a role to play in a number of partnership efforts and strategies to regenerate the city. During 2008/9 and beyond we will contribute to the implementation of the Glasgow Works Strategy (promoting employment), More Choices More Chances (Not in Education Employment or Training) Strategy for vulnerable young people, Glasgow City Financial Inclusion Strategy (promoting financial skills and services), Glasgow City Parenting Strategy, the Glasgow City Voluntary Sector Compact, to foster stronger working relationships between the public and voluntary sectors.
4.2 Local Priorities

During the first quarter of 2008, we engaged with over 100 people from the CHCP Committee, our staff, key stakeholders and local people to discuss the priorities over the coming year to be included within this Plan. These sessions were well attended and various common themes emerged which included:

- Caring for the most vulnerable: agencies and communities should work in partnership to ensure resources are used in the most effective way
- Service User Engagement: this needs to be meaningful and inclusive. A focus on young people and their views should be included.
- Role of the Professional Executive Group (PEG): role of this group and who they represent should be clearer
- Early intervention: enhanced support at an earlier stage, in particular for young people and those with mental health related issues
- Communication: communication between CHCP and local partner organisations to be improved

4.3 Continuing priorities.

The development plan describes the next steps in a number of priority areas where action was instigated during 2007/8. This includes

- Continuing the accommodation and facilities changes, particularly the full opening of the Pollok Civic Realm integration with the refurbished Health Centre and commencing the build programme for the Craigton Road Service Hub in Govan.
- Next steps in redesigning services particularly learning disability services, Children’s services, Community Older People and Physical Disability Services and the continued integration for mental health services.
- Moving forward with a wide range of health improvement programmes and strategies within the area, strengthening the role of the Strategic Health Partnership in South West Glasgow and the implementation of Keep Well.
- The continued support and development of our staff, building the learning and development programme and continuing to develop the organisation.
- Introducing the direct access ‘hubs’ within Pollok and Govan to improve service access and improve pathways for service users to engage with the most appropriate service

5. EQUALITIES

The first monitoring report for NHS Greater Glasgow and Clyde’s Equalities Scheme has been produced using a range of information including information from local CHCP action plans across Greater Glasgow and Clyde. All the local action plans are available on the NHS Greater Glasgow and Clyde website (www.nhsgcc.org.uk). Likewise we also have key responsibilities in contributing to the Single Equalities Scheme for Glasgow City Council.

We have developed an Equality Action Plan for the SW CHCP in order to help us ensure that our services are responsive to all equalities issues. We will respond to the gaps identified within our Action Plan and to the findings from the discussion paper to review how we approach these issues locally. In addition, NHS Greater Glasgow and Clyde have developed a Communication Support and Language Plan. This Plan will provide a more systematic and co-ordinated approach to communication and support to meet the needs of diverse populations across the area. We will work closely with the Corporate Inequalities Team to ensure that links are made locally to ensure that communication and language support issues are addressed.
To assist with this, during 2008/09 we will establish an Equalities Working Group comprising of staff across all care groups and services within the CHCP. This group will consider the needs and gaps in this area and engage with equalities communities to progress significant change.

5.1 Culture and Ethnicity

In South West Glasgow approximately 1,300 asylum seekers live in the area and the proportion of residents from an ethnic minority community is double the Scottish average (4.5%).

We will carry out impact assessments to ensure that equalities is embedded into service review, service development and policy development across all services within the South West CHCP. As part of our Direct Access Hub development we have included an extensive training programme that will include appropriate training in equalities to ensure that staff are equipped with the appropriate knowledge and skills to deal appropriately and efficiently with our diverse population.

Our staff also provide support to the three integration networks operating across the area and are committed to ensuring networks are well connected to CHCP services and planning. To this end we continue to offer CHCP services through the integration drop-in facilities operating across the area and are hosting a CHCP/Integration Networks event during the year to establish key areas for future development.

5.2 Poverty and Inequality

Through the Strategic Health Partnership we are working with partners to agree to provide intensive support to a small number of neighbourhoods experiencing very significant health and care issues in an effort to reduce these health inequalities, this and many other actions to reduce health inequalities are included in Section 6.

5.3 Disability

We are working with the Royal National Institute for the Blind (RNIB) to undertake a research study during the year to improve access to visual care services for residents from black and minority ethnic communities. This work builds on national findings that BME community members are not having their visual impairments identified and treated early enough and we need to encourage uptake and access to these services.

5.4 Inequalities Sensitive Practice Initiative (ISPI)

The Inequalities Sensitive Practice Initiative (ISPI) began in August 2006 and is funded by the Scottish Government until November 2008. The purpose of ISPI is to embed equalities sensitive practice in and across four settings. These settings are Primary Care Mental Health, Integrated Children’s Services, Addictions and the Maternity setting.

The lead for the Primary Care Mental Health setting is based within the SW CHCP. Two priorities that the ISPI work focuses on are gender and poverty.

Over the next six months the priorities for the project will be:

- To take forward a Gender Based Violence Training Audit in the Primary Care Mental Health setting with colleagues from the Corporate Inequalities Team and the Training Consortium
- To link with relevant colleagues in the South West to take forward the Training Needs Analysis in connection with poverty and mental health
- To take forward the joint working with Parent and Children Together Team (PACT) and the Pathways Team
To facilitate a session on sexual abuse referrals across relevant parties in South West CHCP

The initiative is also feeding into the mental health component of the South West Keep Well Initiative as it is hoped that by adopting an Inequalities Sensitive Practice approach, this will help with the overall aim of the sub group to mainstream the joint working. As well as the ISPI initiative we have continued to support the previously successful Men’s Health Service in South West Glasgow, extending provision beyond Pollok. The development of the service has significant user involvement in determining and progressing the service.

6. THEMES AND KEY RELATED ACTIONS

6.1 Focus Resources on Greatest Need

6.1.1 Vulnerable Children and Families

In order to continue to support vulnerable children and their families a range of key priorities have been established across the CHCP:

Integrated approaches to the development of maternity and early years services
This year, there will be significant developments to the co-ordination of pre birth support to families and further extended support to families with very young children. This will include the co-ordination of antenatal services across the CHCP, development of pregnancy pathways for vulnerable families and an enhancement of post birth supports including the further implementation of Health for All Children 4, and the further expansion of Women’s Reproductive Health Service. In addition there will be an increase in services to support emotional wellbeing, parenting, infant feeding and health improvement.

Drug and Alcohol Misuse
A child and youth alcohol group has been established across the CHCP. There will be a preventative programme and awareness raising training for S5 and S6 young people delivered during 2008. This programme will use innovative approaches to reach young people from a cross section of backgrounds by hosting an event to make them aware of the risks associated with alcohol and substance misuse, knife crime and the supports available to them. We will work in partnership with Strathclyde Police to co-ordinate this event.

Development of an Integrated Family Support Strategy
A framework for Family support has now been developed for the South West area. This will include a consistent roll out of:

- Parenting Services for children under and over 5 years
- Enhancement of services to parents in respect to training and employment
- Development of a web based information system for children’s services

Child Protection Services
2008 will see an HMIE inspection of Child Protection Services across Glasgow. Child Protection is a key area of work for our Social Work and Health staff and an area we will continue to develop our practice.

A Southwest Child Protection Forum will be established which will concentrate on the following areas:

- Multi agency training
- Implementation of the Child Protection Committee’s Action Plan
- Raising awareness of the lessons learned from significant case reviews
- Development of interagency practice
Development of Services to support young people with Anti Social Behaviour
A Youth Justice Forum has recently been established and additional resources to support targeted street work with young people in Govan have now been developed.

The Youth Justice Forum will address the support programme to persistent and high-risk young offenders. They will work across agencies to ensure a co-ordinated approach to tackling anti-social behaviour.

Additional Funding
NHS Greater Glasgow and Clyde has been able to access monies from Fairer Scotland funds to support vulnerable children and young people across the city. South West CHCP will work with partners on agreed priorities to ensure this money is spent on the most vulnerable children and young people across the area to support inclusion, early intervention, resilience and family support.

6.1.2 Vulnerable Adults and Older People

We will continue to support our work with adults and older people by:

Preventing hospital admissions and avoiding delays in getting people home:
Work is currently being done to use the range of statistical data that is routinely gathered to develop community based services that could assist in avoiding unnecessary hospital admissions

Protecting Vulnerable Adults and Older People:
The Adult Support and Protection (Scotland) Act 2007 will be implemented in the autumn of 2008 and will place a statutory requirement on local authorities to investigate adult protection concerns and co-ordinate an inter agency care plan to guarantee an individual's safety. Local inter agency training will be provided to raise awareness and ensure that the workforce is competent to carry out these new responsibilities.

A new referral process allowing direct access for Community Podiatry into hospital based Diabetic service for patients with active diabetic foot disease was introduced during the year.

This was started in the South West and has been used as an example of best practice and rolled out across the city. The process involved the design of a form to be used for referral from the CHCP into the acute setting and back to the CHCP. We have identified a liaison Podiatrist and also link Podiatrists at each of our clinical sites that communicate directly with a named Consultant.

The aim of this is to ensure that we meet the SIGN Guidelines for Diabetes and that all diabetic patients with active foot disease are given an assessment in a specialist, multi disciplinary foot clinic.

Podiatry services have introduced a new service, providing acupuncture therapy for lower limb problems. An example of how this works in practice is in the case of a 48 yr old female patient referred to the Podiatry service. As a polio sufferer in her early years the patient had been left with a large leg length discrepancy and a fixed deformity of her ankle. Years of walking with this deformity resulted in her suffering with osteo arthritis in the ankle joint, which caused a lot of pain and discomfort and she walked with a stick and was prescribed painkillers.

This pain had been suffered for a number of years and her G.P referred her to the Foot and Ankle triage service. This service arranged for some x rays to be taken and the diagnosis of osteoarthritis was made. Discussion with the patient regarding surgery took place but the patient felt that she wasn’t ready for surgery at this time and would prefer
to try an alternative route. As a result she was referred to Podiatry for assessment for special insoles (orthoses). Orthoses were fitted for the patient and although walking better the chronic pain caused by the arthritis was still apparent.

Mrs X was offered a course of acupuncture for pain management. After the first treatment the patient was pain free almost immediately and remained so for approx 3 weeks. After the second treatment she remained pain free for 4 weeks. The patient now has only to return to the podiatry service quarterly for acupuncture. She no longer has to take painkillers and can walk without her stick.

User Defined Service Evaluation Toolkit (UDSET)
SW CHCP agreed to participate in a pilot study to identify and measure the impact that services provided to our older people and physical disability care group. This pilot was co-ordinated by a steering group consisting of SW CHCP staff, Social Work services performance staff, and the Joint Improvement Team. Staff from the Older People/Physical disability Teams undertook interviews with twenty five service users and an external consultant was asked to conduct an additional fifty interviews with service users on behalf of the SW CHCP.

Overall the service received by local people indicated that they were satisfied with the service they received. However, the report does highlight some areas for improvement and we will report the full findings to our Committee, Senior Management Team, service users and other relevant city wide groups. A range of feedback sessions, web forums and workshops have been arranged and will take place towards the end of this year.

6.1.3 Keep Well

Phase 2 of ‘Keep Well’ will commence in 2008 in South West CHCP. Adults between 45-64 years of age in the most disadvantaged neighbourhoods in the area will be invited to participate in the Keep Well programme through an initial primary care appointment. Over 3500 residents will have the opportunity for:

- An extended consultation with their GP/member of the primary care team to undertake a detailed health assessment/screening, which can pick up undiagnosed conditions and enable health issues to be raised

- Referral and support onto health related services including smoking cessation and pharmacy long-term medicines, employability, money advice/welfare benefits and literacy services if these are sought.

The focus of Keep Well locally will continue to be:

- Substantial effort to contact and engage eligible patients who have not been in regular contact with health services

- A programme of development and organisational change support for primary care in working with harder to reach/assist patients

- The development of health outreach workers who are able to build relationships with patients and support them to access health care services and motivate change

6.2 Improve Health and Reduce Vulnerability

In South West Glasgow the life expectancy for men (at birth) is nearly four years, and for women two years, lower than the Scottish average in spite of improvements in the last decade. This camouflages bigger differences in some neighbourhoods in the area, where life expectancy for men is as much as nine years lower, and seven years lower for women.
Locally one in every four adults lives with a long-term illness, having a daily impact on their quality of life.

There are 350 new admissions to psychiatric services annually and we have around 11,000 social work clients in this area, 2000 of these are children. In recent years over 340 serious assaults have been recorded annually as well as over 1,000 domestic abuse incidents. This demonstrates some of the problems faced by residents and the importance of promoting mental health and well being alongside services to support physical health.

These facts are taken from the Community Health and Wellbeing Profile for South West Glasgow published by the Centre for Population Health in February 2008. This information is used alongside the recently published Public Health Report ‘A Call to Debate: A Call to Action’ 2007 and local concerns to direct the health improvement work of the CHCP, and our efforts to support partners to play their part in tackling the causes of poor health.

In response to these reports we have established, through Community Planning, a Strategic Health Partnership. The partnership, with public, community and voluntary sector representation has reflected on the challenges, and embarked on establishing a plan of action for partner efforts to support change. Many of the actions listed in this section are developed and delivered in partnership however the final Strategic Health Partnership actions will be reflected in the South West Community Planning Strategy currently in development.

‘A call to Debate: A Call to Action’ presents seven key challenges facing the city, the issues for South West Glasgow are the same;

1. We need to learn from what is working
2. Although health is improving, progress is slow and many are not benefiting from these improvement
3. Our poorest communities need tailored action to enable residents to reap the rewards of better health
4. Our population is changing and we need to prepare for these changes
5. We are following in America’s footsteps in terms of our weight gain and obesity is becoming a very serious issue
6. Deaths from alcohol related illness are now our number one killer and our drinking habits are not changing for the better
7. We must take climate change seriously and act accordingly to support a sustainable city.

The actions in relation to each of these are described below, along with the work during 2008/09 to enhance our screening and prevention services to ensure early detection and prevention of key illnesses.

**6.2.1 We need to learn from what is working**

There are many examples of what is working well from across Scotland and Glasgow. Within South West Glasgow we have been particularly successful in the following areas

- **Employability:** the South West Glasgow Bridging Service was established during 2007/2008 enabling staff to refer service users for employability and related support. This service has attracted over 500 referrals since starting in September 2007, which is double the anticipated uptake. During 2008/09 we will seek to achieve financial security for this service enabling the staff team to work with at least a further 300 service users supporting over 80 people into work.

- **Smoking Cessation:** During 2007/08, 445 residents contacted our Smokefree Community Service. Over 40% of those attending Stop Smoking Intensive Support Groups were smoke-free after a month. Our Smokefree Pharmacy Service supported 1,662 clients to quit with one in every four being smoke-free after a month. This is the
third highest quite success rate in Scotland in 2007. We also supported 145 patients referred for smoking cessation support on leaving hospital.

- Oral Health Programme. The rate of admission to hospital for dental conditions among children is 38% higher than the Scottish average and almost two in every three primary one children have dental decay in South West Glasgow. This however is dramatically better than last year, however significant progress is still required to ensure our children achieve the same good dental health as other Scottish children. The response from local nurseries to the ‘Smile Too’ programme has been heartening and we have made substantial progress in supporting vulnerable parents to register their children with a dentist.

6.2.2 Although health is improving, progress is slow and many are not benefiting from these improvements:

- Family Support: We will implement a Family Support Strategy, which will encompass a wide range of support to families in South West Glasgow. Elements included in the Strategy will be infant feeding, parenting, oral health and support to parents to access training and employment. Key personnel from social work, health, education and the voluntary sector will develop a three-year action plan.
  - An infant feeding co-ordinator will be employed to ensure the implementation of the Greater Glasgow and Clyde infant feeding strategy and action plan
  - A proposal will be submitted to employ a parenting co-ordinator to expand existing support to parents across the whole of the South West area
  - The Childsmile Programme, a Scottish Government demonstration project which offers additional support to vulnerable families in relation to improving oral health will be mainstreamed
  - The Smile Too programme which offers support to local nurseries to implement good oral health practice will be evaluated
  - Weaning Fayres will be extended to increase access to families living in South West Glasgow

- Young People: A seminar for local youth providers hosted by South West Community Planning Partnership was held to begin the process of developing a programme of activities across the area. We will work with the local CPP and feed into this process as it develops. We will also work in partnership to support young people not in education, employment or training (NEET) into learning and work, particularly through supporting the opportunities for young people in school. The successful youth health service will be continued, enabling access to a wide range of support services by young people.

- Mental Health: We will continue to support the ongoing development of the Mental Health Service Providers Network, bringing providers together to look at opportunities for joint working/training; the focus for this year is Financial Inclusion. We will also look to further develop the Network’s links with platForum, the Service Users Network. We will continue to fund and support the local Stress Centre, as part of which we will lead a small working group which will seek to implement the recommendations contained within the Stress Centre Development Report e.g. the establishment of a service user group.

- Smoking: Last year we assisted nearly 450 residents to quit smoking. We will provide at least 12 smoking cessation group opportunities during the year and through Keep Well we will provide some ‘pre-quit’ groups. We will also continue to provide smoking cessation counselling support to individuals who contact us directly or are referred when leaving hospital. During 2008/9 we will also increase the number of local pharmacies able to provide more intensive support to residents that have tried to quit before using nicotine replacement therapies and wish to try again.
• **Health in Later Life**: Commitment has been given to progress the recommendation from three sessions carried out with older people and stakeholders in 2007. The Strategic Planning Group will consider resources/capacity to implement an action plan around the recommendations. Issues include access to services, transport and homecare.

6.2.3. **Our poorest communities need tailored action to enable residents to reap the rewards of better health:**

Over half of our population live within the worst 15% data zones and 1 in every 5 working age adult is not currently in employment. There is now strong evidence that working is good for health and because of this we are one of the partners working to improve the opportunities for local people to get and stay in work. Many of the poorest health rates occur within the same communities/neighbourhoods in our area and because of this we will provide more intensive community support to the worst affected neighbourhoods to support faster change during 2008/9 and beyond.

Within South West Glasgow the Keep Well project is a major development enabling our most excluded residents to access health improvement services. As well as delivering the core Keep Well programme we have extended the provision of access to money advise services, recognising that debt and poverty often prevent residents from considering wider health issues.

Other key developments during 2008/9 aimed at reducing health inequalities, not listed elsewhere, include:

• **Sexual Health/ Teenage pregnancy.** We will pilot and evaluate the schools-based ‘real baby’ simulator programme. The programme seeks to enlighten 14-15 year old pupils about issues surrounding pregnancy and subsequent parenting, to reduce teenage pregnancy rates. The pilot programme will take place in two secondary schools in the South-West CHCP area, and the final report will be available from January 2009.

• **Tenancy Sustainment Development.** The CHCP has part funded a programme to assist with reducing the high turnover rate for young people taking up tenancies. This project will work with young people to help them to develop the knowledge to understand the responsibilities involved in moving away from home and the skills and the motivation to be able to look after themselves in their first tenancy. The programme has been funded by the South West CHCP, Glasgow Housing Association and Communities Scotland with in-kind support from a local housing association and Culture and Sport Glasgow. During 2008/09 we will ensure that a group of our most vulnerable young people are amongst those who will take part in this programme.

6.2.4 **Our population is changing and we need to prepare for these changes**

South West Glasgow has a population of around 116,000 people, nearly 1 in 5 are children. The population has slightly fallen in the last decade, with fewer children and older people. Over 40% of households are single adult households now, and this is likely to increase further. Likewise 35% of all households with children are single parent households, having implications for the networks of family and friends immediately around to provide support and care.

• **Children and Young People**: The ‘Glasgow Healthy Schools Programme’ was established in 2003 to support government policy that all schools should be health promoting establishments by December 2007. Across Glasgow City, all schools are registered on the programme, and in the South-West, eight have achieved accreditation status. During the coming year (2008-09) work will continue to
implement the ‘Schools (health promotion & nutrition) (Scotland) Act 2007, and in
correlation with the new ‘Curriculum for Excellence’ will provide us with the
opportunity to mainstream and embed the current programme into the daily work of
more local schools, and the local authority quality review processes.

• In addition to contributing to the work programmes given in the Equalities section of
this plan, the Asylum/Refugee men’s drop in at Ibrox Community Complex was very
well received during 2007/08. The Govan Galaxy drop in was in response to feedback
from staff and GP’s that asylum seekers/ refugees were isolated and feeling very low.
During the year ahead we are seeking to link this service to the Well Man and Men’s
Health and Activity Forum work already established for all local men.

6.2.4 We are following in America’s footsteps in terms of our weight gain and obesity
is becoming a very serious issue:
The weight range of our population is changing with more people experiencing anorexia
and obesity. The number of people either overweight or obese in Glasgow has risen
rapidly in the past few years with over 60% of adults and 20% of preschool children now
affected. Mental health, diabetes, heart disease, arthritis, high blood pressure and some
cancers are associated with obesity, which affects people of all ages, genders and
deprivation levels. There are however higher rates amongst older people, women, people
with learning disability and those living in deprivation.

We will take action to address obesity and anorexia and the underlying causes through a
range of health improvement activities and programmes:

• The work of the infant feeding coordinator will support families to put in place the
foundations for good nutrition from breastfeeding onwards
• Healthy eating is a key strand of our oral health work from Weaning Fayres through to
the Smile Too programme and Child Smile.
• Throughout our children’s educational journey we will reaffirm the importance of
healthy eating and physical activity through the Health Promoting Schools
programme and by supporting initiatives such as Kool Kids.
• Children often have little control over their food choices at home and we will work with
Cardonald College and others to provide Get Cooking Get Shopping programmes.
• Keep Well enables us to deliver additional ‘Eat Up’ services within the local area. A
Community Food Worker will also be employed to deliver practical sessions to
encourage people to adopt healthier eating practices. An additional health counsellor
has been funded through Keep Well (offering one to one support for those who want
to change their behaviours around physical activity, health eating and weight
management) and new physical activity initiatives within the community will also be
developed.

6.2.5 Deaths from alcohol related illness are now our number one killer and our
drinking habits are not changing for the better:
Alarmingly over 1600 local people are admitted to hospital a year for alcohol related illness
and over 330 residents have died from alcohol causes in the last five years. The problems
arising from smoking and excessive drinking locally are well above the Scottish average and
continue to mean that local people are in the third worst ranked area in the whole of Greater
Glasgow and Clyde for these issues.

We established an alcohol Steering Group that now meets on a regular basis with a multi-
professional membership including representatives from Strathclyde Police and Fire &
Rescue. Items covered include home fire safety visit assessments, which can be requested
by CHCP staff, preventing underage sales of alcohol and the use of alcohol screening tools
and brief alcohol interventions to reduce harmful drinking within in-patient and community
settings. We continue to provide treatment and care services, with a growing number of
residents accessing these alcohol services every year. During 2008/9 we will provide training to health centre and primary care staff to be able to complete brief alcohol interventions with patients – enabling patients to be aware of whether they are drinking too much, and being able to offer support and guidance.

6.2.6 We must take climate change seriously and act accordingly to support a sustainable city.

Craigton Road, our new main hub for the Greater Govan area, will incorporate a number of sustainable features. Creative use of landscaping will protect the building from the elements to ensure the internal temperature remains constant during both summer and winter; the building will use natural air flow design rather than energy demanding ventilation systems. Rainwater will be ‘harvested’ and then redirected to the sanitation system and aerofoil style roofs will be positioned to maximise available daylight.

We have also commenced work on a local transport plan, described in more detail later in the plan, which will incorporate the use of a wide range of transport choice including optimised car parking arrangements, new cycle facilities and effective and accurate travel information provision. This will have the potential to minimise negative effects associated with any additional road traffic and promote more active forms of transport for better health, which may be generated by the creation of our new hub at Craigton Road and help to protect the amenity of the local community.

Recycling and energy use: We are currently in the process of reviewing our premises to identify what is required to establish local recycling schemes and energy efficiency processes. To support this, we also need to establish initiatives, which will promote awareness and encourage staff participation to create a culture where individuals can engage and actively contribute.

Our initial plans are to establish recycling of office equipment and stationery as well as domestic items such as plastic bottles and tin cans. As this programme develops we envisage other areas will be identified where we could reduce wastage and save costs for the CHCP on a long-term basis.

6.2.7 Implementing new screening and immunisation programmes for cancer

The Scottish Government has confirmed that we will implement routine HPV immunisation commencing in September 2008. This vaccine offers substantial protection against cervical cancer and is targeted at girls in their second year at secondary school. In addition a catch-up campaign for girls aged under 18 years of age will be phased in over the next three years. We will plan and implement this vaccination programme within the South West area, working with our six secondary schools and special needs schools.

We will work during 2008/9 for the implementation of the Bowel Cancer Screening Programme in April 2009. The programme will invite adults between 50-74 years of age to be screened. There are often no signs of bowel cancer until it is at a more advanced stage and this screening, as with the breast screening programme, offers residents the opportunity for earlier diagnosis and therefore earlier treatment. The screening has already been tested in other parts of Scotland and we will work to maximise local awareness and uptake of the screening.

6.3 Improve Access

6.3.1 Development of Reception Services

The direct Access Hubs will be established across the Southwest CHCP area in 2008-209. There will be two direct access points – Rowanpark in Govan and Pollok Health Centre in Pollok. This will give communities greater access to services and ensure that services are
better co-ordinated at the point of contact. There will a new Customer Care Team to staff this initiative and they will ensure that residents get appropriate information and support about the service they require.

6.3.2 Working with Hospital Services

We have made significant progress on developing a more joined up approach with colleagues working within hospital services. Working links established have included:

- The CHCP’s lead role in improving cancer care
- Work undertaken in diabetes including local training with hospital staff
- Involvement in a cross section of planning groups to progress the ACAD sites in Glasgow
- Participation in the Planning Executive Group for the new South Glasgow Hospitals

We will work with local partners to ensure that employment, business and career opportunities that come with the South Hospital development are available and open to local people across the South West area.

Last year we worked with Southern General Hospital management to complete a review of the wider benefits that resident's should expect from the South Glasgow Hospital plans up to 2014 and the location of the new Children’s Hospital at the same site. During 2008/09 we will establish a small team to work with partners and communities to make significant progress in ensuring these benefits are realised.

6.3.3 Waiting Times

'Better Health, Better Care' an Action Plan has created a HEAT (Health Improvement Efficiency Access and Treatment) Target of 'the maximum wait from urgent referral to treatment of all cancers is two months'. Within Primary Care it is proposed to review all cancer diagnoses and indeed all referrals with suspected cancer to maximise learning across the CHCP about combinations of symptoms and signs and patient characteristics that are likely to have high probability of a cancer diagnosis and can thus be referred timeously for investigation and treatment.

The pilot described in last year’s plan for 'housebound patients' was successfully completed and the results are being evaluated. A similar pilot took place at the same time in East CHCP, which only offered a transport service for review at the patient’s surgery, and the differences between the two models are also being evaluated.

With respect to electronic booking of investigations utilising 'key words' progress has been slower than anticipated reflecting the complexity of cancer referral pathways but the work described above will help our understanding of the referral processes.

The promotion of the use of the unique patient identifier the Community Health Index continues within the CHCP.

Significant progress has been made in reducing waiting times for a wide range of services provided by Health and Community Care. Efforts will be made to maintain this progress.

A local review of CHCP Occupational Therapy services will be carried out to assist the implementation of Glasgow City Council’s Best Value Review of Aids and Adaptations making it easier and quicker for service users to access aids and adaptations. Waiting time targets will be created for Occupational Therapy to drive forward necessary improvements in this area.

6.3.4 Responsive Community Transport

A great deal of work has gone into creating a city wide approach to transport. The emphasis will now change to devising a solution to the local challenges being identified by a range of
stakeholders. A local transport plan will be developed in partnership with the community and other partners.

Local issues for consideration within the local plan include:

- Lack of co-ordination across CHCP services in relation to provided transport
- The review of day services for learning disability and the move towards more individualised and responsive supports
- The need for smaller, flexible and more responsive vehicles, particularly for children and families services who require vehicles to get children to and from school, escort children across the city and transport children or their families as part of their agreed care plans

6.3.5 Children’s Health Service

The Health Visiting Review will be implemented over 2008-2009. This will see an enhanced provision of support to all families across the area and particularly to the most vulnerable families. Staff will have a key focus on early intervention and prevention and holistic assessment.

Work will continue in 2008-2009 to devolve our specialist children’s health services to the Southwest area including Speech and Language Services; Child and Adolescent Psychiatric Services and Child Development Services. This will ensure greater access to these services for children in the Southwest area and the services of the Child Development Centre supporting children from this area will be relocated in our new service hub at Craigtoun Road.

A single mother with two children had been referred by our Community Addiction Service to the Parent and Child Together Team (PACT) for support with parenting, housing difficulties, financial problems and to support both children. The family were also experiencing significant difficulties with housing arrears, poor home conditions and both children were becoming increasingly isolated from the community.

A range of supports including input from the Health Visitor, Community Nursery Nurse, Money Advice Worker and Family Support worker were provided. This support gave the family an improvement in their home life, increased access to the community and an improved standard of care for the children within the home.

During this time, a domestic violence incident occurred within the home, however, as the PACT team had been involved with the family, additional support could be provided and this gave continuity of care to help the family cope.

The family were supported by Women’s Aid and this provided them with a range of opportunities including a written statement by the mother and an expression of views through a variety of methods by both children. This allowed workers to gain a clearer picture of what each individual family member had experienced during the domestic incident and what their views were.

Due to the intervention and support from various agencies working in partnership with this family, neither child required their name to be placed on the Child Protection Register and there was a marked reduction in parental stress levels and improved physical and mental health.

The PACT team continue to be involved with this family in a supportive capacity. There is little doubt that the complexity of family history and circumstances indicates that direct support will continue to be required in a number of areas for some time. However, the overall picture is much improved for this family. A combination of reduced risk levels and improved parental well-being increases the likelihood of short and long term outcomes being positive for both children.
6.4 Getting the Best from Public Funds

6.4.1 Absence Management

South West CHCP has continued to work to resolve levels of staff absence across a number of service areas in the last year. In response to this and to ensure that we are addressing all issues in relation to non-attendance we have worked to improve our information systems for managers and also to support staff returning to work and within the workplace.

- On a weekly basis we will highlight absence variance to managers to allow them to pick up on issues quickly.
- On a monthly basis we will continue to provide detailed information down to departmental level to again inform on areas of concern.
- An action plan has been developed to enable targets to be agreed locally and progress and achievements to be recorded.
- We are working on a number of areas of staff support, such as the ongoing ‘Stressbusters’ initiative as well as commencing work to gain the bronze Healthy Working Lives award which will improve access to health initiatives for all staff in terms of the work environment and general health issues.
- We will continue to provide support and development for staff to ensure they feel supported in the workplace as detailed in the joint People Strategy which was launched earlier in the year.

6.4.2 Administration

The SW CHCP has continued to lead on the review of administration services across the city. In addition, we are striving to make our systems more effective and efficient and over the next year we will continue to:

- Further integrate Finance, HR and Business Support Functions within CHCP HQ.
- Recruitment of further staff into the Integrated Admin Structure.
- Map out Admin Structure and ensure this meets service delivery requirements.
- Develop and deliver briefing sessions to all CHCP administrative staff on customer care, CHCP awareness and standards.
- Establish Training and Development Forum to develop pathways for admin staff and link to Personal Development Plans and Career development.

6.4.3 Criminal Justice

Criminal justice services across the CHCP in 2008-2009 will be co-located in Langton Road in Pollok. These services will continue to offer a local contact point in both Govan and Pollok for offenders. A range of new services will be developed in the forthcoming year to enhance the support and guidance to Criminal Justice Service users.

A co-ordinated group work programme will be implemented to ensure that all offenders have access to programmes, which will assist them in addressing their offending behaviour.

Community services will be devolved to the southwest area during 2008-2009 and there will be increasing links with this service and the employability service to ensure that offenders get information, advice and support regarding ongoing training and employment.

The Criminal Justice Team will continue to promote high quality assessments for courts and other key partners and will ensure that the Social Work services offered to offenders are effective and responsive.
Criminal Justice Services do not solely concentrate on offenders of crime but have a key role in supporting victims of crime. Work is underway to ensure that victims and their families are adequately supported and the Southwest Criminal Justice team have made close links to other key services to ensure that victims of crime get support when they need it.

6.4.4 Medicines

The 3 year Prescribing Plan has now been developed to support the delivery of high quality and cost effective prescribing by all prescribers. During 2008/09 the Prescribing Support Team and Prescribing Group continue to support prescribers using a number of initiatives including:

- The delivery of education sessions to CHCP staff to increase clinical knowledge and reduce the risks associated with medicine use
- Continued development of a new non-medical prescribers forum to support the growing numbers of non-medical prescribers
- Availability of medication review services for our most vulnerable patients including those at risk of frequent re-admission to hospital and patients residing in long term care homes

The long term medicines service (provided via the pharmacy team) is also a component of the Keep Well project. The aim of this service is to help Keep Well patients who are on multiple medicines (four or more repeat medicines) to understand and manage their medicine.

6.4.5 Health Care Contractors

The CHCP continues to work with pharmacy contractors to support the implementation of the new pharmacy contract. This includes managing the risks associated with establishing new services and supporting them in responding to health and social emergency situations.

The implementation of the national review of eye care services provides the CHCP with an opportunity to strengthen the existing support network for individuals with a visual impairment. A research study will be developed alongside Royal National Institute for the Blind to explore the specific needs of black minority ethnic groups and to explore more effective methods of engagement.

‘Keep Well’ phase 2 will bring substantial development for general practice and pharmacies locally. The key roles for participating GP Practices will be:

- identify the target population
- undertake the tracking and monitoring requirements of the programme
- develop innovative methods of engagement and use effective methods already well established locally
- provide assessment/screening and treat in-house relevant condition risks/illnesses identified during the screening
- address wider health needs including employability, money advice/welfare benefits and literacy services within this patient group
- refer on/signpost to other services engaging in the project, which will support behaviour change.

Practices will be supported to develop skills, confidence and practice among their primary care teams around engagement and negotiating behaviour change with the target group for ‘Keep Well’. In addition key lessons from earlier phases of ‘Keep Well’ such as increased/flexible appointment times will be communicated to Practices as they evolve.
The role of Pharmacists with respect to medication reviews, particularly where concordance issues were identified, and with respect to smoking cessation services needs to be developed within ‘Keep Well’. This will clearly link to Health Improvement with respect to referral for exercise, smoking cessation, adult literacy and money advice in addition to the advice/support normally offered by the primary care health team.

6.4.6 Workforce shape and productivity

A joint People Strategy was launched this year to assist the Partnerships working across Glasgow to develop a single set of values and commitments. The People Strategy sets out what staff should expect from working with us, what we expect from our employees and what we are doing to tackle some of the issues raised in staff surveys and focus groups.

Part of the People Strategy is to improve recruitment and selection practices with more opportunity for staff to develop skills, knowledge and experience in order that they can reach their potential. Locally, the SW CHCP will produce a joint workforce plan incorporating all detail regarding the current and future workforce requirements for both Social Work and Health Services within the South West. This will reflect all areas of current and anticipated service redesign as well as looking to the challenges that both NHS Greater Glasgow and Clyde and Glasgow City Council face to shape the current and future workforce to continue to provide high quality services to all patients and clients. This will recognise that our workforce age and composition will change over the coming years in light of an aging population and the new types of roles and skills that will be required to meet the challenges that lie ahead.

A CHCP Workforce Planning Steering Group has been established to lead on the first plan, which includes representatives from all service areas in both health and social work, and the time frame we will be reporting on will be for 2008 – 2010.

6.5 Create an Effective Organisation

6.5.1 Governance

2007/2008 saw the production of the first Staff Governance Action Plan for South West Glasgow CHCP as required by the NHS Staff Governance Standard, which reported on the work and activity across the CHCP. This will continue to be a focus of reporting activity to meet the 5 aspects of the NHS standard but will grow to incorporate the requirements of the anticipated ‘People Strategy’ from Glasgow City Council in the next 12 months.

Progress will continue to be monitored and reported via the local Staff Partnership Forum, within the Senior Management Team meetings and also as part of the established reporting mechanisms within the CHCP Committee, which receives reports and updates on a quarterly basis.

6.5.2 Practice Governance

The Practice Governance Group, established last year will continue to meet monthly. The terms of reference are

- to produce a Practice Governance Work Plan and review progress against this
- to ensure appropriate linkages are established across key partner agencies with respect to Practice Governance
- to provide reports to the CHCP Committee as required
- to produce an Annual Report
- to support incident investigation, review and organisational learning
The Practice Governance Group helps to ensure the quality, safety and effectiveness of services and practice within the CHCP. It does this through a number of means including incident reporting, complaints review, effectiveness of services/practices thro' audit and research. The Practice Governance Group has also helped to develop a Risk Register within the CHCP.

6.5.3 Standards

South West CHCP has been developing and updating practice standard for staff. This will ensure that staff understand their role and responsibility regarding:

- Case recording
- Communication with service users
- Support and supervision

This work will be completed during 2008-2009 and all staff will be briefed in their role and responsibility.

6.5.4 Business Continuity Arrangements

During 2007/08 we put in place plans for ensuring key services could continue to be provided in an emergency, we undertook planning events and responded to three significant local events. Our Business Continuity Plan is on the NHS website (www.nhsgcc.org.uk) and during 2008/09 we will further develop our plans in relation to sudden significant staff shortages in line with Pandemic Flu national guidance.

6.5.5 Healthy Working lives for our Staff

The South West CHCP has a role to play in improving the health and quality of life of our staff. By registering and committing to attain the Bronze Healthy Working Lives award within the next 18 months, the CHCP will be supporting staff to look at how health and well-being can be actively promoted in the workplace, ensure that health is not adversely affected by work or workplace hazards and provide access to advice and support for staff who need it.

We aim to improve our quality of service by reducing absence rates and supporting staff returning to work, build on our established health and safety processes to continue to reduce accidents and ill-health and continue to work to create a healthier and more motivated workforce.

6.5.6 Planning and Performance Management

We will continue to provide regular performance reports to the South West CHCP Committee, Greater Glasgow and Clyde NHS Board and Glasgow City Council, presenting readable ‘traffic light’ reports on progress in year. We will host at least one major public event to present our progress and receive feedback in year.

We will participate in the forthcoming HMIE Inspection of inter agency Child Protection services and contribute to meeting the actions from this and previous inspections. We will also monitor progress on our Development Plan targets in appendix 1 demonstrating the impact of local improvement work.

6.5.7 Communications

Communication across the South West with our staff, partners and the local community continues to be a priority. We will continue to develop our quarterly newsletters for staff and partners and will implement a Team Brief system across the CHCP for all our staff.
We will continue to work with the Public Partnership Forum members to ensure that the local community are involved in our services.

### 6.5.8 Learning & Education

Developing our staff and integrated working were key priorities for Learning and Education in 2007/08. Substantial effort was given to the implementation of the National Framework for Care Management and Organisational Personal Development Planning Processes. Development of First Line Managers was also crucial with work underway on core programmes of development for this staff group.

During 2008/09 the focus on these initiatives will continue as we seek to ensure that all staff have a current and active Personal Development Plan in place.

### 6.6 Modernise Services

#### 6.6.1 Facilities and Accommodation

We achieved a great deal last year by relocating most of our staff to joint integrated premises. The developments for this year mainly focus on upgrades and increased capacity at sites to meet service developments. The key challenges for the forthcoming year will be to ensure staff awareness and compliance with policies and procedures, also ensuring that facilities processes are effective to meet service delivery needs. Our main priorities include:

- Relocation of Mental Health Project to new premises in Burleigh Street, Govan
- Work commenced on the extension to Rosssdale Resource Centre and on completion will enable the further integration and relocation of Mental Health services within the CHCP
- Work commenced on the extension to Elderpark Clinic and on completion will enable the relocation of Mental Health Elderly Inpatient Services
- Establish a joint Health and Safety Committee to ensure governance for staff, patients and service users
- Deliver joint Health & Safety/Risk Awareness sessions to CHCP staff
- Establish Joint Health & Safety Forum for CHCP
- Establish Building Management Group in each main site
- Support the devolvement of Criminal Justice Services such as Community Service, Throughcare and Supervised Attendance Officer to Langton Road premises

#### 6.6.2 Capital Sites

Discussions have taken place with Social Work Services regarding the implementation of the current strategies regarding elderly care, children’s homes and learning disability day care across the South West.

**Reconfiguration of Residential Care for the Elderly:** Plans have been approved to reduce units across the city with one large 120 bedded unit developed within each CHCP to replace existing units. In South West this will mean the closure of three units. We are currently working with colleagues in Social Work and Development & Regeneration Services to identify a site for this unit, which will design a ‘home for life’ for those in residential care.

**Children’s Units:** Three eight bedded units are required across the South West area. It is the intention that these units would be managed within the SW CHCP and would be a local resource for any young person to be accommodated within the area.

**Learning Disability:** The reform of day services will mean moving towards a modernised model of service with new ways of working with individuals and new premises. We will move from building centred services to services that are client focused and high in quality and the
service model will include a service hub. Again, we are working closely with colleagues in SWS and DRS to find a suitable site for the learning disability hub.

6.6.3 Information services and technology

The development and use of IT continues to be a positive challenge for the CHCP as we identify new areas that require to be effectively supported. We have the opportunity to use new technology in a range of areas and establish IT solutions to create more effective methods of working. Over the past year we have progressed various local pilots and are now at a stage of rolling these out across various locations, which will bring both benefits to staff and users of the service. We will continue to:

- Support the transfer to two remaining sites (Elderpark Clinic and Mental Health Project) to one IT system to enable teams to be operate from one structure
- Roll out electronic Treatment Room and Meeting Rooms Booking Systems across all bases
- Establish processes to provide local ID Badge issuing across CHCP to ensure improves access for staff, security of personal information and corporate standards
- Develop programme to support staff to use newly purchases tablets to undertake minute taking.

6.6.3 Children and Young People

Services to children and young people and their families are co-ordinated and developed through the already established southwest Area Children’s Services Planning Forum. This forum ensures that all key partners in the area agree a number of priorities where services can be improved and better co-ordinated. The priorities for 2008-2009 are:

- Development of Integrated support structures in Learning Communities
- Development of enhanced educational support for Look after and Accommodated Children
- Co-ordination of Health Service in Learning Communities – including the establishment of health drop in sessions in secondary schools
- Focus on Youth Alcohol
- Development of supports to address anti-social behaviour and Youth offending – including the establishment of the Youth Justice Forum – and development of enhanced street work services
- Development and better co-ordination of Child Protection Services – including the establishment of the Child Protection Forum and the commencement of local Child Protection training
- Development of services to support victims of Domestic Violence
- Further development of Family support Services – including further roll out of evidenced based parenting programmes; enhanced support to infant feeding; additional services to support women pre and post birth.
- Development of a youth engagement strategy – to ensure that young people are consulted regarding service development and delivery.

Southwest CHCP lead on the citywide Early Intervention and Prevention planning forum as part of the Integrated Children’s Services Planning agenda. This group have a number of areas of priority that they wish to progress over 2008-2009:

- Develop co-ordinated early years integrated family support strategy across five CHCPs
- Develop effective mechanisms to identify vulnerable families at pre birth
- Contribute to successful implementation of HALL 4
- Develop integrated family support services linked to nurture programmes
• Develop robust mechanisms and support for young people on periphery of anti social behaviour
• Develop effective emotional support programmes within NLCs including evaluation of schools counselling programme and development of Choose Life strategy
• Develop a range of supports for young people in building resilience linked to drug and alcohol misuse

6.7 Shift Balance of Care Closer to Home

6.7.1 Children’s Services

Work will continue to shift the balance of care for looked after and looked after and accommodated children. We will increase our community services over 2008 -2009 to ensure that wherever possible children remain at home and in their communities. Many of the actions already given in the Development Plan seek to reduce the number of children and young people that require Looked After and Accommodated. We will continue to work on:

• Development of the Parent and Children Together Team (PACT) – Integrated teams which provide a range of parenting supports to vulnerable children and their families,
• WRHS Liaison Service – locally established Liaison Group to support vulnerable pregnant women who misuse substances
• Development of the Local Children’s Planning Group which has a range of different priorities to support vulnerable children
• Establishment of a Youth Justice Forum to target persistent young offenders
• Establishment of a Child Protection Forum to keep children safe

6.7.2 Health and Community Care

• Community Care. The CHCP is seeking to help develop the Scottish Patients at Risk of Readmission and Admission (SPARRA) risk-prediction tool which offers health services the opportunity to identify those people who are at greatest risk of emergency admission or re-admission to hospital. We are working with the Information Services Division within NHS National Services Scotland, which is responsible for the collection, maintenance and dissemination of a wide range of clinical and non-clinical data on behalf of NHS Scotland. Since January 2007, we have been exploring with ISD how national and local data can support our aims of service improvement and better health for our population. The aim of this project is to involve ISD and the CHCP working in partnership to enhance the quality of information generated and used locally in the planning and provision of health and care services. Specific attention will be focussed on the ability to predict and target resources to those in greatest need and to avoid the number of unplanned interventions.

• Improving Health Care. Palliative Care. With the ‘Long Term Conditions’ Strategy increasing the focus on the care of patients with conditions such as heart failure and dementia it is timely for the CHCP to develop it's palliative care strategy to include these conditions and extend the principles of good palliative care to non-cancer related conditions.

• Rehabilitation and Enablement Services. A planning framework is being developed to strengthen community based services for adults and older people. This will build on existing work such as the Early Intervention Service at Elderpark and the improved joint working across health and social care. A major priority for the service will be the strengthening of direct access and self-assessment alongside a move towards self managed/self directed support and individual budgets.
The Older People/Physical Disability Early Intervention team was contacted by a woman concerned that her mother was no longer coping at home, refusing to eat, bathe, change clothes and calling her daughter several times during the night. The daughter was very distressed and asking for help.

The duty worker gathered all relevant information from the relative and her GP was contacted and informed that she had been previously referred for Psychiatric Assessment. The assessment had shown low level cognitive impairment and the Psychiatric Service had allocated her an occupational therapist. Further to the initial contact by the daughter, a further telephone call was received from a neighbour raising his concerns about her safety due to him discovering smoke coming from her flat which had seeped into his home during the night.

On further investigation by the neighbour he had discovered that a burning kettle had been left on the cooker. A home visit was arranged for that morning to assess the situation and to contact the GP to ask for a home visit to be carried out that day as an emergency. Following the visit, it was established that she was indeed at risk of injury, very unkempt, and unable to adequately care for her own basic needs. She appeared to have little insight into her current circumstances, however she did agree to a home care package.

The Early Intervention Team contacted the GP for feedback from his visit and it was established that her physical and mental health raised sufficient concerns for the GP to admit her to Hospital that day for further investigations. Psychiatric Services was informed of her admittance to Hospital to ensure that there was a transparency across the agencies. Following the required treatment in hospital, a full holistic assessment was carried out by hospital based social work staff before any discharge.

Due to the quick response by EIT, we were able to send a Worker out that day to begin the assessment process and initiate all relevant agencies to ensure she was provided with the most appropriate services to meet her needs. Her daughter was also contacted to inform her of all developments and to explain the procedures to be put in place for her mother.

As the EIT is a joint team with both Health and Social Work staff, this provided a more joined up approach when dealing with this case and the assessment and partnership working provided a speedier outcome for this family.

6.7.3 Housing

Liaison arrangements have been strengthened throughout 2007 and there is a strong commitment to tackling issues as part of a joint approach. Excellent progress was made in creating a local process to assist vulnerable individuals sustain their tenancies and to prevent homelessness. Programmed work will continue to create agreed local approaches and guidance to sit alongside the formal statements of best practice.

We will continue to contribute to the Community Planning process through our involvement in the Local Housing Forums.

6.7.4 Mental Health

There were considerable service developments and changes last year. A new 24 hour crisis service was developed which act to prevent the need for users to be hospitalised and enable earlier discharge from hospital offering high levels of support to patients and clients. This service is supported by Carr-Gomm Scotland, a voluntary provider of social care support, which was commissioned specifically to support statutory mental health services and clients.
The service is based at Brand Street and is integrated with community mental health services in both the Govan and Pollok localities of the CHCP.

Primary care mental health (Pathways to Wellbeing) was relocated to Pollokshaws and provides an open referral system and has had over 1000 referrals in the last year. The service offers a range of self-help solutions and education classes to promote good mental health as well as time-limited individual therapy to adults of all ages. Carr-Gomm Scotland provides social care support as required. Social Work Services input can be arranged if necessary.

The integration of social work and health has progressed with the majority of staff located in one of the resource centre buildings at Brand Street and Rossdale. The community mental health services now manage all referrals through a single allocation system. The management of the services are integrated within the CHCP structures. The Crisis Service works across both Pollok and Govan localities but operates fro Brand Street Resource Centre.

A new early intervention service has been developed and this is based at Brand Street for individuals who have a first episode of psychosis. This is known as the Esteem Glasgow South service.

Key developments for 2008/09 include:

- Strengthening relationships between hospital and community based services
- Improving discharge planning to prevent readmission
- Establishing a new eating disorder service
- Greater emphasis on recovery, not just symptom control
- Improving engagement with services through assertive case management
- Improving access to the Primary Care Mental Health Team service in particular for older adults
- Working with GPs and Pharmacists to halt the increase in antidepressant prescribing
- Seeking to reduce the suicide rates in SW CHCP through wide spread training for staff to aid early detection of risk
- Working more closely with addictions services to improve outcomes for people with mental disorder and addiction problems
- Further development of the mental health network across the area, enabling service users and carers to influence mental health services but also wider CHCP services through engagement in the Public Partnership Forum, Voices for Change and PlatForum.

6.7.5 Tenancy Sustainment/Preventing Homelessness

The final male hostel closed in March 2008. In terms of achievement this is very significant and marks the end of a period of time which has seen considerable change in services to people experiencing homelessness in the city. This change has seen the commissioning of 610 beds in small-scale supported accommodation projects across the city and the development of 24 support services, which provide care and support to over 4100 households.

Southwest CHCP will ensure that the needs of vulnerable households are a key theme of planning in localities and will focus on preventing vulnerable households becoming homeless. We will work with Local Registered Social Landlords to ensure that tenancy sustainment is a key priority.

6.7.6 Addictions

Over the past year we have continued to work closely with Children and Families to identify children affected by parental alcohol and drug misuse. A new assessment tool has been
identified which will assist us to identify the impact of parental substance misuse on the parenting abilities of this client group.

The Addictions Service currently have 2,275 clients of whom 118 are young people aged 11 – 21 years. A total of 340 clients entered employment/training or voluntary work over the first nine months of 2007 and we would hope that this will continue to increase for the remainder of this period. We have also consistently met the waiting time target of 95% across the South West area and this has enabled us to assess our client’s needs and allow them to access appropriate treatment and care.

During 2008/9 we will:

- Implement the Glasgow Addictions Service Medical Staffing Plan. This plan pulled together a set of proposals in relation to secondary care medical services. Recommendations from the plan include the proposal that secondary care medical services move to alignment within CHCP’s and that community support in the South should be a priority.
- Improve our information quality to provide us with a better analysis of drug use and drug trends
- Implement a shared care approach within addiction and mental health services to ensure a more robust care pathway for our service users that require both services

Jane and her family have been known to Social Work Services for several years. She was a woman who presented with very low self-esteem, low self-worth and personal neglect issues. After being referred to the Community Addiction Team several times and not engaging she was re-referred by the addictions hospital liaison team after being admitted to the Southern General hospital due to severe alcohol withdrawals. She was initially reluctant to engage. However, due to child care issues and the risks posed to her physical health many attempts were made to engage her with the service. Over the next few months she did engage, however due to having difficulties confiding in people she found it very difficult to disclose information and to address the root of her addiction. She relapsed after a few months of attempting controlled drinking and was again admitted to hospital.

Soon afterwards she was posed with the threat of eviction from her home and her daughter was put on the child protection register. At this time she was referred to a welfare rights officer within the South West CHCP and the Community Casework Team due to the high risk of homeless. The welfare rights officer and the care manager accompanied Jane to joint meetings at the housing department to negotiate ways to avoid eviction. This partnership working proved to be successful and a payment agreement was drawn up which was an amount that she could manage weekly.

Through assisting her in this way it helped to develop trust and confidence in the relationship and gradually she began to open up more about her alcohol use and her feelings as to why she felt the need to drink. Triggers, high risk situations and coping mechanisms were identified and a successful relapse prevention plan was developed. As part of the Child protection plan and Jane’s care plan she cleaned and renovated her house and through negotiation with the housing, community casework team and children and families the housing have agreed to put in a new bathroom suite and kitchen.

Throughout this time there was extensive joint working with the children and families and addiction teams, which included joint home visits and joint care plan. Notable improvements were observed and she was now taking time with her physical appearance and also her confidence levels were improving. The result of this was evident in her relationship with her daughter. For example prior to these life changes her daughter refused to live within the boundaries that her mother set but Jane now ensures that her daughter attends her appointments at the Department of Children and Family
Psychiatry and she also sought additional support from Al-Anon.

As Jane has began to achieve some goals, she felt that the next step was to start thinking about getting back to work. She was referred to the CHCP Bridging Service for support in relation to future employment. Parallel to this she completed several courses, including a computer course and self-esteem course. She managed to secure a part-time temporary job and as this proved to be very successful. Her employers were so impressed they kept her on for extra weeks at the end of the contract.

Through providing stability to her daughter and liaising with the school and the CHCP children and families staff, her daughter's confidence improved and she now attends school which is a major step as she has had extremely sporadic attendance for the past 3 years. Surprisingly she has now caught up with curriculum and is on course to choose her subjects in preparation for her standard grades. Due to these improvements her daughter has now been removed from the child protection register.

In conclusion, Jane has made very significant changes to her life, which has had a positive impact on her daughter’s education and self-esteem. It is clear that the seamless partnership approach been the key to resolving this family’s issues.

6.7.7 Learning Disability

Improving health and continuing to facilitate access to primary and secondary care will remain a theme within the Learning Disability plan. This will mean the continuation of the health check programme, linking in with the new General practice learning disability liaison nurses and specific focus for our Allied Health professionals.

For 2008/2009 we will continue to:

- Develop early dementia detection particularly around clients with a diagnosis of Down's syndrome
- Develop a CHCP wide carer and user groups as a priority to feed into the development and modernisation agenda for learning disability services
- Develop and improve how we work with young people

A joint programme on healthy eating was established and has secured some more funding from the health improvement team for this year and a joint psychology /day service /community initiative around lifestyle related to coping with everyday stresses has been established. The development of a specialist audiology service for clients who cannot access mainstream runs once a month at Berryknowes.

The development plan 08-09 for learning disability services includes a major piece of work around the modernisation of day services. This approach will encompass a CHCP wide focus involving the many partners within the CHCP including employment, sport and leisure and community development.

Consultation and engagement processes were undertaken with service users, carers and staff to shape local learning disability day services across the South West at the end of last year. Many issues and points for consideration have been collated from the consultation including:

- Both the services users and carers want to be part of the implementation of changes.
- Carers would welcome a Carers’ Forum for on-going dialogue with the CHCP.
- Both service users and carers are wiling to take on activities such as helping improve inclusion and raising awareness in the local community.
A full report will be submitted to Social Work Services Centre as feedback on the city wide development of learning disability services. An Information Day is planned by the SW CHCP for June 2008 with activities, workshops and information available to those attending.

6.8 Enhance Inclusion for Effecting Change

6.8.1 Community Planning

The South West Area Co-ordination Group was established in November 2007 to support the two local Community Planning Partnership areas of Govan/Craigton and Pollok/Newlands/Auldburn. The Area Co-ordinating Group is charged with providing support and guidance to local Community Planning structures and through their membership, will be able to ensure that community planning is linked more effectively to mainstream decisions on resources and priorities. The South West CHCP will participate in the Area /Co-ordination Group and the two local CPP Boards. We will continue to provide stewardship for the Strategic Health Partnership locally and contribute to the key partnership structures to join up action to create healthy, working, learning, safe and vibrant communities in South West Glasgow. Our contribution will be articulated in the Local Community Plan/Outcome Agreement demonstrated through joint action and problem solving with local people.

6.8.2 Community Development and Engagement

For the first time the South West CHCP will have an integrated Social Work/NHS co-located Community Development and Engagement Team Structure. The team will deliver the development and engagement requirements and ambitions set out in the statutory provisions of the NHS and Local Authority, and those contained within Community Care and Community Planning requirements.

6.8.3 Public Partnership Forum (PPF)

We have a well established and vibrant PPF Executive group with over 20 members. During 2008/9 we will continue to support the PPF Executive Group to challenge and raise service and strategic issues with us. To this end we will embark on a joint development programme for CHCP Committee and PPF Executive Group members to establish an action plan for the year ahead. Last year we held a joint ‘Partnership Matters’ event for residents, voluntary organisations and staff to which 130 people attended. The event resulted in an action plan of activity and responses that were shared with all who attended.

The newly established CHCP Community Development and Engagement Team will continue to build local capacity and enable residents to be heard throughout the organisation. With an additional staff member we will seek to enable differing community structures to relate well together, extending the care group, carers and neighbourhood representation where required.

Some of the PPF Executive members are now represented on the Local Community Planning Partnerships and we will support, where appropriate, the joint working with communities that has been instigated last year.

6.8.4 Voice for Change

The Community Development and Engagement Team will work with service user/carer groups to develop a local Voices for Change Network, which will build capacity and provide a voice for the most excluded and hard to reach residents. The first phase of establishing the network will be completed during 2008/9.
6.8.5 Voluntary Sector and Provider Organisations

The voluntary sector and provider organisations (those contracted to provide packages of care) are represented directly or through a representative forum member on partnership structures operated by us. This is crucial to enable us to capture the vision and issues of this sector. During 2008/9 we will translate and implement the Community Planning Voluntary Sector Compact and continue to create regular opportunities to consider strategic and operational issues with the voluntary sector.

6.8.6 Carers

The CHCP created a local Carers Reference Group to ensure a consistent approach to supporting carers. Building on this successful initiative, it is proposed that the two independent carers centres as well as other local groups dealing with carers issues, will be linked into to the work of this group and will assist in forming a list of priorities for carers across the area. Some of the key priorities include:

- Information, Advice and Support
- Increased Respite and Short Breaks
- Working in partnership across the South West
- Establishing an LD Carers Group

The Glasgow Joint Carers Strategy was launched in June 2008 and following a period of consultation, the South West CHCP will be hosting a local event to hear the views of carers across the South West on the content of this strategy. We will also engage with carers across the area to address their issues in an enabling, inclusive and supportive way.
7. HOSTING RESPONSIBILITIES

7.1 Health at Work

The South West CHCP hosts this service on behalf of Greater Glasgow and Clyde NHS Board. The team of 18 staff are located in the Festival Business Park in Govan and have worked effectively throughout 2007/8 to ensure the services work across the NHS system in line with national and local Healthy Working Lives objectives.

We will now support the implementation of the Health at Work Strategy 2008-11, along with the joint GGC NHS Board, Glasgow City Council Staff Health Action Plan, affecting nearly 50,000 staff across the two organisations. This will be monitored through the Director of Public Health and Directors of Human Resources for NHS GG&C and GCC.

Through the team we will ensure the NHS Board continues to support the implementation of ‘Glasgow Works’ through leading, as task champion, the Action 11 Working Group on Employer Engagement and related activity.

We will work with the Scottish Centre for Healthy Working Lives (SCHWL) on the delivery, partnerships and developments of the award scheme and related activity. The team worked with 148 employers during 2007/8, collectively accounting for 40% of employees in the GGC NHS Board area.

Health at Work will utilise the workplace setting to deliver on NHS objectives and targets in the following ways:

- To bring about workplace culture change the team will:
  - increase the appetite for NHS messages and drivers by targeted marketing, dissemination of legislation, and policy translation
  - support employers to make sustainable changes by providing a policy and strategy development service
  - build capacity for health improvement in the workplace setting by delivering training, creating lay health workers, and providing resources and grants
  - enable community involvement by encouraging workplaces to play an integral role within their locality
  - engage with employers, utilising them to bring about strategic changes for better health for all within the wider policy environment
  - support the NHS to be an exemplar by influencing organisational change to improve the health of staff and their families within the NHS and Partnerships

- To fulfil their contribution to improving population health and reducing health inequalities the team will:
  - improve employee health and wellbeing by increasing health improvement knowledge and practice in workplaces
  - improve community health by utilising employees and workplaces as messengers of health messages to wider networks eg friends/family
  - reduce health inequalities by encouraging workplaces to focus resources on those with most need
  - reduce poverty by encouraging the creation of supportive workplace environments which enable people to retain employment or more easily gain employment
8. **FINANCIAL PLANNING AND RESOURCING**

8.1 **Getting the Best Value for Public Funds**

Throughout 2007/08 there was clear recognition of the requirement to achieve value for money in delivering the best possible service to clients within available resources. The relocation and integration of Social Work and Health staff throughout the area has been a move towards integration, which, along with the other areas highlighted within this plan, will facilitate the move towards improved use of available resource.

As part of the overall strive towards improving service integration alongside achieving general efficiency savings, plans are continuing to be developed by service leads to address areas where further efficiency savings can be achieved. An important element of this strategy is to avoid disruption to service delivery therefore it is accepted that changes should be made on an incremental basis.

Additional resource has been targeted at strengthening organisational development within the CHCP and it is expected that the benefits of this will be achieved in terms of increased overall efficiency.

With prescribing costs representing around one third of the NHS budget a significant effort was directed to ensuring the highest possible prescribing quality could be achieved. Prescribing quality can be described as prescribing that is appropriate, safe, effective and economic.

As part of the overall NHS Greater Glasgow & Clyde performance review of this key area a Prescribing Management Report was issued highlighting that the South West CHCP has performed very well in a number of key indicators and in fact had performed best in a number of indicators. This external review is encouraging and clearly confirms that the prescribing processes in place are proving effective. It is recognised that it is essential to continue driving towards improved overall prescribing quality.

8.2 **2008/09 Financial Planning**

There will be an ongoing commitment to achieving value for money in delivering services that achieve the maximum benefit to clients and patients in the most efficient manner.

It is recognised that the financial picture for 2008/09 will continue to present the requirement for tight financial constraints. The GCC Budget & Service Plan for 08/09 will require additional efficiencies to be achieved. Work will continue to focus on achieving efficiencies through the development of the integration agenda and reviews of current service delivery models.

The basis for the initial devolvement of budgets to CHCP’s by NHS Greater Glasgow and Clyde was to provide funding to support the existing service requirements. The Health Board noted the intention to review resource allocations to CHCPs based on agreed needs indicators as a basis for the revised allocation formula. Work is currently progressing on a revised model for Children & Families and Older Peoples Services. It is anticipated that the existing needs within this CHCP geographical area will be identified in the revised allocation proposal. It is unlikely that full implantation of resource reallocation will be achieved in 2008/09.

8.3 **Capital Programme**

Work has continued throughout the period in respect of planning for a CHCP Service Hub at Craigton Road where a total spend of £13.1m has been approved.
The Pollok Health Centre extension has been completed and this has allowed the further integration of Health & Social Work Services within the CHCP.

It is anticipated that work will complete during 07/08 on the Elderpark Clinic extension, which will provide consulting space and office accommodation to allow South West Community Mental Health Teams to come together on one site.

Funding was provided in 2007/08 to move staff from Govan Town Hall to new accommodation at Rowan Park. In addition the move included the relocation of a number of NHS staff as part of the integration agenda.

Formula capital was allocated to a number of areas during 2007/08 and these are detailed in the table below. The CHCP Capital Planning Group will continue to review capital planning proposals during 2008/09.
1. LOCAL PERFORMANCE MANAGEMENT PRIORITIES

2. STRUCTURE DIAGRAM
### Access

- **Implementation of the Integrated Assessment Framework**

  - Staff in Social Work, Health and Education now trained. The framework is currently being implemented for all children attending a Children’s Hearing.

  - A single report completed by all agencies on children attending Children’s Hearings in order to improve access to services and service responses to children’s needs. 100% of children who require a full assessment will have an integrated assessment report. Every child who is subject to a Child Protection Case Conference will have an integrated assessment.

### Service Provision

- **Implementation of the Health Visiting Review**

  - Review currently being implemented

  - Health Visitors will concentrate on supporting the most vulnerable children and their families. All children across the CHCP area will receive consistent Health Improvement Support. We will increase the number of vulnerable families worked with 10%.

### Outcomes

- **Shifting the Balance of Care**

  - Intensively reviewing the numbers of children and young people Looked After and Accommodated away from home

  - Staff are working with partner agencies to offer a range of parenting and support programmes for vulnerable children and their families

  - Reduce the numbers of children and young people in purchased and residential school placements by 5%.

- **Development of an Integrated Family support Strategy**

  - 250 families across the area to be involved in parenting/family support,
### Using Resources More Effectively

<table>
<thead>
<tr>
<th>Priority</th>
<th>Where we are now</th>
<th>What we want to achieve 08 - 09</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Establish Youth Justice Forum</em></td>
<td>Youth Justice forum now in operation</td>
<td>A better co-ordinated response to dealing with persistent young offenders. Effective case progression for 180 persistent young offenders or young people with anti social behaviour. Local training programme for in excess of 200 interagency staff. Better communication between agencies. Move to a single children’s services structure across the CHCP area. Ensure that 100% of vulnerable children or children who require statutory interventions have a designated worker and a clear care plan. Ensure that all staff working in children’s services across the CHCP have adequate support and supervision.</td>
</tr>
<tr>
<td><em>Establish Child Protection Forum</em></td>
<td>Child Protection Forum currently being established</td>
<td>Plan currently being established to integrate Health and Social Work Integrated Children’s Teams.</td>
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<tr>
<td><em>Development of integrated Children’s Teams</em></td>
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Youth Justice forum now in operation
Child Protection Forum currently being established
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</thead>
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<tr>
<td><strong>Access</strong></td>
<td>Regular monitoring and evaluation of reports implemented across CHCP. Ongoing training being delivered for staff on the effective completion of reports. Criminal Justice Services users currently having access and support from the Bridging Services.</td>
<td>100% offenders subject to a Social Enquiry Report will have their: Employment status recorded. Ethnicity recorded. Will be properly risk assessed. Reports will be submitted to court on time. 150 Offenders will have access to enhanced support for training and employment.</td>
</tr>
<tr>
<td><strong>Service Provision</strong></td>
<td>Criminal Justice Services in Southwest CHCP currently reviewing the level and standard of probation work.</td>
<td>100% of offenders subject to a statutory order are: Seen within 7 days. Have an allocated worker. Order formally reviewed after 3 months. 4 contacts per month while subject to an order.</td>
</tr>
<tr>
<td><strong>Outcomes</strong></td>
<td>Criminal Justice Services currently being devolved to CHCPs.</td>
<td>100% of offenders in southwest CHCP subject to Social Work Criminal Justice Services will have quality Assessment and Social Work Intervention at any stage of the Criminal Justice Process including initial reports, Community Sentencing Disposals, Prison or post sentencing stage.</td>
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### Using Resources More Effectively

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<tr>
<td>Offence Focused Work</td>
<td>Development of programmed work in the CHCP with Offenders including Offenders convicted of Domestic Violence</td>
<td>Construct and Change Programme to be rolled out across the CHCP. 60 Offenders will be involved in the construct programme. 25 offenders will be involved in the Change Programme</td>
</tr>
<tr>
<td>Priority</td>
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</tbody>
</table>
| **Access**             | Currently developing a strategy for our rehabilitation and enablement services | • Easy access to services through improved GP referral processes. Key priorities – cancer, diabetes, stroke  
• Extension of direct access arrangements for podiatry, physiotherapy and occupational therapy  
• Strengthening of community geriatrician role  
• Improve the use of single shared assessment and deliver awareness raising training for all staff on care management  
• Improve service provision for older people with mental health difficulties or dementia  
• Improve support to carers. Increase number of carer’s assessments. Target 110 in 08/09. |
| **Service Provision**  | Clinical forum established to strengthen links with GPs and hospital based services | • Improve links with MCNs and Collaboratives.  
• Establish local steering groups for specific long term conditions  
• Improve waiting times for all AHP services  
• Improve services for people with sensory impairment |
| **Outcomes**           | Work underway with ISD to improve information management processes.              | • Development of anticipatory care initiatives  
• Strengthening of Health In Later Life initiative by increasing participation and involvement in service planning |
| **Using Resources more effectively** | Performance framework established.                                               | • Workforce planning exercise  
• Strengthening of District Nursing resource  
• Development of team leader model  
• Increase numbers of people allocated to care manager to 80%  
• Introduce revised resource screening to improve use of range of service budgets  
• Review current residential and day care provision  
• Promote clinical and cost effectiveness prescribing to ensure CHCP remains with allocated budget. |
### ADDICTIONS – TO BE UPDATED WITH HEADINGS AS PER CH&F and H&CC

<table>
<thead>
<tr>
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<th>Current Status/Baseline</th>
<th>Local Target to be achieved 08 - 09</th>
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<tbody>
<tr>
<td><strong>Access</strong></td>
<td>Reviewing appointment system with a view to offering structured drop in days as well as appointment based service</td>
<td>Increase by 5% the number of people accessing treatment</td>
</tr>
<tr>
<td><strong>Employment/Education and Training</strong></td>
<td>Referrals continuing to increase to the Bridging Service. Will work with this service to increase access to service users via shared care clinics</td>
<td>Increase by 10% the number of clients entering Employment, Education and/or Training</td>
</tr>
<tr>
<td><strong>Parental Substance Misuse</strong></td>
<td>Awaiting roll out of assessment paper work from Glasgow Addictions Partnership to assess the impact of children affected by parental substance misuse</td>
<td>All services users (existing and new) will be assessed</td>
</tr>
<tr>
<td><strong>Staffing</strong></td>
<td>Planning sessions in place to take forward integrated working through March, April and May</td>
<td>Integrate teams across South West area to improve the consistency of service across the area</td>
</tr>
<tr>
<td><strong>Data quality</strong></td>
<td>Currently auditing data quality via business reports (Carefirst)</td>
<td>Improve quality of secondary data by 20%</td>
</tr>
<tr>
<td>Priority</td>
<td>Current Status/Baseline</td>
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<tr>
<td>3 Absence Management</td>
<td>Current absence levels remain high. Additional resource will assist in targeting areas of concern on an ongoing basis</td>
<td>Management of absence locally Joint process for both GCC and NHS GGC. NHS target of 4% to be achieved by March 2009. Management training and support. Further analysis of trends/causes/reporting.</td>
</tr>
<tr>
<td>4 Healthy Working Lives</td>
<td>Registration for award ongoing following Committee agreement in December.</td>
<td>Pursue this agenda and how impacts on above. Bronze award to be achieved within 18 months.</td>
</tr>
<tr>
<td>5 Workforce Planning</td>
<td>Discussions regarding outline process completed. Discussion regarding establishing working group at SMT</td>
<td>Develop workforce plan for CHCP on a joint basis with GCC over the next 12 months.</td>
</tr>
<tr>
<td>6 Knowledge and Skills Framework/Personal Development Plans</td>
<td>Monthly Steering Group meeting and reporting to the NHS Board and GCC</td>
<td>Continue to progress across all NHSGGC staff to achieve target of 100% KSF coverage by June 2008 and implementation of PDPs for both GCC and NHS staff.</td>
</tr>
<tr>
<td>7 Policy Development</td>
<td>New policy on Work Life Balance (NHS) and Attendance Management agreed. Discipline and Grievance expected in coming months</td>
<td>Implement across CHCP to invigorate use of process and procedures to manage attendance and other areas of staff governance. Joint training / standard use of policies across integrated teams.</td>
</tr>
</tbody>
</table>
### HEALTH IMPROVEMENT AND PLANNING – TO BE UPDATED AS PER CH&F AND H&CC

<table>
<thead>
<tr>
<th>Priority</th>
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<tr>
<td>10 Alcohol</td>
<td>Achieve X screenings using the setting-appropriate screening tool and appropriate alcohol brief intervention, in line with SIGN 74 guidelines by 2010/11</td>
<td></td>
</tr>
<tr>
<td>11 Smoking Cessation</td>
<td>Total population of smokers = 24,704</td>
<td>Support 8% (1,976) of smoking population in successfully quitting (at one month post quit) over the period 2008/09 – 2010/11. Target for year 1 = 593</td>
</tr>
<tr>
<td>12 Infant Feeding</td>
<td>Increase proportion of new-born children exclusively breastfed at 6-8 weeks from 26.6% in 2006/07 to 33.3% in 2010/11</td>
<td></td>
</tr>
<tr>
<td>13 Engagement</td>
<td>Audit of X Community Groups engaged in CHCP activity</td>
<td></td>
</tr>
<tr>
<td>14 Contacts and Publicity</td>
<td>X number of community members attending events and meetings during year X number of publications X number of people receiving publications/newsletters</td>
<td></td>
</tr>
</tbody>
</table>
Contact Details

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www.chps.org.uk
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Robert Dolan

Community Addictions Manager
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Professional Leads
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Ken O'Neill

Lead Nurse Adviser
Martin Hattie (Acting)

Lead Allied Health Professional
Mandy Abbott

Lead Social Worker
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