AGENDA ITEM No.14

EAST RENFREWSHIRE COUNCIL

11 September 2019

Report by Chief Officer – Health and Social Care Partnership

EAST RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP ANNUAL PERFORMANCE REPORT 2018/19

PURPOSE OF REPORT

1. This report advises the Council of the Annual Performance Report for the Health and Social Care Partnership for 2018/19.

RECOMMENDATION

2. The Council is asked to note and comment on the contents of the report.

BACKGROUND

3. The Public Bodies (Joint Working) (Scotland) 2014 Act requires each Integration Joint Board to publish an Annual Performance Report setting out an assessment of performance in planning and carrying out the integration functions for which they are responsible. The Integration Joint Board must also provide a copy of this report to each constituent authority (East Renfrewshire Council and NHS Greater Glasgow & Clyde).

4. The required content of the performance reports is set out in The Public Bodies (Joint Working) (Content of Performance Reports) (Scotland) Regulations 2014. In addition the Scottish Government has issued guidance for the preparation of performance reports, which should comprise:

- Performance against national health and wellbeing outcomes;
- Performance in relation to integration planning and delivery principles;
- Performance in relation to strategic planning and any review of strategic plan during year;
- Financial planning, performance and best value;
- Performance in respect of locality arrangements;
- Inspections of services;
- Details of any review of the strategic plan.

REPORT

5. This year is the first year of the HSCP Strategic Plan 2018-21 and this is our third Annual Performance Report. The Annual Performance Report is a high level report and more detail on local targets and activities is available in our quarterly and six-monthly performance reports to the Integration Joint Board Performance and Audit Committee.

6. The Annual Performance Report sets out how we have delivered on our vision and commitments over 2018/19. We review our performance against agreed local and national performance indicators and against the commitments set out in our second Strategic Plan, which covers the period 2018-21. The report is principally structured around the priorities set out in our strategic plan, linked to the National Health and Wellbeing Outcomes as well as those for Criminal Justice and Children and Families.

7. The main elements of the report set out: the current strategic approach of the East Renfrewshire Health and Social Care Partnership; how we have been working to deliver our strategic priorities over the past 12 months; our financial performance; detailed performance information illustrating data trends against key performance indicators; and, key work areas we will be focusing on as we move forward.

8. National performance indicators can be grouped into two types of complementary measures: outcome measures and organisational measures.

9. The national outcome measures are based on survey feedback available every two years from a national survey of people taken from a random sample based on GP practice populations. These people have not necessarily used HSCP services. The survey was last carried out in 2017 and as such no current data is available for these measures. The HSCP collects local data of people who have used our services and supports. This is included in the report as it is collected throughout the year and can be tracked over a longer time period. We believe this better reflects outcomes achieved by the Health and Social Care Partnership.

10. The national organisational measures are taken from data that is collected across the health and care system for other reasons. In all cases we have included the latest available data. Full end year data was not available for some national indictors. In line with Scottish Government guidance we have reported calendar year data (Jan-Dec 2018) for these measures and identified these in the report.

11. The remaining performance information in the report relates to the key local indicators and targets developed to monitor progress against our Strategic Implementation Plan 2018-21. Our performance indicators illustrate progress against each of our seven strategic priorities. Chapter 4 of the report gives trend data from 2016/17 and uses a Red, Amber, Green status key to show whether we are meeting our targets.

12. In addition to activity and performance in relation to the seven strategic priorities the report includes sections on:

- Public protection;
- Our hosted Specialist Learning Disability Service;
- How we support our staff.

13. Performance indicators that have seen the greatest improvement in 2018/19 include:

- Outcomes for children following support from our parenting programmes.
- Outcomes for people using addiction services moving through support services to recovery.
- Helping older people and people with long-term condition maintain independence at home.
- Reducing unplanned hospital care by reducing emergency admissions and attendance/admission from care homes.
- Supporting the needs of unpaid carers.

14. The report was approved by the Integration Joint Board on 26 June 2019.

FINANCE AND EFFICIENCY

15. This report includes some high level end of year financial performance information. A separate Health and Social Care Annual Accounts Report is available.

CONSULTATION AND PARTNERSHIP WORKING

16. The Health and Social Care Partnership Strategic Plan makes a commitment to working together:

- With individuals as partners in planning their own care and support.
- With carers and families as partners in the support they provide to the people they care for. We will ensure the supports carers and families can sometimes require themselves are recognised.
- With communities as partners in shaping the care and supports available and in providing opportunities for people to get involved in their communities.
- With organisations across sectors, including our Community Planning partners and the Third Sector. We will work in partnership to co-commission, forecast, prioritise and take action together.

17. There are multiple examples of this commitment in action throughout the report.

IMPLICATIONS OF THE PROPOSALS

Staffing

18. One of the national outcomes is 'People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide. There is a section in the report on this outcome.

Legal

19. The Annual Performance Report is a statutory requirement of the Integration Joint Board.

Equalities

20. The Integration planning and delivery principles include a requirement that Integration Joint Boards:

- Take account of the particular needs of different service users.
- Takes account of the particular needs of service users in different parts of the area in which the service is being provided.
- Take account of the particular characteristics and circumstances of different service users.

21. There are examples of this throughout the report.

22. There are no implications in relation to risk, policy, property, or IT.

CONCLUSIONS

23. The Annual Performance Report is the third performance report for East Renfrewshire Health and Social Care Partnership. This report provides a comparison of our performance against Scotland and the previous baseline year.

RECOMMENDATIONS

24. The Council is asked to note and comment on the contents of the report.

REPORT AUTHOR AND PERSON TO CONTACT

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August 2019

HSCP Chief Officer: Julie Murray

BACKGROUND PAPERS

https://www2.gov.scot/Resource/0047/00473516.pdf
Annual Performance Report 2017/18
Annual Performance Report 2016/17

East Renfrewshire Health and Social Care Partnership

Annual Performance Report

2018/19

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1. Introduction

1.1 Purpose of Report

The Public Bodies (Joint Working) (Scotland) Act 2014 requires Integration Joint Boards to publish an Annual Performance Report, setting out an assessment of performance in planning and carrying out those functions for which they are responsible.

This is the third report for the East Renfrewshire Integration Joint Board. It sets out how we have delivered on our vision and commitments over 2018/19. We review our performance against agreed local and national performance indicators and against the commitments set out in our second Strategic Plan, which covers the period 2018-21.

The main elements of the report set out:

- the current strategic approach of the East Renfrewshire Health and Social Care Partnership (HSCP);
- how we have been working to deliver our strategic priorities over the past 12 months;
- our financial performance; and,
- key work areas we will be focusing on as we move forward.

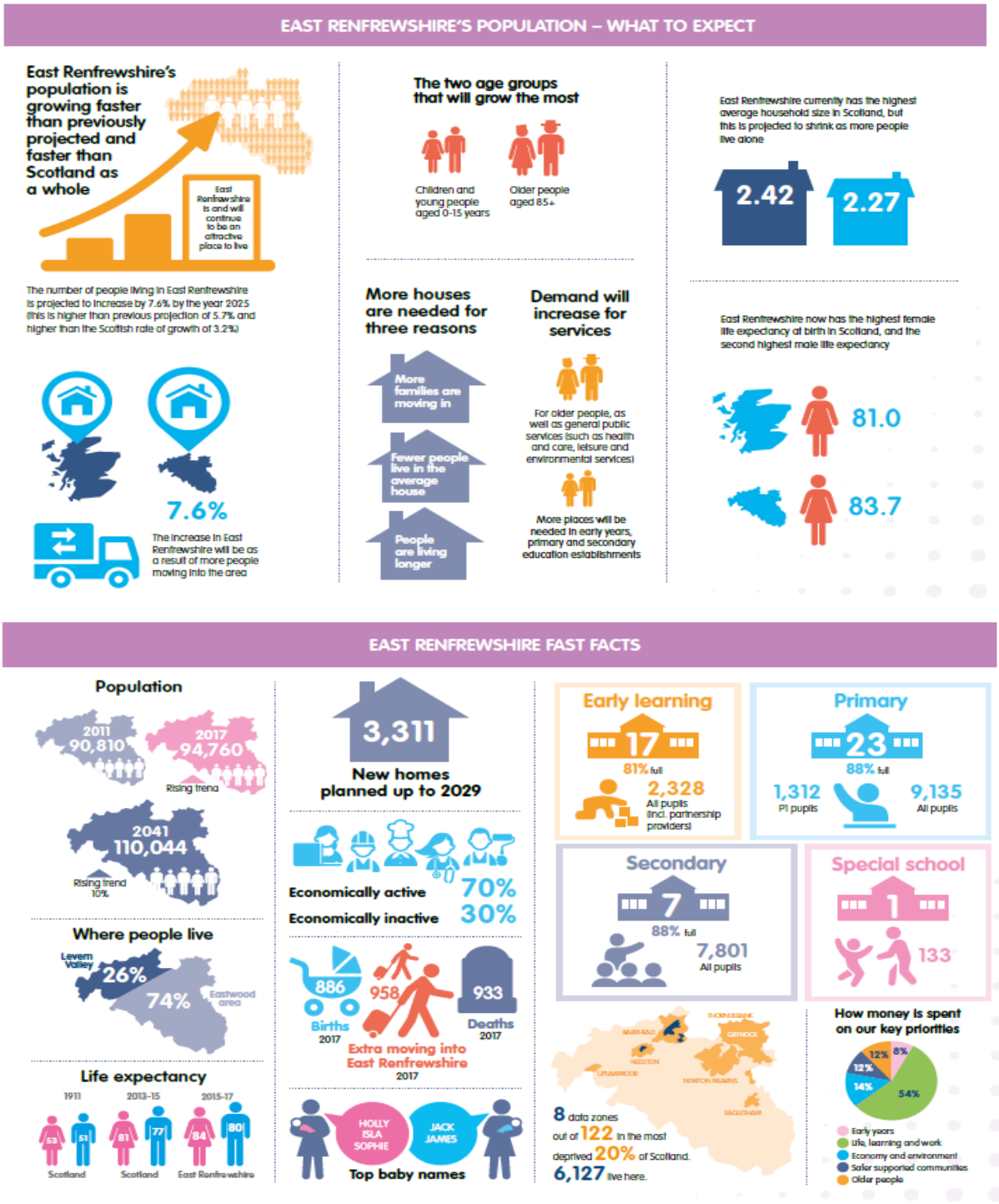
Detailed performance information illustrating data trends against key performance indicators is included in the Chapter 4 of the report.

1.2 Local context

East Renfrewshire covers an area of 174 square kilometres and borders the city of Glasgow, East Ayrshire, North Ayrshire, Renfrewshire and South Lanarkshire.

Our population is growing and reached 94,760 in 2017. 74% of the population live in the Eastwood area (Busby, Clarkston and Williamwood, Eaglesham and Waterfoot, Giffnock, Netherlee and Stamperland, Newton Mearns and Thornliebank) and 26% live in the Barrhead area (Barrhead, Neilston and Uplawmoor).

East Renfrewshire has an increasing ageing population with a 44% increase in the number of residents aged 85 years and over during the last decade.



East Renfrewshire Health and Social Care Partnership (HSCP) was established in 2015 under the direction of East Renfrewshire's Integration Joint Board (IJB) and it has built on the Community Health and Care Partnership (CHCP), which NHS Greater Glasgow and Clyde and East Renfrewshire Council established in 2006.

Our Partnership has always managed a wider range of services than is required by the relevant legislation. Along with adult community health and care services, we provide health and social care services for children and families and criminal justice social work.

During the last 13 years our integrated health and social care management and staff teams have developed strong relationships with many different partner organisations. Our scale

and continuity of approach have enabled these relationships to flourish. We have a history of co-production with our third sector partners and we are willing to test new and innovative approaches.

East Renfrewshire HSCP is one of six partnerships operating within the NHS Greater Glasgow and Clyde Health Board area. We work very closely with our fellow partnerships to share good practice and to develop more consistent approaches to working with our colleagues in acute hospital services.

1.3 Our Approach

1.3.1 Our Strategic Vision and Priorities

In East Renfrewshire we have been leading the way in integrating health and care services. From the outset of the CHCP we have focused firmly on outcomes for the people of East Renfrewshire, improving health and wellbeing and reducing inequalities. Under the direction of East Renfrewshire's IJB, our new HSCP builds on this secure foundation. Throughout our integration journey during the last 13 years, we have developed strong relationships with many different partner organisations. Our longevity as an integrated partnership provides a strong foundation to continue to improve health and social care services.

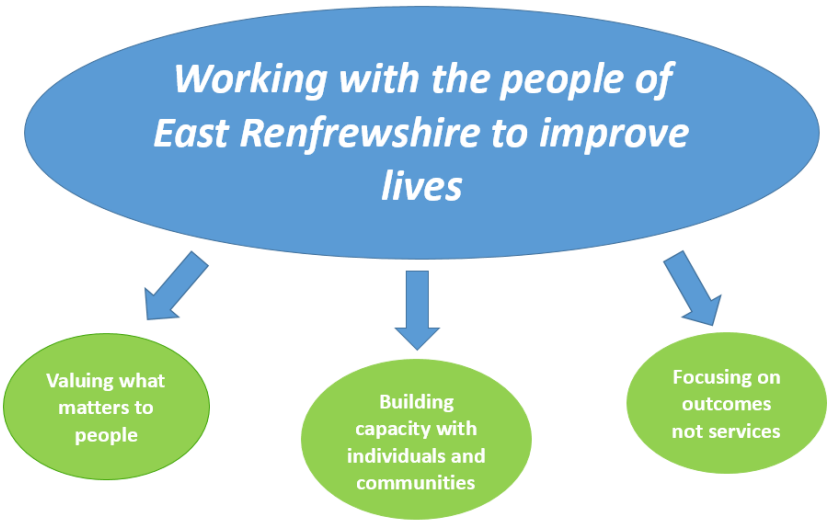
Our Vision

Our vision statement, *"Working together with the people of East Renfrewshire to improve lives"*, was developed in partnership with our workforce and wider partners, carers and members of the community. This vision sets our overarching direction through our Strategic Plan. At the heart of this are the values and behaviours of our staff and the pivotal role individuals, families, carers, communities and wider partners play in supporting the citizens of East Renfrewshire.

We developed integration touchstones to progress this vision. These touchstones, which are set out below, are used to guide everything we do as a partnership.

- *Valuing what matters to people*
- *Building capacity with individuals and communities*
- *Focusing on outcomes, not services*

The touchstones keep us focused when we are developing and improving the quality of our service delivery.



Our Strategic Plan

Our first Strategic Plan covered the period 2015-18 and took its priorities from the National Health and Wellbeing Outcomes. It set our high level planning intentions for each priority and was underpinned by an Annual Implementation Plan reviewed and monitored at HSCP level.

In 2017-18 we reviewed our Strategic Plan in collaboration with our partners and local communities and began developing the priorities for our second plan. We considered our current performance using the national outcomes and indicators over the period of the first plan and sought feedback from our communities through national and local surveys. Our engagement activity was led by the third sector interface in partnership with Thrive, a commissioned external agency. We also looked at changes in the community planning, regional planning and the NHS Greater Glasgow and Clyde wider partnership landscape.

Through a series of workshops with our Strategic Planning Group, we recognised the need to reduce our strategic priorities in order to give more focus to areas of improvement. Much of our work from our previous strategic plan has continued. However, it was recognised that to meet the range of challenges presented by pressures on our finances and our growing and ageing population, we must fundamentally change the way we work together.

Our new plan that has been developed recognises that the partnership must extend beyond traditional health and care services to a real partnership with local people and carers, volunteers and community organisations, providers and community planning partners. We must place a greater emphasis on addressing the wider factors that impact on people's health and wellbeing, including activity, housing, and work; supporting people to be well, independent and connected to their communities.

The plan recognises that emergency admissions, out of hours pressures and carer stress are signs that we do not yet have all the right systems in place. We are committed to increasing the opportunities for people to talk with us earlier, exploring what matters to them and supporting them to plan and take action to anticipate and prevent problems and crises. By putting in place the right support at the right time we believe that we can improve lives and reduce demands on the health and care system.

Moving forward, hospitals will provide highly specialist treatment for people who are acutely unwell, with more locally provided rehabilitation and recuperation services. We have strong relationships with GPs in East Renfrewshire and over the course of the current strategic plan will be investing in primary care services to support people to better manage health conditions. We know that people staying in hospital longer than necessary makes them deteriorate and lose their independence and by reaching out to hospitals and providing a range of local supports we will get people back to East Renfrewshire sooner.

The strategic plan for 2018-21 sets out seven strategic priorities where we need to make significant change or investment during the course of the plan. These are:

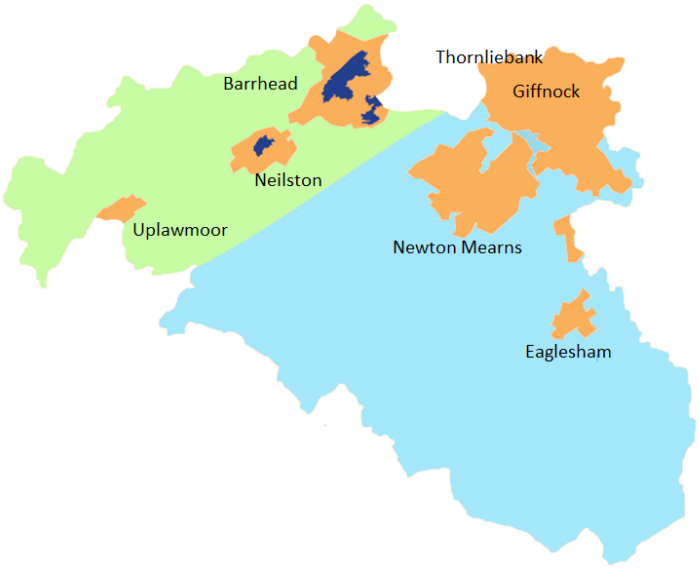
- Working together with **children, young people and their families** to improve mental wellbeing
- Working together with our community planning partners on new **community justice** pathways that support people to prevent and reduce offending and rebuild lives
- Working together with our communities that experience shorter life expectancy and **poorer health** to improve their wellbeing
- Working together with people to maintain their **independence at home** and in their local community
- Working together with people who experience **mental ill-health** to support them on their journey to recovery
- Working together with our colleagues in primary and acute care to care for people to reduce **unplanned admissions** to hospital
- Working together with **people who care for someone** ensuring they are able to exercise choice and control in relation to their caring activities

1.3.2 Locality planning in East Renfrewshire

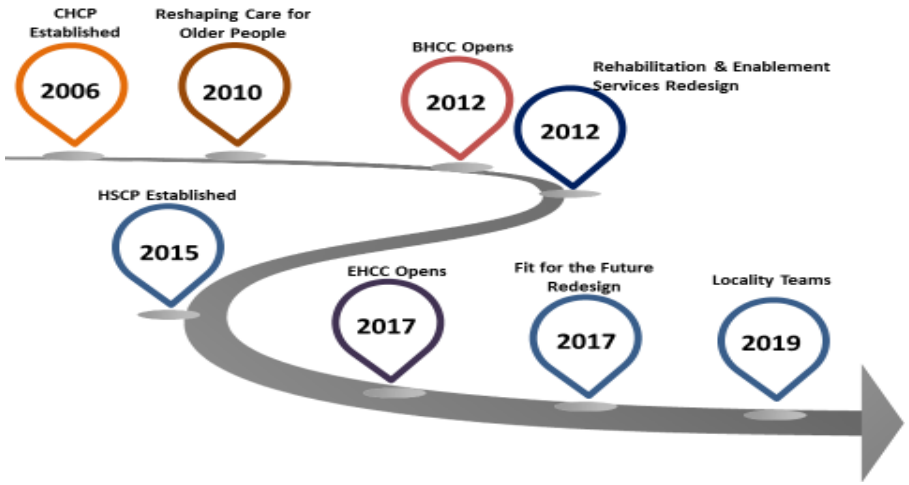
In the East Renfrewshire HSCP Strategic Plan 2015-18 we divided the area into three localities based around our GP clusters. Since the last plan, our GP clusters for the Eastwood area have changed with the GPs in the Eastwood Health and Care campus forming one cluster and the GP practice in Newton Mearns and Clarkston forming the other. As GP practice populations do not reflect natural communities, we found it difficult to co-ordinate this approach. As a result we have moved to two localities: one for Eastwood and another for Barrhead.

Our new localities also reflect our hospital flows, with the Eastwood Locality linking to South Glasgow hospitals and the Barrhead Locality to the Royal Alexandra Hospital in Paisley. The Barrhead Locality and Eastwood Locality Managers came into post in 2018. They have responsibility for both locality-based teams and services hosted on behalf of the entire HSCP.

Our locality planning arrangements continue to develop and will be supported by new planning and market facilitation posts and financial reporting at a locality level.



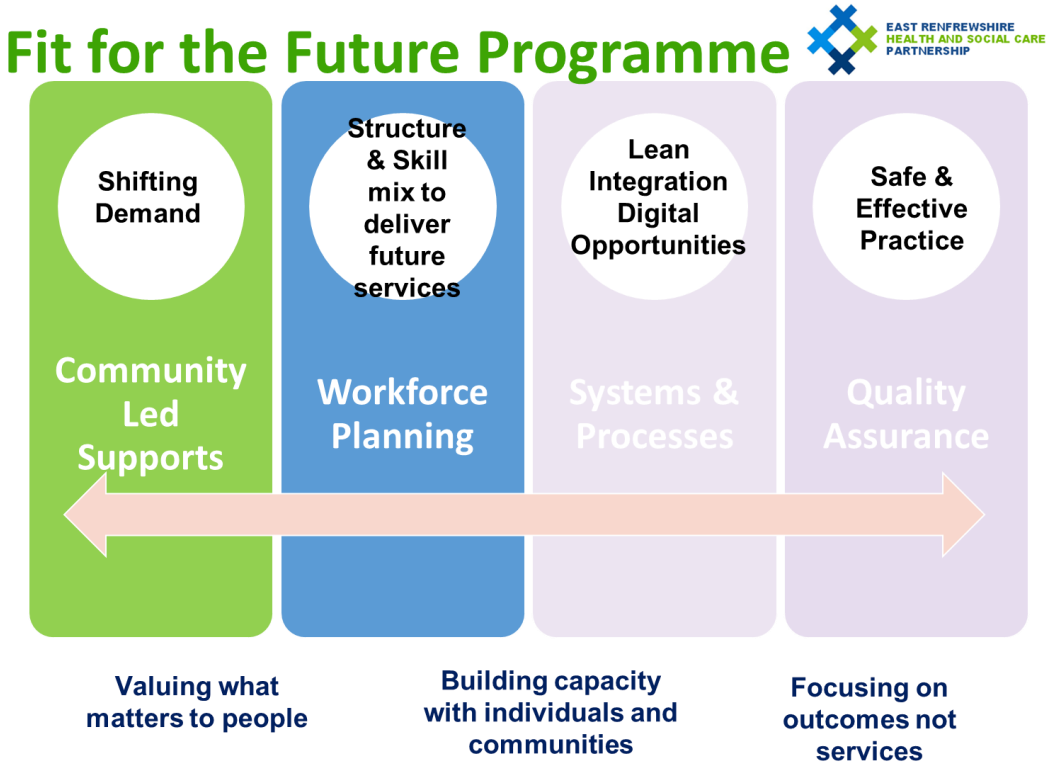
1.3.3 Realising the strategy through operational delivery



Developing our integrated Health and Care Centres at Barrhead and Eastwood provided us with an ideal opportunity to facilitate a fundamental change in the operational delivery of health and social care for people in East Renfrewshire. Eastwood Health and Care Centre was designed to support the further integration of health and care, along with wider Council and third sector services, in a setting that promotes wellbeing.

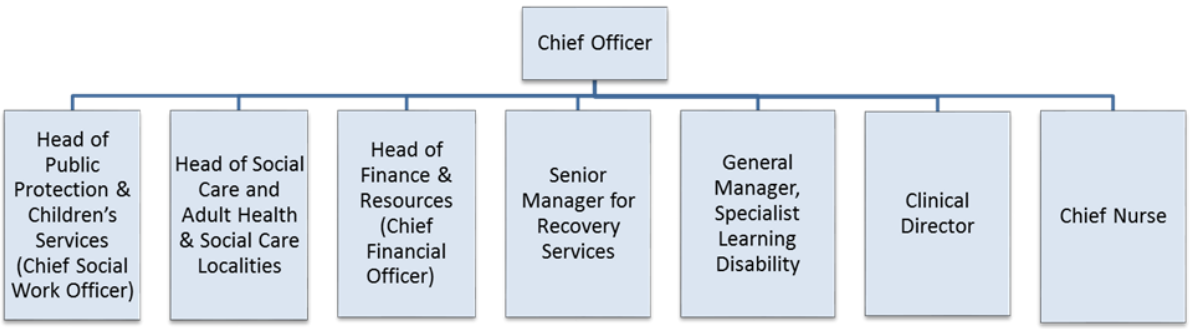
In order to prepare for the move to the Eastwood facility (opened 2017), a significant transformation programme was undertaken. We worked with staff groups to design zones that collocated workers and teams, in environments that supported their ways of working and fostered collaboration. Before finalising the physical design in Eastwood, we tested our new working environment in Barrhead Health and Care Centre. Reassuringly, both users and staff have evaluated the building design and functionality of the Eastwood Health and Care Centre very positively and it remains a reference design for future centres.

More recently our Fit for the Future change programme (FFTF) has included end to end operational service reviews in conjunction with a review of our organisation structure and in line with our vision.

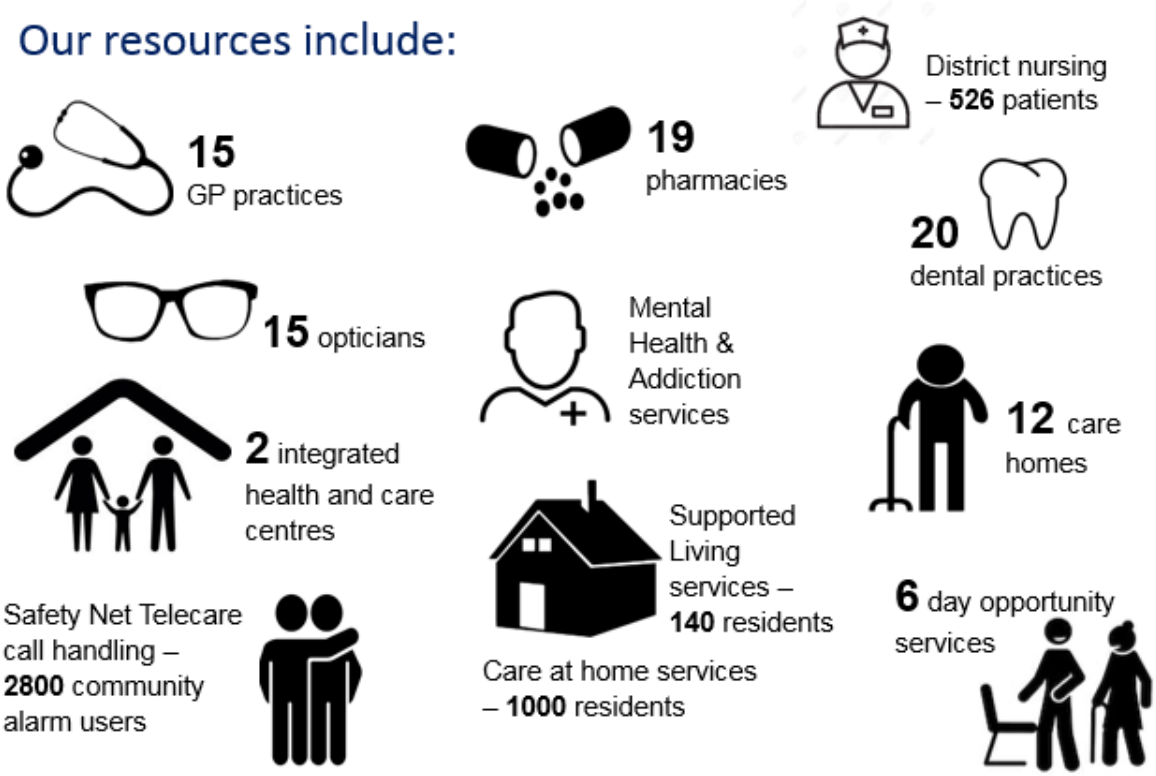


The Chief Financial Officer (CFO) is responsible for ensuring that all project work and service designs are properly supported and that sound financial and risk governance is in place. This includes modelling and monitoring the FFTF programme.

This new structure modelled through FFTF recognised the need to strengthen the link between strategy and operations, and to develop a stronger locality focus. Strategic planning, market facilitation and improvement capacity are being embedded in the locality structure. As the new teams come into place over the coming year, they will undertake self-evaluation and planning activity to support the strategic direction. The structure of our leadership team is shown below.



Our partnership provides a wide range of health and social care service for local people including the examples given below.



1.3.4 Our integrated performance management framework

Since the establishment of the Community Health and Care Partnership in 2006, there has been a commitment to integrated performance management.

Our performance management framework is structured around our new Strategic Plan, with all performance measures and key activities clearly demonstrating their contribution to each of our seven strategic planning priorities. The framework also demonstrates how these priorities link to the National Health and Wellbeing Outcomes and East Renfrewshire's Community Planning Outcomes.

An Implementation Plan and a supporting performance framework accompany our 3-year Strategic Plan. Working with key stakeholders, we developed these through outcome-focused planning. The plan is presented as a series of 'driver diagrams'. These diagrams show how we will achieve our strategic outcomes through 'critical activities' measured by a suite of performance indicators. This is the basis for strategic performance reporting to the Integration Joint Board (IJB) and it also feeds into East Renfrewshire Council's Outcome Delivery Plan and NHS Greater Glasgow and Clyde's Operational Plan. Our Strategic Performance Reports are presented to the IJB Performance and Audit Committee every six months (at mid and end year). We also provide quarterly updates (at Q1 and Q3) when data updates are available.

Every six months we hold an in-depth Performance Review meeting which is jointly chaired by the Chief Executives of NHS Greater Glasgow and Clyde and East Renfrewshire Council. At these meetings both organisations have the opportunity to review our Strategic Performance Report and hear presentations from Heads of Service, which set out performance progress and key activities across service areas.

The HSCP draws on qualitative and quantitative information from a range of sources. Our main sources of performance data include ISD Scotland, Scottish Public Health Observatory and National Records Scotland. We also use local service user data and service data from NHS Greater Glasgow and Clyde.

We gather service user feedback from a variety of sources. These include patient/service user surveys through for example, our Primary Care Mental Health Team; day centres and community groups; and users of our integrated health and social care centres. We also gather local feedback from East Renfrewshire Council's Citizens' Panel, Talking Points data and the National Health and Wellbeing Survey. We support a Mental Health Carers Group, where carers are able to raise issues about their needs and the support they receive.

2. Delivering our key priorities

2.1 Introduction

This section looks at the progress we have made over the past 12 months to deliver the key priorities set out in our new Strategic Plan. We also set out performance for cross-cutting areas that support our strategic priorities including public protection and staff engagement. For each area we present headline performance data showing progress against our key local and national performance indicators. In addition to an analysis of the data we provide qualitative evidence including case studies and feedback from local people engaging with our services. We also illustrate which of the National Health and Wellbeing Outcomes we are contributing to through each area of activity.

A full performance assessment covering the period 2016/17 to 2018/19 is given in Chapter 4 of the report.

2.2 Working together with children, young people and their families to improve mental wellbeing

National Outcomes for Children and Young People contributed to:
Our children have the best start in life and are ready to succeed
Our young people are successful learners, confident individuals, effective contributors and responsible citizens
We have improved the life chances for children, young people and families at risk

2.2.1 Our strategic aim

We provide ongoing support to children who are described as vulnerable due to being looked after and in our care, or on the edges of care, who need targeted interventions to safeguard their wellbeing.[1] Our new Strategic Plan established a targeted priority of improving mental wellbeing of children and young people. We have been aware for some time of the pressures on our Child and Adolescent Mental Health Services (CAMHS), our disproportionate use of mental health inpatient beds and the number of GP consultations for mental wellbeing. Local community consultation also confirmed this as an area of concern for local residents.

Research suggests that half of adult mental health problems have begun by the age of 15, and thrh problems, and once acquired they tend to persist. Mental ill health in children, young people and adults is strongly correlated with exposure to childhood adversity and trauma of various kinds. Adverse Childhood Experiences (ACEs) are an established indicator of exposure to such trauma. ACEs range from verbal, mental and physical abuse, to being exposed to alcoholism, drug use and domestic violence at home.

[1] Our main activities to support children and young people in East Renfrewshire are set out in "Getting it right with you" East Renfrewshire's Children's Services Plan 2017-2020.

Our aim is to **improve mental wellbeing among children, young people and families in need**, by:

- Providing the appropriate and proportionate mental health responses for children and young people;
- Increasing confidence among parents most in need of support as a result of targeted interventions;
- Improving maternal health and wellbeing;
- Strengthened family capacity through prevention and early intervention.

2.2.2 The progress we've been making

- 89% increase in improved outcomes for children after parent/carer completion of our Psychology of Parenting Project (PoPP)
- 100% positive response to Viewpoint question "Do you feel safe at home?"
- 90% of children/young people attending our Family Wellbeing Service with improved emotional health at end of programme in 2018/19
- Balance of Care for looked after children - 94% of children being looked after in the Community (5th best in Scotland)
- 100% of all accommodated children waited no longer than 6 months for a Looked After Review meeting to make a permanence decision
- 0% Child Protection re-registrations within 18 months (best in Scotland)

2.2.3 How we've been delivering

The Integration Joint Board are aware that many East Renfrewshire children and young people are presenting at GP services with requests for support around anxiety, depression, and distress. Parents expressing worry about the wellbeing of children and young people have been calling upon specialist and clinical services such as CAMHS, or Educational Psychology to respond.

We are aware that these traditional service have been experiencing high demand resulting in longer waiting times. And in many cases this is not the most appropriate support for the young person and their family.

As an alternative approach we have established our **Family Wellbeing Service**, to support these children and young people who present with a range of significant mental and emotional wellbeing concerns. Children 1st have been commissioned to deliver this service since September 2017. The Family Wellbeing Service works with the HSCP to deliver holistic support based in GP surgeries to:

- Improve the emotional wellbeing of children and young people aged 8–16;
- Reduce the number of inappropriate referrals to CAMHS and other services;
- Support appropriate and timely recognition of acute distress in children and young people accessing clinical help if required;
- Improve family relationships and help build understanding of what has led to the distress and concerns;
- Engage, restore and reconnect children and young people with school and their wider community.

The service has been delivering positive outcomes for those accessing support. In 2018/19, 90% of the children and young people were recorded as having improved emotional health at the end of the programme. At November 2018, 100% of parents completing our feedback questionnaire stated that they felt more positive about the future for their family as a result of the Family Wellbeing Service.

Although we continue to experience very high demand for our **CAMHS service**, we are seeing the impact of putting in place more appropriate and proportionate support through a reduction in rejected CAMHS referrals (14.9% in 2018/19; down from 34.9% in 2017/18) and a reduction in missed CAMHS appointments (8.3% - down from 16.7%).

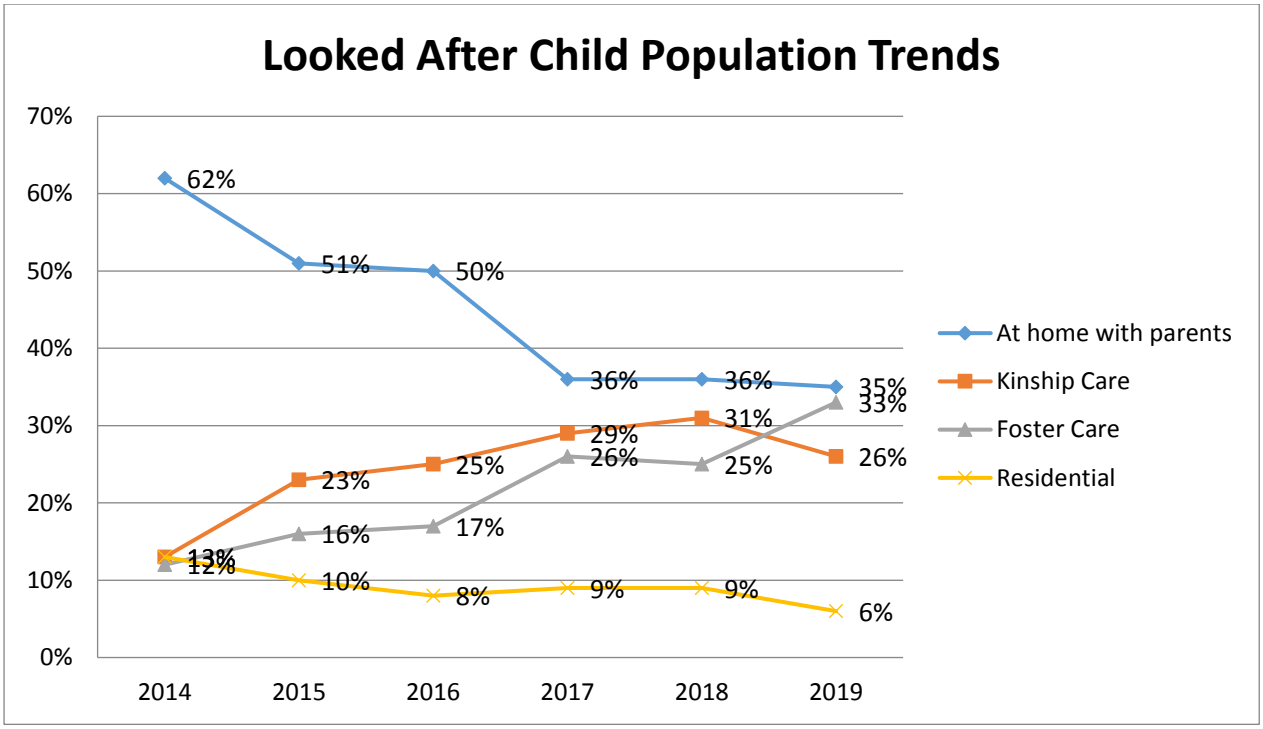
As part of our preventative approach, we are committed to strengthening family capacity and building confidence among parents where this is required. We continue to invest in and develop our **Psychology of Parenting Project (PoPP)** which offers support to families experiencing difficulties with behaviour. Families can access one-off interventions (discussion groups) focusing on a specific topic. There are also two high quality, evidence-based programmes - Triple P and Incredible Years – offering more intensive support for parents due to challenging developmental behaviours and distress.

In 2018, 89% of the children participating demonstrated improved outcomes as measured by SDQ (Strengths and Difficulties Questionnaire) – higher than the national average 82% and a significant improvement from 79% in 2017/18. 60% of parents/carers who start the PoPP programme go on to complete - again this is higher than the national average of 53%.

We continue to perform well in keeping children safe in their local community wherever possible and acting quickly to make decisions. Through this work and work with our care experienced young people we aim to improve life chances.

Through **PACE (Permanence and Care Excellence)** we have seen positive joint working, a strong commitment to change, and a developing 'common understanding' of permanence across the whole system. We have streamlined our processes to ensure that children, young people and their families/carers are included throughout the process in decision-making and care planning. Our commitment to supporting permanence is reflected in the achievement that all accommodated children in East Renfrewshire waited no longer than 6 months for a Looked After Review meeting to make a permanence decision in 2018 (100% - target 80%).

To support the wellbeing of our looked after children we work to ensure they access the most appropriate destinations possible. We are proud that 94% of our looked after children are supported in the community rather than institutional settings (up from 91.5% for the previous available year).



On 31 March 2019, 112 children and young people in East Renfrewshire were looked after in a range of settings. 62 of the children were boys (55%) and 50 were girls (45%). This constitutes approximately 0.5% of the total children's population of the area and is one of the smallest proportions in Scotland. We have continued to consolidate the PACE Programme, working to improve outcomes for children by securing permanent destinations for them. This can be seen in a continued overall reduction of looked after children, in particular those looked after at home by birth parents.

Further analysis of our reduction in children who are looked after at home has shown that from March 2018 to March 2019 a total of 17 Compulsory Supervision Orders for children and young people at home with parents were terminated. Of the 17 children and young people, 53% of their cases have been closed to social work.

In 2018/19 we have seen fantastic levels of engagement with our looked after children. 45% of East Renfrewshire's looked after children (aged 10 and over) are participating in activities through the East Renfrewshire Champions Board. This compares with a national benchmark of 10% participation (Life Changes Trust).

The Champions Board continues to go from strength to strength. The first theme in 2018 focused on mental health issues and generated actions including recruitment of new staff and training across departments. The Board also worked on issues around housing and accommodation, with a residential event taking place in May involving 24 young people. The Mini Champs initiative, involving younger children aged 8-11 years, is developing further with 12 younger children attending and participating from across local primary schools.

The overall aim of **East Renfrewshire Champions Board** is to improve life chances of looked after young people both within our community planning partnership and in the wider community. A central focus is on inclusion and participation allowing looked after young people a meaningful forum to directly influence and, through time, redesign services that affect them in a co-produced way by influencing their corporate parents.

Through our Champions Board we offer looked after young people leadership opportunities, develop relationship-based practice and the opportunity to change practice and policy. Our aim is to demystify and challenge misconceptions about looked after children and young people and strengthen awareness of the barriers that they face whilst offering opportunities to develop policy and practice to overcome these. Moreover we aim to reduce stigma and ensure that our looked after young people flourish and become all that they can be so that they move into adulthood and beyond, achieving their aspirations.

We continue to support the safety of **children at risk** in East Renfrewshire through strong multi-agency working. Last year, 100% of child protection investigations and associated safety plans were agreed by an Initial Referral Discussion involving Police, Social Work and Health. We are also the best performing partnership in Scotland for minimising Child Protection re-registrations with no re-registrations (within 18 months) in 2017/18. Overall, we have a 100% positive response rate to the Viewpoint question, “Do you feel safe at home?”

To support children, young people and families at risk from domestic abuse we work in partnership with a range of agencies including Women’s Aid. Outcomes reporting for children and young people is aligned to GIRFEC wellbeing indicators. 87% of all children and young people supported in the service noted an overall improvement in their outcomes. 77% noted an improvement in their health and wellbeing, 57% noted improvement in their confidence and self-esteem and 70% reported improvement in their safety.

2.3 Working together with our community planning partners on new community justice pathways that support people to prevent and reduce offending

National Outcomes for Community Justice contributed to:
Prevent and reduce further offending by reducing its underlying causes
Safely and effectively manage those who have committed offences to help them reintegrate into the community and realise their potential for the benefit of all

2.3.1 Our strategic aim

The East Renfrewshire Community Justice Outcome Improvement Plan sets out our core outcomes, what we will deliver as partners and how this will contribute to and improve the lives of people with lived experience of the community justice system from point of arrest through to returning from custody.

Over the course of this plan the East Renfrewshire HSCP will strengthen links with other community services and programmes to provide greater access and support for people to prevent and reduce offending. Through this work we will ensure that people moving through the criminal justice system have better access to the services they require, including welfare, health and wellbeing, addiction services, housing and employability.

Our aim is to **support people to prevent and reduce offending and rebuild their lives**, by:

- Reducing the risk of offending is through high quality person centred interventions;
- Ensuring people have improved access to through-care and comprehensive range of recovery services;
- Ensuring effective interventions are in place to protect people from harm.

2.3.2 The progress we've been making

- 100% of people reported that their community payback order helped to reduce their offending.
- 84% of community payback work placements were completed within court timescale.
- 55% of people with convictions referred to employability services demonstrated a positive employability outcome.
- 64% of women and 87% of children accessing domestic abuse support services demonstrated a positive improvement in their outcomes.
- 94% of people were able to access alcohol and drug services that support their recovery within three weeks.
- 22% of people moved from drug/alcohol treatment into recovery and 23% demonstrated a positive improvement in their alcohol and drug recovery outcomes.

2.3.3 How we've been delivering

We work with our partners to lead, develop, support and promote **Smart Justice** measures that work for those who have offended, those who have been harmed and for our community at large

In 2018/19, East Renfrewshire's **Community Payback Team** completed 10,779 hours of activity equating to £88,496 of unpaid work which directly benefited the local community. The Community Payback Team have been involved in a range of new projects during the year bringing benefits to the environment, local community and service user groups including local people with learning and physical disabilities. We continue to receive regular feedback from the public on the positive impact that community payback has had on their local community.

- *"Our charity shop has had a fantastic service from unpaid work this year. Two people who completed placements have remained as volunteers following the completion of their hours."*
- *"The support that has been provided by the team has ensured that the families we work with (some of which are the most disadvantaged in society) are able to maintain their tenancies appropriately."*
- *"I feel that the service is pivotal in the work that I do with families and that its value is of great significance."*

Bee-Haven

A great example of the team's work that will be of benefit to the community and wider environment is the Bee-Haven project. This innovative project has seen the Community Payback Team working in partnership with staff and service users at the Thornliebank Resource Centre to prepare a site at Eastwood Health and Care Centre for a new community-led bee-keeping project. We hope to see the project fully operational in 2019/20.

Dunterlie Foodshare

The Community Payback Team worked in partnership with Dunterlie Community Hub to deliver a new food share project. This has seen the team processing and delivering food parcels to those in need.

Corner space

This project brings together the Community Payback Team with local voluntary agencies including Men's shed and disability groups to create a new community space and sensory garden in Eastwood.

Across the partnership we have made significant progress to ensure we have a suitably qualified workforce supported by a clear pathway for domestic abuse referrals. As part of our community planning work to protect people from harm we implemented a multi-agency risk assessment conference (MARAC) for high risk domestic abuse victims. The MARAC is now fully operational as of March 2019. East Renfrewshire is also one of the first local authorities recognised in Scotland as accredited Safe and Together Champions delivering gold standard child protection domestic abuse training to staff.

We provide a high level of support for women and children who have experienced **domestic abuse**. Working in partnership with East Renfrewshire Women's Aid Service a total of 1025 women, children and young people accessed the helpline, drop in and direct support services. Demand continues to grow year on year with a 100% increase in support provided over the last 5 years of operation. In the past year we have seen two-thirds (64%) of domestic abuse victims and 87% of children receiving support reporting improving their personal outcomes with safety, health and wellbeing, and empowerment and self-esteem scoring highly.

We continue to deliver a comprehensive range of services to support people recovering from **drug and alcohol addiction**. Our local Community Addictions and Recovery Team provide tailored support including planning for recovery, one-to-one and group support, family support and links to other agencies and resources to help people in their recovery journey.

Our local recovery community is continuing to grow from strength to strength with the P.A.R.T.N.E.R. Group (People Achieving Recovery Together Now East Renfrewshire) being instrumental to achieving this. The group provides mutual aid support and is run by people who are in recovery and have life experiences which they can pass on to any one struggling with addiction. In the last year P.A.R.T.N.E.R. expanded and groups run weekly including both day and evening meetings in Barrhead. In September last year P.A.R.T.N.E.R. participated in the Recovery Walk Scotland in Glasgow with over 3,000 people taking part from across Scotland.

2.3 Working together with our communities that experience shorter life expectancy and poorer health to improve their wellbeing

National Health and Wellbeing Outcomes contributed to:
NO1 - People are able to look after and improve their own health and wellbeing and live in good health for longer.
NO3 - People who use health and social care services have positive experiences of those services, and have their dignity respected
NO4 – Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
NO5 – Health and social care services contribute to reducing health inequalities

2.4.1 Our strategic aim

East Renfrewshire's Community Planning Partnership has developed locality plans for the two localities (Arthurlie, Dunterlie and Dovecothall and Auchenback) that have areas within the 20% most deprived areas in Scotland, with significantly poorer outcomes in health, education, housing and employment. A third locality plan is being developed for Neilston. Plans have been developed using a community-led approach, which supported local residents to form steering groups to drive the process. Most of this work has been led by the Council's community planning team but health improvement staff have been involved in supporting the process.

Each plan has a set of priorities that reflect the unique needs of that locality. The plans form a basis for further work to which we are committed as a community planning partner. We will continue to support targeted health improvement interventions in our communities that experience the greatest health inequalities.

Our aim is to **improve wellbeing in our communities that experience shorter life expectancy and poorer health**, by:

- Reducing health inequalities by working with our communities;
- Mitigating health inequalities through targeted interventions.

2.4.2 The progress we've been making

- Our premature mortality rate remains significantly below the national average at 301 per 100,000 (Scotland 425)
- Male life expectancy at birth in our 15% most deprived communities is 73.9 compared to 69.7 for Scotland.
- Female life expectancy at birth in our 15% most deprived communities is 79.2 compared to 75.7 for Scotland.

2.4.3 How we've been delivering

Our **Health Improvement Team** promote self-help and information campaigns throughout the year via face to face events, social media and information resources. Information about self-help and community support is provided via the 'Your Voice' Bulletin which is sent directly to individuals on our database and also available in public places and online. Information materials and health campaign information are also available in Eastwood Health and Care Centre and in other local public and community facilities.

During 2018/19 Health Improvement have delivered and coordinated a range of training and information sessions to build staff/partner capacity to address health behaviour and raise awareness of health related issues. Topics included sexual health, breastfeeding awareness, Childsmile training, mental health, breast health, bowel screening, cancer screening for people with additional needs, second hand smoke training, smokefree training, health behaviour change training and physical activity.

Specialist **smoking cessation** services have been promoted across East Renfrewshire with particular emphasis on reaching those in our most deprived communities. A drop-in service and support group continues to be delivered weekly in Barrhead Health and Care Centre and one-to-one support is also available for individuals either face to face or by telephone.

We promoted the 2018 No Smoking Day in March 2018 by having staff present in the Auchenback Resource Centre and all Barrhead and Neilston pharmacies. In August 2018 we supported the local community in Auchenback to promote smoke free play areas at their local Health and Safety event to reduce children's exposure to smoking and second hand smoke.

Strength and balance **exercise sessions** are being delivered in the Dunterlie area of Barrhead to encourage local people to access physical activity and walking groups have been set up in Barrhead and Neilston. Chair based exercise groups for older adults are also provided in Barrhead and other venues.

The Live Active programme funded by ERHSCP and NHSGGC is being actively promoted in Barrhead to increase referrals and we have strengthened links with East Renfrewshire Culture and Leisure Trust (ERCLT) and other exercise providers to develop smooth referral pathways between services.

East Renfrewshire HSCP provided funding for an active health and wellbeing manager within ERCLT. This post has been developing the **Ageing Well** brand and has supported projects in Barrhead such as Dunterlie Tenancy Sustainability Project. Health Improvement staff have continued to provide information resources for community projects and events.

We have undertaken breast cancer awareness promotion in Barrhead, delivered Bowel Cancer UKs ‘Good Bowel Health’ Screening Workshops to Learning Disability Teams and ran a communication campaign to promote bowel screening in 2018 as part of bowel cancer awareness month.

2.4 Working together with people to maintain their independence at home and in their local community

National Health and Wellbeing Outcomes contributed to:
NO2 - People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
NO3 - People who use health and social care services have positive experiences of those services, and have their dignity respected
NO4 – Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services

2.5.1 Our strategic aim

A key strategic aim for our partnership is to ensure that people with support needs continue to enjoy a good quality of life in their own home and local community. We do this through a wide range of community-led supports and interventions to ensure that individuals have choice and control in the decisions that affect their life.

We are working together with local people, community groups and organisations to redesign a new 'front door' and new ways of engaging with people in their communities. We have set up new local Talking Points, where people can talk to different health and care staff and community volunteers about what matters to them. Through this approach we ensure that people have access to the right conversation at the right time and have the right support to maintain their independence.

Through our partnership with East Renfrewshire Culture and Leisure Trust we have put in place a great service for older people under the Ageing Well programme, with a range of activities that support and encourage older people to be physically and mentally active and maintain their independence. For those people who require support for their daily lives, we are moving to a model of "the right amount of support". In 2019 we are introducing a new individual budget calculator for self-directed support. This will remove the barriers and potential inequity of our current equivalence model and provide a more simple and transparent approach. We want to make sure that all our systems support choice and control and we are also introducing outcome focused support plans that move away from the task and time approach and allow more innovation and flexibility. This different approach will require support, training and a culture change across our partnership.

We will continue to work in partnership to increase the day opportunities available to people, and community involvement in our resource and health and care centres. Our work in localities will build on our strong local partnerships and social enterprise approach, encouraging innovation that supports people to live independently in the community and offers alternatives to residential care.

Our aim is to **support people to maintain their independence at home and in their local community**, by:

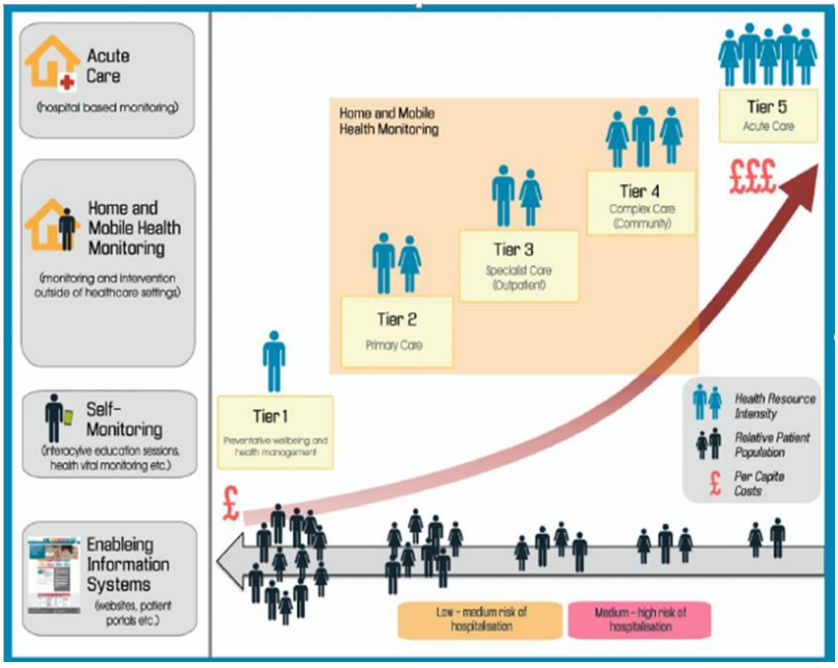
- Ensuring the people we work with have choice and control over their lives and the support they receive;
- Helping more people stay independent and avoid crisis though early intervention work;
- Ensuring people can maintain health and wellbeing through a range of appropriate activities.

2.5.2 The progress we've been making

- 74% of those receiving reablement (homecare) support have seen their care needs reduced
- 92% of people reported that their 'living where you/as you want to live' needs were being met
- 7.5% of adult social work spend is spent through SDS Options 1 and 2 (5th best in Scotland)
- 62.5% of people aged 65+ with intensive needs are receiving care at home

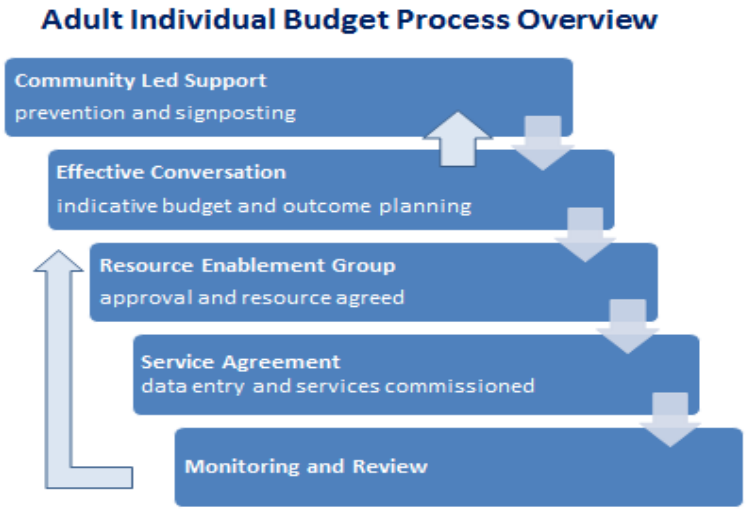
2.5.3 How we've been delivering

We have been modernising our approaches to support independence. This has seen the development of our **Home and Mobile Health Monitoring (HMHM)** service. Almost 90% of East Renfrewshire's GP practices now use HMHM to support the management of hypertension and some practices also offer it for the management of COPD. Since the service began in 2017 over 600 patients have been enrolled to the service which has saved over 1800 face to face appointments.



Throughout 2018/19 we have continued to expand our **telecare** provision. Through active promotion of the service, new marketing materials and refreshed web pages including online application, over 2,000 residents have benefitted from Telecare over the course of the 3 year national Technology Enabled Care (TEC) programme. We continue to work in close partnership with other teams and organisations to support independence at home.

We have developed a new way of planning with people who need support so that they have greater choice and control over their lives. Our current method of **resource allocation** for adults is based on equivalency. The equivalency model uses an hourly value of care cost as the basis of calculation of the individual budget for a support package. We have reviewed this approach and developed a new method for agreeing an individual budget that fits with our new ways of planning with people and allows more innovation and flexibility to meet their desired outcomes.



The 'right amount of support' individual budget calculator will be used for all types of resource provision from modest one-off interventions through to a complex care package. This removes the barriers and potential inequity of traditional eligibility criteria and recognises the importance of prevention. The individual budget calculator will be rolled out across adult care over the course of 2019/20.

In 2018/19 we redesigned the way people can access support and information at the first point of contact – our "front door". Our new **Initial Contact Team** came into place in May 2019.

Our team have been trained in good conversations that focus on what matters to each person and what assets and community supports could help them achieve this.

Occupational Therapy Rapid Access is also part of our new Initial Contact Team. This redesigned service has reduced waiting times for occupational therapy assessment and more efficient access to e-advice and equipment to support independence. The response from the public has been positive.

To support early intervention and ensure people get the right support before reaching a crisis point we have been delivering a series of **Talking Points** information and signposting sessions across East Renfrewshire. Talking Points 'are places in your community where you can come along and get information, support and advice about adult health, wellbeing and community activities going on where you live'. The Talking Points Core Partners Group consists of 12 cross-sector partners; Voluntary Action East Renfrewshire, Carers Centre, Care and Repair, Recovery Across Mental Health, East Renfrewshire Disability Alliance, Enable Scotland, HSCP, ERC Communications Team, Self-Directed Support Forum, Neilston Development Trust, East Renfrewshire Culture and Leisure Trust/Libraries, and Community Volunteers.

In 2018/19 we delivered 21 'Talking Points' engagement events supporting early intervention to 124 people – only 6 required direct referral to HSCP services.

We continue to support people with **learning disabilities** to live independently in our communities. There are approximately 150 people living independently with support and 85 living at home with their family with some support. Only one person was admitted to the specialist learning disability inpatient service in 2018/19 and is now back being supported in the community.

We support a wide range of meaningful activities in the community for people with learning disabilities. This includes social enterprise groups delivering bike workshops, jewellery making, gardening groups and kitchen/café training. We support a foodbank which provide opportunities for people with learning disabilities to develop skills for moving on to more formal training and potential employment. We also support a range of community groups, e.g. social/ leisure groups that allow people to follow their interests as well as health groups.

For **older people**, we support a range of health and leisure activities in the community under our Ageing Well programme to help people keep their bodies and minds as active as possible.

east renfrewshire CULTURE and LEISURE

Ageing Well with ERCL in numbers 2018

#ageingwellwithERCL

1565 attendances at **Live Active** group gym sessions

141 new **Live Active** fitness members **526** new referrals

14844 attendances at our **Vitality** classes

219 new referrals

702 regular users

557 attendances at our singing groups

2093 visits to our dancing groups

4031 walking group attendances

1277 walking football attendances

17544 Attendances at other group fitness activities

2.5 Working together with people who experience mental ill-health to support them on their journey to recovery

National Health and Wellbeing Outcomes contributed to:
NO1 - People are able to look after and improve their own health and wellbeing and live in good health for longer.
NO3 - People who use health and social care services have positive experiences of those services, and have their dignity respected
NO4 – Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services

2.6.1 Our strategic aim

Health and Social Care Partnerships across Greater Glasgow and Clyde are committed to working together to develop a whole system five-year strategy for adult mental health. Delivering on our strategy will involve a whole series of actions and service changes.

Our local services in partnership with third sector organisations like Recovery Across Mental Health (RAMH) will move to recovery-oriented care, supporting people with the tools to manage their own health. A recovery-based approach has the potential to improve quality of care, reduce admissions to hospital, shorten lengths of stay and improve quality of life. While service users will always have access to the clinical and therapeutic services they need, a recovery approach will require services to embrace a new way of thinking about illness, and innovative ways of working. Those changes include:

- A change in the role of mental health professionals and professional expertise, moving from being 'on top' to being 'on tap': not defining problems and prescribing treatments, but rather making their expertise and understandings available to those who may find them useful.
- A recognition of the equal importance of both 'professional expertise' and 'lived experience' and a breaking down of the barriers that divide 'them' from 'us'. This must be reflected in a different kind of workforce (one that includes peer workers), and different working practices founded on co-production and shared decision making at all levels.

We will work together across Greater Glasgow and Clyde to improve responses to crisis and distress, and unscheduled care. This strategy signals a further shift in our balance of care moving away from hospital wards to community alternatives for people requiring longer term, 24/7 care with mental health rehabilitation hospital beds working to a consistent, recovery-focused model.

Our aim is to **support people experiencing mental ill-health on their journey to recovery**, by:

- Ensuring East Renfrewshire residents who experience mental ill-health can access appropriate support on their journey to recovery.

2.6.2 The progress we've been making

- 54% accessing psychological therapies within 18 weeks (improving).
- Link Workers in all GP Practices
- 49% reduction in bed days for individuals accessing Dialectic Behavioural Therapy (DBT)

2.6.3 How we've been delivering

Our Primary Care Mental Health Team (PCMHT) have been working to reduce our waiting times for psychological therapies which we acknowledge are currently too high due to capacity issues in the service. The proportion of people accessing psychological therapies within the 18 week target has fallen to 54% this year from 80% last year. However, we have seen improved performance in the second half of the year with the figure rising from 49% at mid-year 2018/19.

We have agreed to use some of our Action 15 monies to recruit extra capacity in the PCMHT to reduce the waiting times.

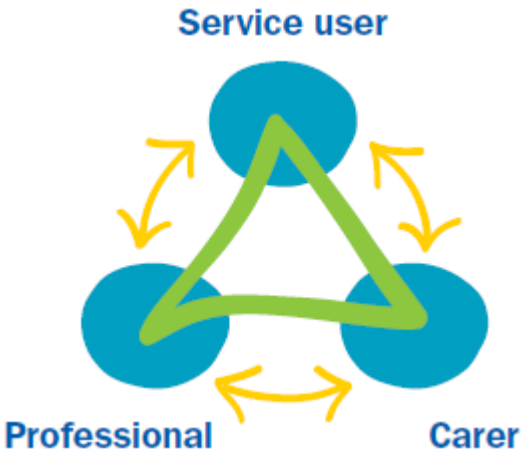
To support appropriate responses to individuals with mild to moderate mental health issues we have put in place alternative pathways for people needing supports. This includes the expansion of Link Workers to all GP surgeries in East Renfrewshire. Delivered in partnership with RAMH, the **Link Workers** signpost people to a wide range of support providers offering physical, social and psychological interventions. The workers have provided support to more than 800 local people.

We have also been promoting the use of computerised cognitive behavioural therapy (**cCBT**) through our GPs, with people referred to an online course of therapy. There has been good uptake of this alternative model with 394 referrals from GPs to cCBT in 2018/19.

Although early days, these alternative approaches are having a positive impact on managing demand for our services and we saw a 15% reduction in GP referrals to the PCMHT in the second half of 2018/19.

We have been referring individuals who have a Borderline Personality Disorder to the Dialectic Behavioural Therapy (DBT) service in South Glasgow and have seen a 49% reduction in the use of acute mental health days following the intervention compared to the average use in the previous three years.

We are focused on supporting carers and family members affected by mental health issues. In 2018/19 we undertook a Test of Change using national funding for carers to look at creative approaches to managing times of crisis and supporting the ongoing caring role. We have supported the establishment of a **Mental Health Carers Group** which is now up and running. The group is focused on implementing the Triangle of Care good practice model. The model sets out key standards and provides resources to support mental health service providers to ensure carers are fully included and supported when the person they care for has an acute mental health episode.



2.7 Working together with our colleagues in primary and acute care to care for people to reduce unplanned admissions to hospital

National Health and Wellbeing Outcomes contributed to:
NO2 - People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
NO4 – Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services

2.7.1 Our strategic aim

We are committed to a programme of work with colleagues in acute services to ensure that only those people who require urgent or planned medical or surgical care go to hospital. Together we are looking at the most frequent preventable causes of admission and putting in place new services and pathways to support people in the community wherever possible, including at the end of life. Our aim will always be to return people home as quickly as possible and to support people at home wherever possible. However sometimes people require additional supports. Over the lifetime of our plan we intend to develop Bonnyton House using six beds as an intensive rehabilitation resource to prevent hospital admission and to ensure a safe return home for people discharged from hospital. We will also create a further six beds so that people who need end of life care, who can't be supported to die at home, could also be supported at Bonnyton.

We have been concerned that the building of new care homes in East Renfrewshire has led to an increase in our most frail and complex older population. This places many demands on our local services including GPs and out of hours services. We want to work together with local care homes, the people who live there and their families to ensure that they get the best care for this final stage of their lives. Over the course of our strategy we will redesign our services to focus on this, ensuring that our most skilled nurses and staff are available to offer specialist advice and support.

We will work together with our colleagues in primary care to put in place the new GP contract and Primary Care Improvement Plan. This will see GPs as the Expert Medical Generalist senior clinical decision maker in an extended primary health care team. The new contract will support local GPs to spend more time in managing patients with complex care needs. Over the course of our strategy we will support primary care teams to grow to support more patients in the community, with additional pharmacy, community treatment (e.g. phlebotomy), other health professionals and link workers.

Our aim is to **reduce unplanned admissions to hospital (through working together with our colleagues in primary and acute care)**, by:

- Supporting people at greatest risk of admission to hospital;
- Working with local partners to reduce attendances and admissions;
- Ensuring our services support rehabilitation and end-of-life care.

2.7.2 The progress we've been making

- Average of 4 delayed discharges per month
- 20,212 A&E attendances (adults) - 4% increase from 2017/18
- 7,320 emergency hospital admissions (adults) – a 1.5% reduction from 2017/18 (and down 9.7% from 2016/17)

2.7.3 How we've been delivering

During 2018/19 we invested in our improvement function by adding the role of Unscheduled Care Programme Implementation and Development Officer. This is providing extra capacity to engage closely with our GP practices, care homes and locality teams.

Reducing **Accident and Emergency attendances** continues to be challenging area for us. Over the course of 2018/19 there were 20,212 attendances by adults, above our target of 18,332. We have been engaging with GPs at cluster level and individual practice level and we have been using data to highlight those patients with 9 or more attendances in the last year. Findings to date have demonstrated that Anticipatory Care Plans, Link Workers and closer working with the Community Addiction Team could offer support to a number of these patients.

A similar approach has been taken to collaborating with our local care homes. Annual A&E attendances from care homes have fallen to 429 this year from 541 in 2017/18. Care homes have agreed to share performance reports provided by the Improvement team. Performance and improvement actions are also discussed at the Care Home Provider Forum with an Unscheduled Care item within each agenda.

Adult emergency **hospital admissions** have reduced from 7,432 in 2017/18 (and 8,032 in 2016/17) to 7,320[2]. Annual emergency admissions from care homes have fallen to 261 this year from 338 in 2017/18.

In 2018/19 we have been developing our approaches to supporting frailty and reducing the risk of falls. In December we introduced a new monitoring tool for frailty, the Rockwood Frailty assessment tool, with training for staff delivered by the HSCP Falls Lead Officer. Since its introduction, 417 scores have been recorded on our Care First system. Monthly reports are provided. Using data from our monthly monitoring reports, we are developing information pathways to support signposting and referral to the most appropriate supports throughout an individual's frailty journey.

[2] Figure relates to calendar year Jan-Dec 2018 due to incomplete data for 2018/19.

Frail Elderly NHS continuing care for East Renfrewshire residents was historically provided in Mearnskirk House, a 72 bed, PFI funded building owned and managed by Walker Healthcare. Due to changes in national guidance for 'Hospital Based Complex Clinical Care' this facility was no longer required and during 2018/19 we moved the remaining East Renfrewshire residents to alternative facilities. The IJB agreed to invest the funding released from this change of model to expand the range of community based supports within East Renfrewshire. In 2018 we focused on the development of intensive rehabilitation to prevent admission and to ensure a safe return home for people discharged from hospital supported by the skills of the residential staff and the rehabilitation teams in the community.

Over the course of the last Strategic Plan we tested a number of changes to the way we support people back to East Renfrewshire as soon as possible following a stay in hospital. In 2018 we developed the Home for Hospital Team as part of our Adult Health and Care Localities. The team will develop strong links with hospital sites to enable early identification and referral of East Renfrewshire residents. The team work with residents and their families to plan support for discharge from hospital, which may include intermediate care arrangements. During 2019/20 more work will take place to improve links between the team and community nursing, rehabilitation and care at home.

Anticipatory Care Planning (ACP) is about individual people thinking ahead and understanding their health. It helps people make informed choices about how and where they want to be treated and supported in the future. Ultimately, it means that health and care practitioners will work with people and their carers to ensure that the right thing is done at the right time by the right person. The ACP approach led by East Renfrewshire HSCP has now been implemented across the six HSCPs in Greater Glasgow.

We remain committed to strengthening **End of Life** provision in our communities. During 2018/19 greater collaboration with Prince and Princess of Wales and Accord Hospices has resulted in a shared Palliative Action Plan being developed. Focused work has taken place to explore East Renfrewshire residents dying within the hospital setting in last 6 months of life using data and case file reviews. An event attended by a wide range of stakeholders including care at home providers, care homes, Macmillan, District Nurses, GPs, carers, hospices and staff from GG&C and HSCP identified a number of things we do well and improvement opportunities. Our Palliative Forum are taking this work forward, chair shared by HSCP and Hospice.

Primary Care Improvement Plan

2018/19 was the first year of implementing East Renfrewshire's Primary Care Improvement Plan. The plan will enable the role of the GP moving forward to evolve into the expert medical generalist. The new GP role will be achieved by embedding multi-disciplinary

primary care staff to work alongside and support GPs and practice staff to reduce GP practice workload and improve patient care.

Key impacts of the plan in its first year include:

- Community Link Workers now rolled out to all GP practices in East Renfrewshire and have provided support to 800 people.
- We provided a community nurse based service for housebound patients (not on existing District Nurse caseloads) requiring the Influenza Vaccine to reduce GP workload. A total of 170 vaccines were administered to the housebound patients by six District Nursing staff across eleven GP surgeries.
- 13 of our 15 practices have pharmacotherapy input (at a level of at least 0.4WTE) - a breadth of cover not matched in any other HSCP.
- At the end of last year 100% of GP practices had agreed to use Home and Mobile Health Monitoring (HMHM) for hypertension management. So far all but two practices have recruited patients to the service. Just over 640 patients have benefitted from the service with an estimation of over 1800 face-to-face appointments saved. We will upscale the provision of this type of support moving forward.
- We have put in place Advanced Practice Physiotherapists as the first point of contact. There is evidence that this approach has resulted in a direct release of GP time and streamlining of the patient journey. During March and April 2019, 465 appointments were made available with 92% uptake. This is a great example of Seeing the Right Person, at the Right Time.
- Community Healthcare Support Workers are now in every practice providing phlebotomy, support for B12 deficiency, blood pressure monitoring and new patient registrations.
- Our Know Who to Turn To campaign continues to direct people to the right person, right place at the right time.
- Data and understanding demand patterns - It's essential that we have data to evidence the shift in activity to the new roles within the extended primary care team, freeing the GP to develop the expert medical generalist role. Working collaboratively with Practice Managers in each locality we developed our template to gather baseline data. Regular reports will be provided to monitor shifts in demand and how the freed capacity has been re-shaped to support our complex individuals.

2.8 Working together with people who care for someone ensuring they are able to exercise choice and control in relation to their caring activities

National Health and Wellbeing Outcomes contributed to:
NO6 - People who provide unpaid care are supported to look after their own health and wellbeing, including support to reduce any negative impact of their caring role on their own health and wellbeing

2.8.1 Our strategic aim

Working together, stakeholders including HSCP staff, the Carers Centre, Voluntary Action East Renfrewshire (VAER), the Care Collective and people with experience as carers have considered information and guidance for the Carers (Scotland) Act 2016 as it emerged from Scottish Government along with our local context and implications for implementation of the Act, including local people's thoughts and experiences of caring and support for carers. They have identified the following conditions for success:

- Carers can participate in the decisions and the design of services that affect them;
- Stigma associated with the challenges of caring is reduced;
- Accurate information in relation to rights, eligibility criteria, statutory and non- statutory support is available and accessible.

Over the course of our strategic plan we will work together to improve access to accurate, timely information that meets carers' needs and awareness of the range of supports for carers. We will continue to encourage collaboration between providers of supports to carers ensuring local provision best meets carers' needs. We will provide information and training to raise awareness of the impact of caring responsibilities and ensure we have trained advisers in a range of organisations who can develop plans with and for carers.

Through our work on self-directed support we will develop and implement a consistent and clear prioritisation framework and ensure that carers and support organisations are aware of the availability of suitable respite care and short-break provision. Working together with education we have been developing support systems that appreciate young carers and build resilience through opportunities for peer support. This includes implementing a process for a young carers statement that has been designed by young carers for young carers and is owned by the young carer.

Our aim is to **ensure people who care for someone are able to exercise choice and control in relation to their caring activities**, by:

- Ensuring staff are able to identify carers and value them as equal partners;
- Helping carers access accurate information about carers' rights, eligibility criteria and supports;
- Ensuring more carers have the opportunity to develop their own carer support plan.

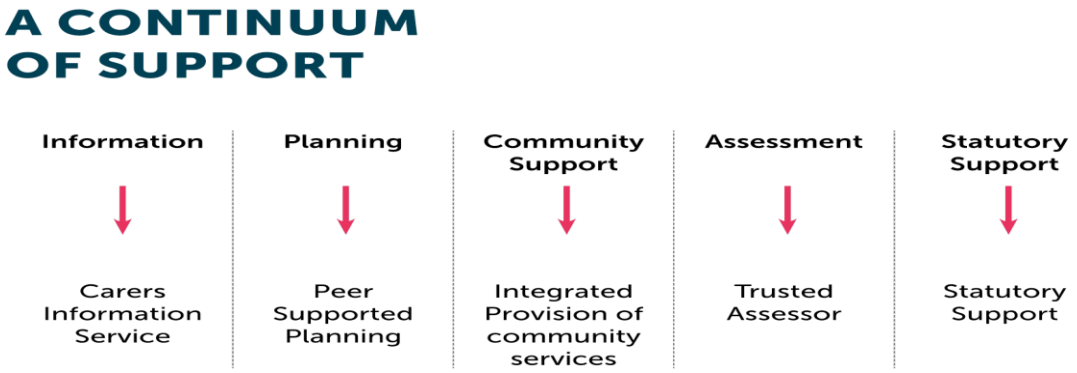
2.8.2 The progress we've been making

- 78% of people reported 'quality of life for carers' needs fully met
- 37% of carers feel supported to continue in their caring role (2017/18 - in line with Scottish average)

2.8.3 How we've been delivering

Our local indicator shows 78% of carers reporting satisfaction with their quality of life and this indicator has improved by 8% since 2016/17. However, the 2017/18 Scottish Health and Care Experience Survey showed that just 37% of carers felt supported in their caring role. While this is in line with the Scottish average, we would like to see this indicator improve and remain focused on ensuring that local people who provide unpaid care are valued and supported.

Working in partnership with the Care Collective (East Renfrewshire Carers and Voluntary Action East Renfrewshire), the HSCP has undertaken a range of activities to support the implementation of the Carers Act and establish a holistic approach to supporting local carers. We believe we have developed a sound continuum of support for improving outcomes for carers of all ages. To support this the HSCP has agreed to create a specific lead role on carer related work to promote the understanding and uptake of the legislation within East Renfrewshire. The role of the Carers Lead will develop over 2019/20.



Development of **community-based integrated support** for carers in East Renfrewshire includes access to advice, support, planning and community activities. In 2018/19 we developed our Sci Gateway referral pathway (which went live May 2019) – GP practices will be able to make direct referrals to the local carers centre. This will support the early identification and support of carers.

We have continued to develop and improve our approach to **assessment and planning** of support for carers. In 2018/19 we finalised our Eligibility Framework (launched June 2018). In line with the Carers Act, East Renfrewshire has produced an eligibility framework for both adults and young carers. It is clear about the no charging position for eligible services. The framework is designed around the principles of supporting the carer in their carer role, seeking to understand the impact of being a carer and planning appropriate supports.

We are working closely with partners to ensure we develop the appropriate range of creative **short breaks and respite** options as support for families with their caring role. We previously undertook a comprehensive 'market comparison' of short break opportunities including cost and eligibility as appropriate. In January 2019 we launched our Short Breaks Statement. This statement will form the basis of how we develop short breaks for carers within East Renfrewshire. It provides useful links to sources of advice, information and support and will be reviewed annually as per the Act with partners from the carers centre.

2.9 Public protection

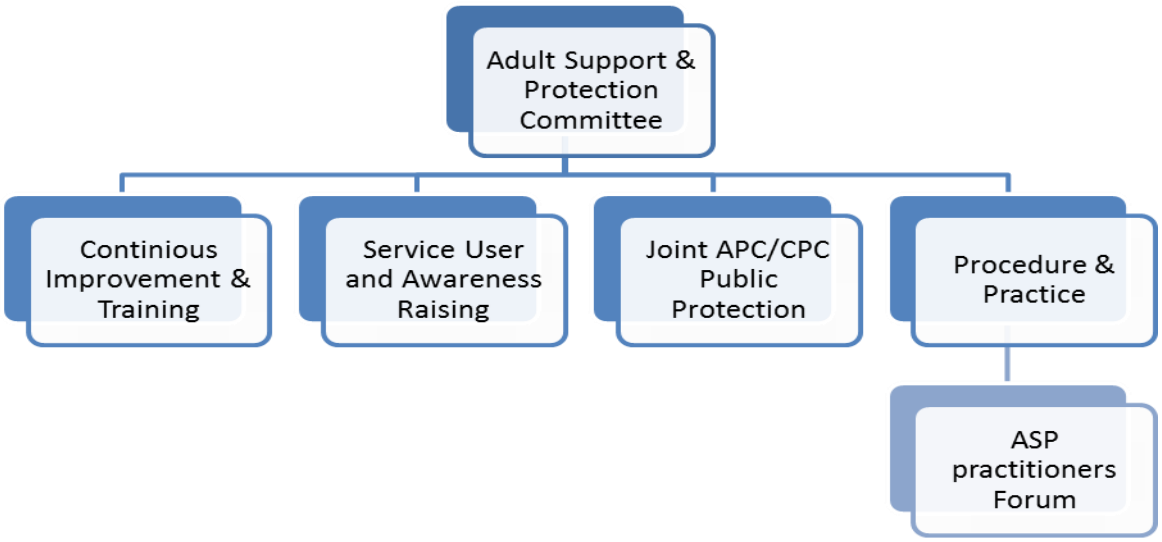
National Health and Wellbeing Outcomes contributed to:
NO7 - People using health and social care services are safe from harm

2.9.1 Our strategic aim

Ensuring people are safe is a vital part of our work. We take a multi-agency approach to deliver our community planning outcomes:

- Residents are safe and supported in their communities;
- Children and adults at risk are safer as a result of our intervention.

Following a period of self-evaluation of Adult Support and Protection (ASP) practice within East Renfrewshire HSCP we developed an action plan to address areas for improvement and we have been delivering on this over the course of 2018/19. This work is supported by a subcommittee structure with oversight by the Adult Support and Protection Committee and Chief Officers Public Protection Group.



Our aim is to **ensure residents are safe and supported in their communities**, through:

- Prevention - People, communities and services actively promote public protection;
- Identification and Risk Assessment - Services know who is most at risk and understand their needs;
- Interventions - Communities and individuals are supported to manage and reduce risk;
- Monitoring and Reviewing Risk - Services effectively measure progress and identify further problems quickly.

2.9.2 The progress we've been making

- 82% of adults supported at home agreed they felt safe (2017/18)

2.9.3 How we've been delivering

The HSCP has been working to develop its process in relation to Adult Support and Protection and continue to improve our practice, systems and compliance. Over the course of 2018/19 we have also been working to improve the robustness and accuracy of our data monitoring.

There has been significant work undertaken within the HSCP to develop our practice, including wide ranging consultation with staff at all levels, the issuing of clear and concise practice guidance for staff, and the introduction of a number of forums to allow regular dialogue with key staff groups.

In 2018/19 100% of adults at risk reported that they had their views taken into account when attending case conferences. And in terms of participation 100% of agencies provided written reports when requested for ASP case conferences in East Renfrewshire.

We continue to raise awareness of adult protection issues and available support. We deliver protective information in local communities and have developed new ASP leaflets. In 2018/19 we delivered a wide range of training including ASP Council Officer Training, ASP Risk Assessment Training and ASP Basic Awareness Training.

We have been improving our data collection with the introduction of new paperwork in October 2018. This improved approach is helping us build our intelligence and understanding of public protection issues and trends in East Renfrewshire. From this we can see that 58% of ASP inquiries were completed within 5 working days and 36% of ASP investigations completed within 8 working days from date of referral. We are now working on improving our timescales by streamlining our pathways.

Our feedback survey in March 2019 found that 81% of staff were confident in decision-making in relation to Adult Support and Protection.

2.10 Hosted Services – Specialist Learning Disability Service

We continue to host the **Specialist Learning Disability Inpatient Service** that supports people requiring a hospital admission. The service works in partnership to manage demand and ensure appropriate support is available in the community on discharge.

Over the course of 2018/19 we have seen an improvement in the number of people without an arranged placement to move on to after staying in hospital. At year end, of the 27 beds occupied, 14 people had placements identified (up from 3 in July 2018), 12 people were recorded as delayed (down from 16 in July 2018) and 0 people were waiting for transfer from mental health services (down from 9 in July 2018). Bed occupancy was 100% with a waiting list throughout 2018 - average waiting time was 42 days. Waiting time improved due to increased rates of discharge.

We continue to focus on delivering resettlement and retraction for our long stay service users. In 2018/19 there were three discharges of people previously considered as unable to live successfully in community settings. We continue to develop our approaches to resettlement in partnership with other HSCPs in Greater Glasgow.

In 2018/19 we became only the second Learning Disability service in Scotland to achieve the Royal College of Psychiatrists, Accreditation for Inpatient Mental Health Services (AIMS). The process of working towards accreditation led to around 50 service improvement initiatives. We also received a positive Mental Welfare Commission inspection report highlighting good care.

2.11 Supporting our staff

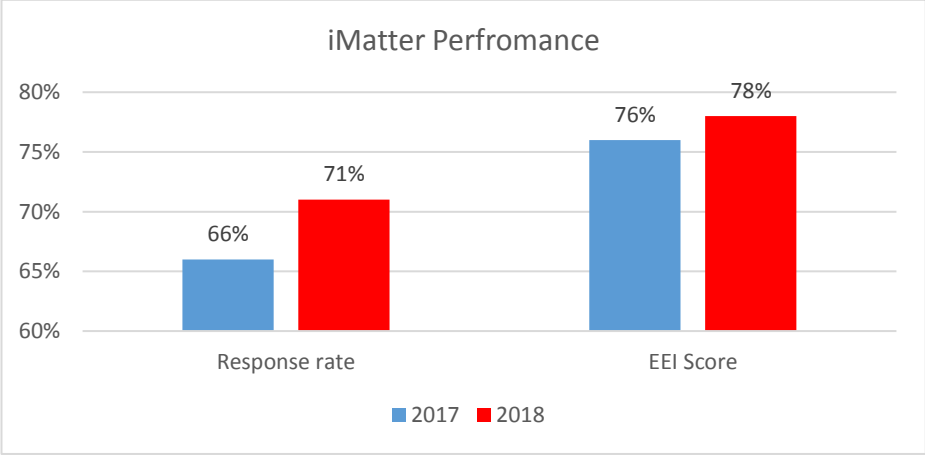
National Health and Wellbeing Outcomes contributed to:
NO8 – People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide

2.11.1 Our strategic aim

We are focused on developing and maintaining a workforce that is engaged and fully committed to delivering the outcomes and key objectives of the HSCP. 2018 was the second year that the HSCP participated in the iMatter survey and team planning. This is a staff experience continuous improvement tool designed with staff in NHS Scotland to help individuals, teams and Boards understand and improve staff experience.

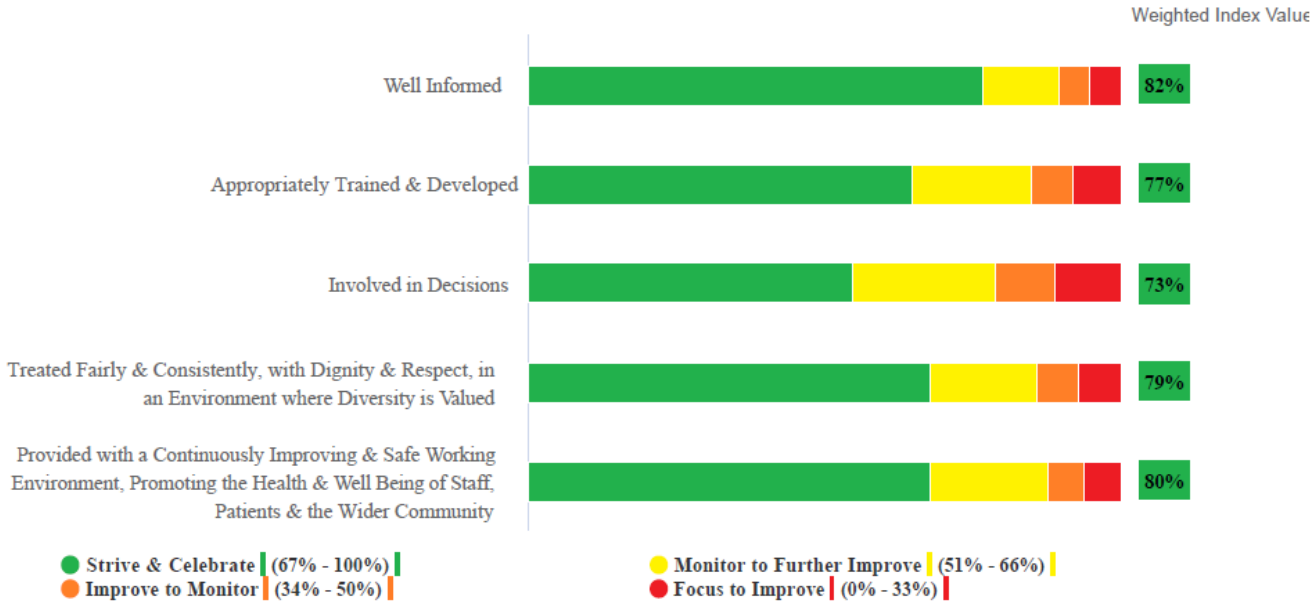
2.11.2 The progress we've been making

In 2018 we saw even better participation in iMatter than we had in 2017. The chart below shows that in the last year participation grew by 5% to 71% and that our Employee Engagement Index (an aggregated score relating to key employee engagement measures) also increased to 78%. iMatter is increasingly being used as a development tool with a high level of teams completing Action Plans in response to the survey results.



In 2018 there were improved scores across all of the 28 iMatter questions (with the exception of one that remained the same). The 'strand scores' given below show performance against the main employee engagement topics. 'Appropriately trained and developed' improved by 5% from 2017 while the other four topics all showed improvement by 2-3%.

Staff Governance Standards - Strand Scores



87%

"I am clear about my duties and responsibilities"

83%

"I understand how my role contributes to the goals of my organisation"

84%

"I am treated with dignity and respect as an individual"

89%

"My direct line manager is sufficiently approachable"

82%

"My work gives me a sense of achievement"

3. Financial performance and Best Value

National Health and Wellbeing Outcomes contributed to:
NO9 - Resources are used effectively and efficiently in the provision of health and social care services

3.1 Introduction

Within this section of the report we aim to demonstrate our efficient and effective use of resources. Our Annual Report and Accounts 2018/19 is our statutory financial report for the year. We regularly took finance reports to the IJB throughout the year.

3.2 Financial Performance 2018/19

The annual report and accounts for the IJB covers the period 1st April 2018 to 31st March 2019, with comparable figures shown for 2017/18.

In addition to the net funding of £132.951 million received from our partners and other income we had also planned to use up to £0.954 million from reserves to bridge our Fit for the Future change programme to balance our budget for 2018/19. The budgets and outturns for the operational services as reported during the year to the IJB are summarised below.

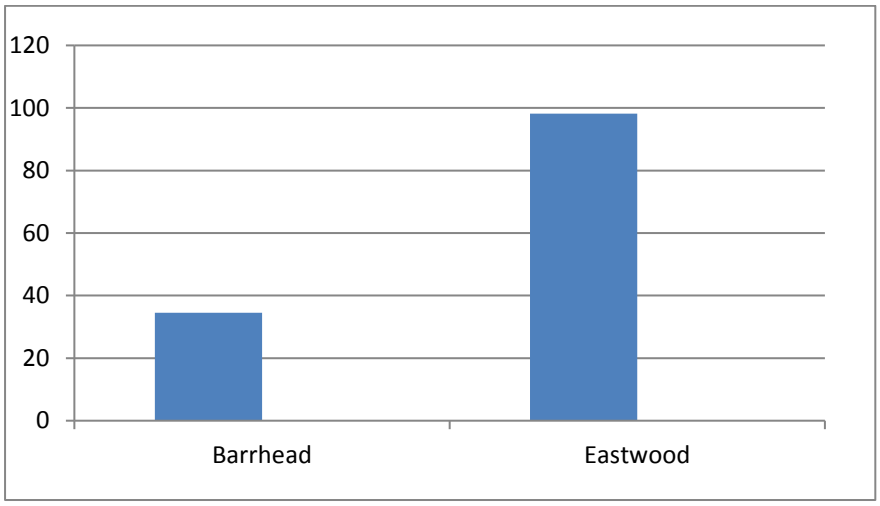
Service	Budget	Spend	Variance (Over) / Under	Variance (Over) / Under
	£ Million	£ Million	£ Million	%
Children and Families	10.508	9.708	0.800	7.61%
Older Peoples Services	28.995	29.223	(0.228)	(0.79%)
Physical / Sensory Disability	4.664	4.608	0.056	1.20%
Learning Disability – Community	12.091	12.138	(0.047)	(0.39%)
Learning Disability – Inpatients	8.085	7.962	0.123	1.52%
Mental Health	4.377	3.958	0.419	9.57%
Addictions / Substance Misuse	1.554	1.522	0.032	2.06%
Family Health Services	22.217	22.209	0.008	0.04%
Prescribing	15.766	16.194	(0.428)	(2.71%)
Criminal Justice	0.039	-	0.039	100%
Planning and Health Improvement	0.299	0.225	0.074	24.75%
Management and Administration	8.396	8.586	(0.190)	(2.27%)
Planned Contribution from Reserves	0.954	0.556	(0.398)	(41.69%)
Net Expenditure Health and Social Care	**116.037**	**115.777**	**0.260**	**0.22%**
Housing	0.290	0.290	-	0.00%
Set Aside for Large Hospital Services	16.624	16.624	-	0.00%
Total Integration Joint Board	**132.951**	**132.691**	**0.260**	**0.22%**
Barrhead Locality	**34.567**	**34.500**	**0.192**	
Eastwood Locality	**98.384**	**98.192**	**0.068**	

The £0.260 million underspend (0.22%) is in line with the reporting taken to the IJB during the year and this is added to our reserves.

The main variances to the budget were:

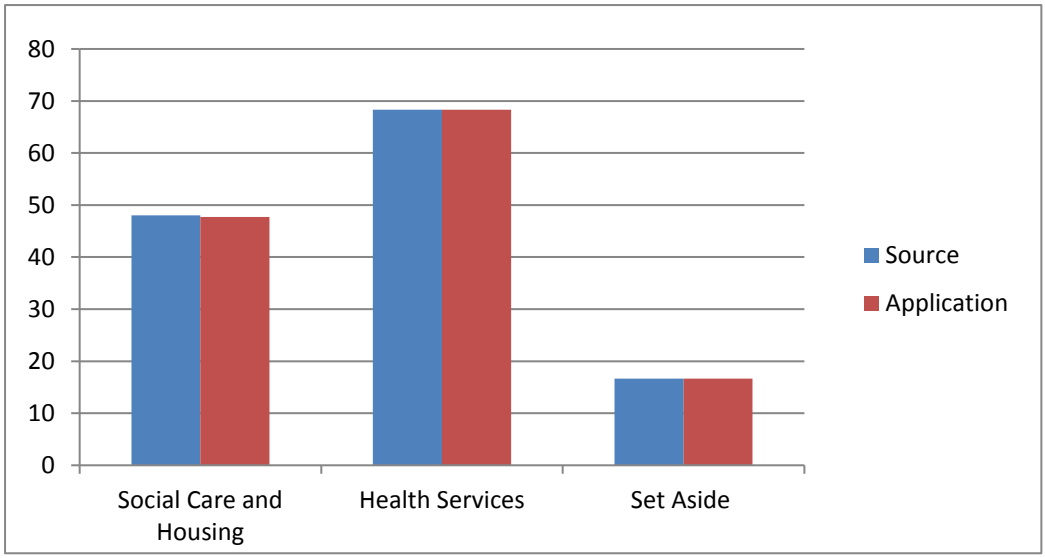
- Underspends in a number of services from staff turnover and vacant posts during the year, in part relating to the implementation of our structure but also reflecting recruitment and retention issues within health and social care.
- Care package costs were less than committed as we did not have a difficult winter.
- The overspend in prescribing is a result of both cost and volume, with a number of drugs on short supply during the year.
- East Renfrewshire IJB hosts the Specialist Learning Disability Services on behalf of the other five IJBs who are coterminous with Greater Glasgow and Clyde. The service achieved £0.125 million savings early from the ongoing bed redesign model.

Expenditure of £132.691 million by Locality



The expenditure split by Locality is shown using a combination of support plans and population.

Source and Application of our Net Funding of £132.951million



In addition to the expenditure above a number of services are hosted by the other IJBs who partner NHS Greater Glasgow and Clyde and our use of those hosted services is shown below; this not a direct cost to the IJB.

SERVICES PROVIDED TO EAST RENFREWSHIRE IJB BY OTHER IJBs WITHIN NHS GREATER GLASGOW AND CLYDE	2018/19 £ Million
Physiotherapy	0.434
Retinal Screening	0.053
Podiatry	0.452
Primary Care Support	0.295
Continence	0.293
Sexual Health	0.613
Mental Health	0.876
Oral Health	0.858
Addictions	0.335
Prison Health Care	0.184
Health Care in Police Custody	0.163
Psychiatry	3.811
NET EXPENDITURE ON SERVICES PROVIDED	**8.367**

3.3 Reserves

We used £0.802 million of reserves in year to balance our budget and we also invested new monies into earmarked reserves. The year on year movement in reserves is summarised below.

	£ Million	£ Million
Reserves at 31 March 2018		4.809
Planned use of existing reserves during the year	(0.902)	
Funds added to existing reserves during the year	0.338	
New reserves created during the year	1.092	
Net increase in reserves during the year	0.528	
Reserves at 31 March 2019		5.337

3.4 Prior Year Financial Performance

The table below shows a summary of our year-end under / (over) spend by service and further detail can be found in the relevant Annual Report and Accounts and in year reporting.

	2018/19	2017/18	2016/17	2015/16
SERVICE	**(Over) / Under £ Million**	**(Over) / Under £ Million**	**(Over) / Under £ Million**	**(Over) / Under £ Million**
Children and Families	0.800	0.083	0.537	0.604
Older Peoples Services	(0.228)	0.153	(0.046)	1.763
Physical / Sensory Disability	0.056	(0.167)	(0.280)	(0.345)
Learning Disability - Community	(0.047)	(0.214)	0.986	(1.801)
Learning Disability - Inpatients	0.123	-	-	-
Mental Health	0.419	0.409	0.393	0.354
Addictions / Substance Misuse	0.032	0.018	0.1229	0.085
Family Health Services	0.008	-	-	-
Prescribing	(0.428)	-	-	-
Criminal Justice	0.039	0.011	0.013	0.027
Planning and Health Improvement	0.074	0.001	0.039	0.029
Management and Admin	(0.190)	0.483	(0.144)	(0.335)
Planned Contribution to / from Reserves	(0.3976)	(0.9536)	**	-
Net Expenditure Health and Social Care	**0.260**	**(0.177)**	**1.622**	**0.381**

** In 2016/17 we agreed to carry forward our planned underspend to reserves to provide flexibility to allow us to phase in budget savings including our change programme.

3.5 Future Challenges

The IJB continues to face a number of challenges, risks and uncertainties in the coming years. The Medium Term Financial Plan sets out the potential cost pressures of c £5.1 to £5.7 million per year for the five years 2019/20 to 2023/24.

For 2019/20 the cost pressure was £5.7 million and when we applied the available funding from our partners for uplifts and pressures the remaining gap and therefore savings requirement was £3.1 million. We have an agreed plan for these savings for 2019/20 however a similar scale of challenge in future years will mean an impact on our frontline services and care packages.

Demographic pressures remain a very specific challenge for East Renfrewshire as we have an increasing elderly population with a higher life expectancy than the Scottish average and a rise in children with complex needs resulting in an increase in demand for services.

A number of wider issues such as the economy; the impact of Brexit, Regional Planning, potential reform of NHS boards and local government could all impact on the future of the service we provide and our ability to meet the needs of the communities we serve.

As we have successfully operated integrated services for a number of years we have already faced a number of challenges and opportunities open to newer partnerships, however our funding and savings challenge take no account of this history. Whilst we have agreed a population based approach for future (NHS) financial frameworks and models this does not address the base budget.

Prescribing Costs; the cost of drugs prescribed to the population of East Renfrewshire by GPs and other community prescribers is delegated to the IJB. This is a complex and volatile cost base of around £16 million per year. Financial year 2018/19 was the first year without any risk share or underwriting of this cost and despite increasing our budget by 5% we ended the year with an £0.428 million overspend.

Developing our performance and financial reporting in more detail at a locality level will allow fuller reporting and understanding of future trends and service demands.

We plan to deal with these challenges by:

- We have an agreed Medium Term Financial Plan and will maintain this with updates at least annually. We will also continue to use scenario based financial planning and modelling to assess and refine the impact of different levels of funding, pressures and possible savings.

- We have identified and prioritised savings proposals for 2019/20 and have indicated that future year savings proposals may require us to move to the adoption of a criteria based model for care package support.

- We will realign our financial reporting to reflect our new service structure.

- We have recognised the challenges in the medium term and will continue to use “invest to save” and “test of change” models. Our reserves strategy allows us to smooth the impact of change and to implement savings on a phased basis. Some examples include:
  - Investment in an additional pharmacy technician to mitigate prescribing pressures
  - Implementing our Digital Programme
  - Care at Home to support recruitment and retention and service improvement
  - Partnership Framework development
  - Organisational Learning and Development

- The IJB continues to operate in a challenging environment and our financial, risk and performance reporting will continue to be a key focus of each IJB agenda to ensure efficient and effective use of resources and best value in delivering health and social care service.

4. Performance summary

4.1 Introduction

In the previous chapter of this report we outlined key areas of work carried out by the HSCP over the course of 2018/19. In this final chapter we draw on a number of different sources to give a more detailed picture of how the partnership is performing.

The sections below set out how we have been performing in relation to our suite of Key Performance Indicators structured around the strategic priorities in our Strategic Plan 2018-21. We also provide performance data in relation to the National Integration Indicators and Ministerial Steering Group (MSG) Indicators. Finally, we provide summary information on performance reporting during Inspections carried out in 2018/19.

4.2 Performance indicators

Key to performance status	
Green	Performance is at or better than the target
Amber	Performance is close (approx 5% variance) to target
Red	Performance is far from the target (over 5%)
Grey	No current performance information or target to measure against

Direction of travel*	
↑	Performance is IMPROVING
–	Performance is MAINTAINED
↓	Performance is WORSENING

*For consistency, trend arrows always point upwards where there is improved performance or downwards where there is worsening performance including where our aim is to decrease the value (e.g. if we successfully reduce a value the arrow will point upwards).

Strategic Priority 1 - Working together with children, young people and their families to improve mental wellbeing					
Indicator	**2018/19**	**Current Target**	**2017/18**	**2016/17**	**Trend from previous year**
Percentage of children looked after away from home who experience 3 or more placement moves *(DECREASE)*	**1.4%**	11.0%	1.2%	7.1%	–
Percentage of positive response to Viewpoint question "Do you feel safe at home?" *(INCREASE)*	**100%**	91%	94%	85%	↑

Strategic Priority 1 - Working together with children, young people and their families to improve mental wellbeing					
Indicator	**2018/19**	**Current Target**	**2017/18**	**2016/17**	**Trend from previous year**
Accommodated children will wait no longer than 6 months for a Looked After Review meeting to make a permanence decision *(INCREASE)*	**83%**	80%	100%	n/a	↓
Children and young people starting treatment for specialist Child and Adolescent Mental Health Services within 18 weeks of referral *(INCREASE)*	**74%**	90%	89%	90%	↓
Child & Adolescent Mental Health - longest wait in weeks at month end *(DECREASE)*	**34**	18	35	31	↑
100% of parents of children who have received an autism diagnosis have opportunity to access Cygnet post diagnostic programme within 12 months of receiving diagnosis. *(INCREASE)*	**100%**	100%	97%	n/a	↑
% of children/ young people attending Family Wellbeing Service with improved emotional health at end of programme *(INCREASE)*	**90%**	100%	100%	n/a	↓
% Mothers confirming they have received information about close and loving relationships from staff *(INCREASE)*	**100%**	80%	n/a	n/a	-
Increase in improved outcomes for children after parent/carer completion of POPP *(INCREASE)*	**89%**	81%	79%	78%	↑
Balance of Care for looked after children: % of children being looked after in the Community (LGBF) *(INCREASE)*	**n/a**	Data only	93.6%	91.5%	↑
% Child Protection Re-Registrations within 18 months (LGBF) *(DECREASE)*	**n/a**	Data only	0%	9%	↑

Strategic Priority 2 - Working together with our community planning partners on new community justice pathways that support people to prevent and reduce offending and rebuild lives					
Indicator	**2018/19**	**Current Target**	**2017/18**	**2016/17**	**Trend from previous year**
Community Payback Orders - Percentage of unpaid work placement completions within Court timescale. *(INCREASE)*	**84%**	80%	92%	96%	↓

Strategic Priority 2 - Working together with our community planning partners on new community justice pathways that support people to prevent and reduce offending and rebuild lives					
Indicator	**2018/19**	**Current Target**	**2017/18**	**2016/17**	**Trend from previous year**
Criminal Justice Feedback Survey - Did your Order help you look at how to stop offending? *(INCREASE)*	**100%**	100%	100%	100%	↑
% of service users moving from drug treatment to recovery service *(INCREASE)*	**22%**	9%	12%	9%	↑
% Change in individual drug and alcohol Recovery Outcome Score *(INCREASE)*	**23%**	17%	n/a	17%	↑
% Change in women's domestic abuse outcomes *(INCREASE)*	**64%**	70%	65%	66%	↓
% Positive employability and volunteering outcomes for people with convictions. *(INCREASE)*	**55.0%**	60.0%	n/a	n/a	–
People agreed to be at risk of harm and requiring a protection plan have one in place. *(INCREASE)*	**100%**	100%	n/a	n/a	–

Strategic Priority 3 - Working together with our communities that experience shorter life expectancy and poorer health to improve their wellbeing					
Indicator	**2018/19**	**Current Target**	**2017/18**	**2016/17**	**Trend from previous year**
Increase the number of smokers supported to successfully stop smoking in the 40% most deprived SIMD areas. (This measure captures quits at three months and is reported 12 weeks in arrears.) *(INCREASE)*	**n/a**	24	20	27	↓
Health and Social Care Integration - Core Suite of Indicators NI-11: Premature mortality rate per 100,000 persons aged under 75. (European age-standardised mortality rate) *(DECREASE)*	**n/a**	Data Only	301	297	–

Strategic Priority 4 - Working together with people to maintain their independence at home and in their local community					
Indicator	**2018/19**	**Current Target**	**2017/18**	**2016/17**	**Trend from previous year**
Number of people self directing their care through receiving direct payments and other forms of self-directed support. *(INCREASE)*	**n/a**	500	491	364	↑
Percentage of those whose care need has reduced following re-ablement *(INCREASE)*	**74%**	60%	62%	64%	↑
Percentage of people aged 65+ who live in housing rather than a care home or hospital *(INCREASE)*	**95.9%**	97%	96.6%	96.8%	↓
People reporting 'living where you/as you want to live' needs met (%) *(INCREASE)*	**92%**	90%	84%	79%	↑
SDS (Options 1 and 2) spend as a % of total social work spend on adults 18+ (LGBF) *(INCREASE)*	**n/a**	Data Only	7.5%	6.6%	↑
Percentage of people aged 65+ with intensive needs receiving care at home. (LGBF) *(INCREASE)*	**n/a**	62.0%	62.5%	61.1%	↑

Strategic Priority 5 - Working together with people who experience mental ill-health to support them on their journey to recovery					
Indicator	**2018/19**	**Current Target**	**2017/18**	**2016/17**	**Trend from previous year**
Mental health hospital admissions (age standardised rate per 1,000 population) *(DECREASE)*	**n/a**	2.3	-	1.5	↑
Percentage of people waiting no longer than 18 weeks for access to psychological therapies *(INCREASE)*	**54%**	90%	80%	56%	↓
Primary Care Mental Health Team (Bridges) wait for referral to 1st appointment within 4 weeks (%) *(INCREASE)*	**14%**	100%	21%	n/a	↓
Primary Care Mental Health Team (Bridges) wait for referral to treatment appointment within 9 weeks (%) *(INCREASE)*	**8%**	100%	30%	33%	↓

Strategic Priority 6 - Working together with our colleagues in primary and acute care to care for people to reduce unplanned admissions to hospital					
Indicator	**2018/19**	**Current Target**	**2017/18**	**2016/17**	**Trend from previous year**
People (18+) waiting more than 3 days to be discharged from hospital into a more appropriate care setting including AWI *(DECREASE)*	**4**	0	4	4	-
Acute Bed Days Lost to Delayed Discharge (Aged 18+ including Adults with Incapacity) *(DECREASE)*	**2,284**	1,893	1,860	2,704	↓
No. of A & E Attendances (adults) *(DECREASE)*	**20,212**	18,332	19,344	18,747	↓
Number of Emergency Admissions: Adults *(DECREASE)*	**7,320***	7,130	7,432	8,032	↑
Emergency admission rate (per 100,000 population) for adults *(DECREASE)*	**10,368***	11,492	10,482	11,419	↑
Emergency bed day rate (per 100,000 population) for adults *(DECREASE)*	**114,744***	117,000	120,419	122,193	↑
Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges) *(DECREASE)*	**79***	100	79	83	-
A & E Attendances from Care Homes (NHSGGC data) *(DECREASE)*	**429**	360	541	n/a	↑
Emergency Admissions from Care Homes (NHSGGC data) *(DECREASE)*	**261**	204	338	166	↑
% of last six months of life spent in Community setting *(INCREASE)*	**88%**	92%	85%	86%	↑

* Full year data not available for 2018/19. Figure relates to 12 months Jan-Dec 2018.

Strategic Priority 7 - Working together with people who care for someone ensuring they are able to exercise choice and control in relation to their caring activities					
Indicator	**2018/19**	**Current Target**	**2017/18**	**2016/17**	**Trend from previous year**
People reporting 'quality of life for carers' needs fully met (%) *(INCREASE)*	**78%**	72%	72%	70%	↑

Organisational measures					
Indicator	**2018/19**	**Current Target**	**2017/18**	**2016/17**	**Trend from previous year**
Percentage of days lost to sickness absence for HSCP NHS staff *(DECREASE)*	**6.8%**	4.0%	8.5%	7.2%	↑
Sickness absence days per employee - HSCP (LA staff) *(DECREASE)*	**16.4**	10.9	13.0	13.6	↓
Percentage of HSCP (NHS) complaints received and responded to within timescale (5 working days Frontline, 20 days Investigation) *(INCREASE)*	**80%**	70%	100%	63%	↓
Percentage of HSCP (local authority) complaints received and responded to within timescale (5 working days Frontline; 20 days Investigation) *(INCREASE)*	**72%**	100%	81%	68%	↓

4.3 National Integration Indicators

The Core Suite of 23 National Integration Indicators was published by the Scottish Government in March 2015 to provide the basis against which Health and Social Care Partnerships can measure their progress in relation to the National Health and Wellbeing outcomes. As these are derived from national data sources, the measurement approach is consistent across all Partnerships.

The Integration Indicators are grouped into two types of measures: 9 are based on feedback from the biennial Scottish Health and Care Experience survey (HACE) and 10 are derived from Partnership operational performance data. A further 4 indicators are currently under development by NHS Scotland Information Services Division (ISD). The following tables provide the most recent data for the 19 indicators currently reportable, along with the comparative figure for Scotland, and trends over time where available.

4.3.1 Scottish Health and Care Experience Survey (2017/18)

Information on 9 of the National Integration Indicators are derived from the biennial Scottish Health and Care Experience survey (HACE) which provides feedback in relation to people's experiences of their health and care services. The most recent survey results for East Renfrewshire are summarised below.

National indicator	2017/18	Scotland 2017/18	2015/16	East Ren trend from previous survey	Scotland trend from previous survey
NI-1: Percentage of adults able to look after their health very well or quite well	**94%**	93%	96%	↓	↓
NI-2: Percentage of adults supported at home who agreed that they are supported to live as independently as possible	**74%**	81%	80%	↓	↓
NI-3: Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	**64%**	76%	77%	↓	↓
NI-4: Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	**60%**	74%	69%	↓	↓
NI-5: Total % of adults receiving any care or support who rated it as excellent or good	**77%**	80%	82%	↓	↓
NI-6: Percentage of people with positive experience of the care provided by their GP practice	**84%**	83%	88%	↓	↓
NI-7: Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	**76%**	80%	79%	↓	↓
NI-8: Total combined % carers who feel supported to continue in their caring role	**37%**	37%	45%	↓	↓
NI-9: Percentage of adults supported at home who agreed they felt safe	**82%**	83%	82%	–	–

Data from ISD release, 7 June 2019

4.3.2 Operational performance indicators

National indicator	2018/19	Scotland 2018/19	2017/18	2016/17	Trend from previous year
NI-11: Premature mortality rate per 100,000 persons	**n/a**	425	301	297	–
NI-12: Emergency admission rate (per 100,000 population) for adults	**10,368***	**12,201**	10,484	11,419	↑
NI-13: Emergency bed day rate (per 100,000 population) for adults	**114,744***	**118,646**	120,419	122,193	↑
NI-14: Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges)	**79***	**102**	79	83	–
NI-15: Proportion of last 6 months of life spent at home or in a community setting	**88%**	89%	85%	86%	↑
NI-16: Falls rate per 1,000 population aged 65+	**24.1***	**22.6**	22.4	21.2	↓
NI-17: Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	**84%**	82%	88%	88%	↓
NI-18: Percentage of adults with intensive care needs receiving care at home	**n/a**	61%	63%	58%	↑
NI-19: Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	**171**	805	117	228	↓
NI-20: Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	**22%***	24%	24%	23%	↑

Data from ISD release, 7 June 2019

* Full year data not available for 2018/19. Figure relates to 12 months Jan-Dec 2018.

The indicators below are currently under development by NHS Scotland Information Services Division (ISD).

National indicators in development
NI-10: Percentage of staff who say they would recommend their workplace as a good place to work
NI-21: Percentage of people admitted to hospital from home during the year, who are discharged to a care home
NI-22: Percentage of people who are discharged from hospital within 72 hours of being ready
NI-23: Expenditure on end of life care, cost in last 6 months per death

4.4 Ministerial Strategic Group Indicators

A number of indicators have been specified by the Ministerial Strategic Group (MSG) for Health and Community Care which cover similar areas to the above National Integration Indicators.

MSG Indicator	2018/19	2017/18	2016/17	2015/16	Trend from 2017/18
Number of emergency admissions (adults)	**7,320***	7,432	8,032	7,922	↑
Number of emergency admissions (all ages)	**8,313***	8,513	9,199	9,123	↑
Number of unscheduled hospital bed days (acute specialties) (adults)	**61,383***	62,967	62,901	58,271	↑
Number of unscheduled hospital bed days (acute specialties) (all ages)	**62,875***	64,769	64,455	60,064	↑
A&E attendances (adults)	**20,212**	19,344	18,747	18,332	↓
A&E attendances (all ages)	**27,850**	27,011	25,888	25,300	↓
Acute Bed Days Lost to Delayed Discharge (Aged 18+ including Adults with Incapacity)	**2,284**	1,860	2,704	2,366	↓
% of last six months of life spent in Community setting (all ages)	**88%****	85.2%	85.8%	85.6%	↑
Balance of care: Percentage of population at home (supported and unsupported) (65+)	**n/a**	95.9%	95.7%	95.6%	↑
Balance of care: Percentage of population at home (supported and unsupported) (all ages)	**n/a**	99.1%	99.0%	99.0%	–

Data from ISD release, 5 July 2019 (MSG Indicators)
* Full year data not available for 2018/19. Figure relates to 12 months Jan-Dec 2018.
** Data from ISD release, 7 June 2019 (Core Suite of Integration Indicators)

4.5 Inspection performance 2018/19

East Renfrewshire HSCP delivers a number of in-house services that are inspected by the Care Inspectorate. The following table show the most up to date grades as of 31 March 2019.

Key to Grading:
1 – Unsatisfactory, **2 –** Weak, **3 –** Adequate, **4 –** Good, **5 –** Very Good, **6 –** Excellent

Service	Date of Last Inspection	Quality of Care and Support	Quality of Environment	Quality of Staffing	Quality of Management & Leadership
Adoption Service	02/11/2016	5	Not Assessed	Not Assessed	5
Barrhead Centre	23/02/2018	6	Not Assessed	Not Assessed	6
Fostering Service	08/11/2016	5	Not Assessed	Not Assessed	5
Housing Support Unit (Care at Home)	19/03/2019	1	Not Assessed	2	1

HSCP Holiday Programme	21/07/2017	6	Not Assessed	Not Assessed	5
Kirkton Service	24/10/2014	4	5	5	4
Thornliebank Resource Centre	07/04/2016	4	Not Assessed	Not Assessed	4

The Care Inspectorate launched the new self-evaluation framework for care homes for older people in July 2018, which is based on the Health and Social Care Standards. The last inspection for Bonnyton House was under the new quality inspection framework. Frameworks for other service types will be introduced during 2019.

Service	Date of Last Inspection	How well do we support people's wellbeing?	How good is our leadership?	How good is our staff team?	How good is our setting?	How well is care and support planned?
Bonnyton House	01/11/2018	4	3	4	3	3

4.6 Key performance achievements

The table below gives the indicators where performance has shown the most significant improvement over the past 12 months (April 2018 – March 2019).

Indicator	2018/19	2017/18
Children and Young People		
100% of parents of children who have received an autism diagnosis have opportunity to access Cygnet post diagnostic programme within 12 months of receiving diagnosis.	**100%**	97%
Increase in improved outcomes for children after parent/carer completion of POPP	**89%**	79%
Recovery from alcohol and drug addiction		
% of service users moving from drug treatment to recovery service	**22%**	12%
% Change in individual drug and alcohol Recovery Outcome Score	**23%**	17% (16/17)
Living independently		
Percentage of those whose care need has reduced following re-ablement	**74%**	62%
People reporting 'living where you/as you want to live' needs met (%)	**92%**	84%
SDS (Options 1 and 2) spend as a % of total social work spend on adults 18+ (LGBF)	**7.5%** (17/18)	6.6% (16/17)
Percentage of people aged 65+ with intensive needs receiving care at home. (LGBF)	**62.5%** (17/18)	61.1% (16/17)
Percentage of adults with intensive care needs receiving care at home	**63%** (17/18)	58% (16/17)
Reducing unplanned hospital care		
Number of Emergency Admissions: Adults	**7,320** (2018)	7,432

Emergency admission rate (per 100,000 population) (adults)	**10,368** (2018)	10,482
Emergency bed day rate (per 100,000 population) (adults)	**114,744** (2018)	120,419
A & E Attendances from Care Homes (NHSGGC data)	**429**	541
Emergency Admissions from Care Homes (NHSGGC data)	**261**	338
% of last six months of life spent in Community setting (all ages)	**88%**	85%
Supporting carers		
People reporting 'quality of life for carers' needs fully met (%)	**78%**	72%

4.7 Indicators we are seeking to improve

Ongoing improvement is sought across all services within the HSCP and the performance management arrangements in place are designed to facilitate this. There are specific areas we would like to improve going forward and these are set out in our current Strategic Plan.

Key indicators we would like to improve on include the following:

Children and Young People

- Children and young people starting treatment for specialist Child and Adolescent Mental Health Services within 18 weeks of referral
- Child and Adolescent Mental Health - longest wait in weeks at month end

Criminal Justice

- % Positive employability and volunteering outcomes for people with convictions

Adult Support and Protection

- % Change in women's domestic abuse outcomes

Living independently

- Increase the percentage of people aged 65+ who live in housing rather than a care home or hospital.

Mental Health services

- Percentage of people waiting no longer than 18 weeks for access to psychological therapies
- Waiting times for Primary Care Mental Health Team (Bridges)

Unscheduled care: Working in partnership with NHS acute services

- People waiting more than 3 days to be discharged from hospital into a more appropriate care setting
- Number of A&E Attendances

5. Looking forward / Improvement activity

5.1 Introduction

As a partnership we are continuously monitoring and evaluating our performance and seeking to improve the services and support we provide to local people. This section highlights a few of the key areas we will be focusing on in 2019/20 to develop our approaches and bring necessary improvements.

5.2 Care at Home

A recent inspection of our in-house Care at Home service highlighted a number of concerns and areas for improvement which we have been working on and will continue to deliver in 2019/20. We have established a comprehensive improvement plan which will see a wide range of activity including improvement to the following areas:

- Care and Support Personal Plans – new quality processes and documentation.
- Medication Management – updated policy, training module and assessment tool.
- Review of Personal Plans – improved planning and review processes.
- Complaints Handling – improved quality in our handling of complaints through training, better processes for compliance and more learning/analysis from complaints.
- Service Delivery Times – in consultation with service users and analysing visit time data we will aim to deliver the most appropriate scheduling for homecare.
- Staffing levels – addressing recruitment and retention issues within the service.
- Staff training and supervision – improving supervision and staff development within the service.

5.3 Unscheduled care - A&E attendances; delayed discharges

Reducing demand on the hospital sector remains a key priority for the partnership and we will work to reduce our A&E attendances that remain high.

We will continue to work closely with GPs at cluster and practice level to focus on data to identify parts of the system where there are high levels of A&E attendance. We will continue to develop our preventative approaches including developing and promoting the use of Anticipatory Care Plans and supporting the role of Link Workers in our GP practices. We will also work closely with other community-based services where they are in a position to provide earlier support to individuals likely to be frequent attenders at A&E.

We will work to minimise delayed discharge from hospital. In order to achieve the target time of 72 hours we continue to require more community based provision. The medium term aspiration is that the costs of increased community services will be met by shifting the balance of care from hospital services. The work to agree a funding mechanism to achieve this remains ongoing with NHS Greater Glasgow and Clyde and its partner IJBs.

5.4 Adult Support and Protection

We are continuing to develop our model and processes for supporting people at risk of and experiencing harm. In 2019/20 this will see specific focus on areas for improvement identified in a recent audit of ASP including: how we report significant events (chronologies); our approach to risk assessment and management; making best use of advocacy; and strengthening multi-agency working.

5.5 Improving data, intelligence and strategic planning

We are developing our Data and Management Information Strategy and have strengthened performance and governance reporting in our new staffing structure. This is an ongoing focus for the partnership and will support informed planning and decision making.

We have refreshed the membership of our Strategic Planning Group and we are commencing work to support development of our future contractual frameworks for Care at Home and Care and Support to develop sustainable, outcome focused services. We have identified funding to support this development.

5.6 Reducing staff absence

Staff absence affects the delivery of services and we continue to focus our efforts on maximising attendance. We will continue to take a targeted approach to absence management analysing absence data by service area. Absence panels will continue to monitor compliance with our Maximising Attendance policy and the HR Advice and Support Unit will provide dedicated support to service and teams identified as having specific challenges with absence.

Appendix One - National Outcomes

The National Health and Wellbeing Outcomes prescribed by Scottish Ministers are:

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

The National Outcomes for Children are:

- Our children have the best start in life and are ready to succeed.
- Our young people are successful learners, confident individuals, effective contributors and responsible citizens.
- We have improved the life chances for children, young people and families at risk.

The National Outcomes for Criminal Justice are:

- Prevent and reduce further offending by reducing its underlying causes.
- Safely and effectively manage those who have committed offences to help them reintegrate into the community and realise their potential for the benefit of all.