AGENDA ITEM No.10

EAST RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

East Renfrewshire Council

NHS Greater Glasgow and Clyde

Meeting of East Renfrewshire Health and Social Care Partnership	Integration Joint Board
Held on	19 August 2015
Agenda Item	Strategic Plan
Title	10

Summary

The purpose of this report is to seek approval of the Partnership's Strategic Plan for the period 2015-18. The Strategic Plan sets a date of 7 October 2015 for the delegation of functions and services by East Renfrewshire Council and the NHS Greater Glasgow and Clyde Board to the Integration Joint Board. This is subject to the completion of the Financial Due Diligence Report.

Presented by	Candy Millard, Head of Strategic Services

Action required

It is recommended that the Integration Joint Board:-

- Approve the Strategic Plan for the period 2015-18
- Agrees a date of 7 October for the delegation of functions and services following consideration of the Financial Due Diligence Report at its next meeting

Implications checklist – check box if applicable and include detail in report

☐ Financial	☐ Policy	☐ Legal	☐ Equalities
☐ Staffing	☐ Property	☐ IT	☐ Efficient Government

EAST RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

INTEGRATION JOINT BOARD

19 August 2015

Report by Julie Murray, Chief Officer Designate

STRATEGIC PLAN

PURPOSE OF REPORT

1. The purpose of this report is to seek approval of the Partnership's Strategic Plan for the period 2015-18 which sets a date of 7 October for the delegation of functions and services by East Renfrewshire Council and the NHS Greater Glasgow and Clyde Board to the Integration Joint Board.

RECOMMENDATION

2. It is recommended that the Integration Joint Board:-
   - Approve the Strategic Plan for the period 2015-18
   - Agrees a date of 7 October for the delegation of functions and services following consideration of the Financial Due Diligence Report at its next meeting

BACKGROUND

3. As required by legislation, the members of the Strategic Planning Group have been involved in the development of the Strategic Plan; have considered each draft and have been engaged in the development of the final document.

4. There has been considerable consultation on the development of the Plan, which has ensured that the undernoted stakeholders have been consulted directly on the development of the Plan:
   - Health professionals
   - Users of health care
   - Carers of users of health care
   - Commercial providers of health care
   - Non-commercial providers of health care
   - Social care professionals
   - Users of social care
   - Carers of users of social care
   - Commercial providers of social care
   - Non-commercial providers of social care
   - Staff of the Health Board and local authority who are not health professionals or social care professionals
   - Non-commercial providers of social housing
   - Third sector bodies carrying out activities related to health or social care
   - Other developing health and social care partnerships within the NHSGGC area

REPORT

5. The Plan includes the Strategic Priorities for ensuring delivery against National Outcomes sets in line with our Partnership's Vision ***Working together with the people of East Renfrewshire to improve lives"*** by:
   - Valuing what matters to people
   - Building capacity with individuals and communities
   - Focusing on outcomes, not services

6. Localities, and locality planning, provide a key mechanism for strong local clinical, professional and community leadership for the future development of our Strategic Priorities. To ensure that services are planned and led locally in a way that is engaged with the community, we have consulted widely on our locality planning approach and have developed an approach set out in the Strategic Plan that combines:
   - close alignment of health and care services with GP practices in localities based on GP practice populations
   - a focus on the different health and wellbeing outcomes in different local areas of East Renfrewshire
   - strong links and engagement with different communities within East Renfrewshire

7. High level strategic needs assessment and a summary of locality information is included within the plan with links to further detailed work. This analysis has informed the development of the plan and will be used to strengthen our locality planning.

8. In our strategic planning conversations local people, staff and partners have demonstrated a keen interest to working together in shaping health and social care in East Renfrewshire. The consistent messages from everyone who engaged with the strategic plan conversation document included:
   - Overwhelming support for the vision and values from service users, carers and health and social care staff.
   - An interest in knowing more about health and social care in East Renfrewshire.
   - Support of the partnership's strategic priorities.
   - The strategic plan conversation document was accessible and easy to read and engage with.

9. The Strategic Plan will be supported by an Implementation Plan and Performance Data Directory that will be reported to the next meeting of the Integration Joint Board.

10. Given the Chief Finance Officer does not take up her new post until 17th August and has not yet had the opportunity to undertake the required due diligence, the date of the next IJB meeting is proposed as the date from which services and functions will be delegated.

FINANCE AND EFFICIENCY

11. The financial resources required to deliver the Strategic Plan Priorities are outlined within the plan.

12. The date of 7 October is subject to the outcome of the outstanding audit review and its impact on the process of Financial Due Diligence.

CONSULTATION

13. Our strategic planning group has placed great emphasis and priority on meaningful engagement. We have listened to our partners, including our cross-sector partners, our staff, the people who use services and their carers, who have told us the best methods to engage with them. These include being transparent about aims and intentions, avoiding the use of jargon and using plain English, using a variety of approaches to sharing information, and providing locally relevant examples so people can relate and contribute.

14. Based on this feedback and our Community Planning Partnership standards for community engagement, we have begun a strategic planning conversation with our communities which we have committed to continuing over the coming years and future plans. We have used a mixed approach in consulting on the draft Strategic Plan including:

    Online publication of Strategic Plan and associated materials

    - The establishment of dedicated Health and Social Care Integration website[1] to host copies of Strategic Plan and invite online comment/feedback, Joint Strategic Needs Assessment and Strategic Planning Group meeting materials.
    - Use of East Renfrewshire online consultation Citizen Space[2] survey tool, which is utilised by East Renfrewshire Council for all consultations with the community.
    - Staff bulletins in the Director's Brief newsletter on the launch of the strategic plan, outlining key messages and inviting staff to get involved.
    - Supported by physical copies of plan out to Third Sector Interface, Carers Centre, GP Practices, libraries, affiliated health and care offices.
    - Formally shared with other partnerships within Greater Glasgow.

    Use of social media and technology

    - Facebook messages, inviting engagement on-line or in-person at local drop-in sessions.
    - Twitter messages inviting people to get involved in shaping health and social care in East Renfrewshire.
    - Use of information screens to raise awareness of drop-in face to face sessions (including Libraries, sports centres, Eastwood Theatre, Barrhead Health and Care Centre) supported by information fliers.

    Face to face

    - Protected Learning Time GP Engagement event 'Let's Take Time to Talk'.
    - Leadership event with CHCP health and social care managers.
    - Staff Engagement events led by the Senior Management Team.
    - General drop-in opportunities in the mornings and afternoons.
    - General drop-in opportunities in the evenings.
    - Staff drop-in opportunities in Eastwood and Barrhead.
    - Carer themed conversations.

[2] http://getinvolved.eastrenfrewshire.gov.uk/

PARTNERSHIP WORKING

15. The plan has been developed by the Strategic Planning Group which has full partnership representation in line with the Public Bodies (Joint Working) (Scotland) Act, 2014.

IMPLICATIONS OF THE PROPOSALS

Staffing

16. The plan gives an overview of the services, professions and staff groups, over which the Integration Joint Board will have operational oversight and which will be managed locally through the Chief Officer

Property

17. None

Legal

18. Approval of the draft Strategic Plan by the date agreed by Integration Joint Board will trigger the delegation of functions and services from the Parties.

Equalities

19. A full Equalities Impact assessment is included as an appendix to draft Strategic Plan.

Sustainability

20. There are no immediate sustainability issues arising from any decisions made on this report. However, the sustainability implications arising from work undertaken through

CONCLUSIONS

21. The Strategic Planning Group has developed and consulted on the Strategic Plan following the regulations and guidance issued by the Scottish Government. The Strategic Plan will continue to be a living, dynamic plan. The information we have used to help plan ahead will evolve over time, and so too will the contents of the plan, which will be reviewed and updated each year.

22. Over 2015-16 we will work in partnership to develop our priorities and ensure that our resources best meet the needs of our locality areas. We will do this in a flexible way, involving local people, professionals and service providers in discussion.

RECOMMENDATIONS

23. It is recommended that the Integration Joint Board:-
    - Approve the Strategic Plan for the period 2015-18
    - Agrees a date of 7 October for the delegation of functions and services following consideration of the Financial Due Diligence Report at its next meeting.

REPORT AUTHOR AND PERSON TO CONTACT

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July 2015

BACKGROUND PAPERS

Public Bodies (Joint Working) (Scotland) Act, 2014

The Public Bodies (Joint Working) (Prescribed Consultees) (Scotland) Regulations 2014

KEY WORDS

Strategic Plan; Localities;

East Renfrewshire Health and Social Care Strategic Plan 2015-18

Working together with the people of East Renfrewshire to improve lives

Draft 03.08.15

Contents

Appendices

Declaration

This Strategic Plan for East Renfrewshire Health and Social Care Partnership has been prepared by a cross sector Strategic Planning Group with representation in line with the Public Bodies (Joint Working) (Scotland) Act 2014. This plan has been agreed at the first meeting of the Integration Joint Board on 19 August 2015 for enactment on 7 October 2015.

Signatories:

Julie Murray
Chief Officer
East Renfrewshire Health and Social Care Partnership

Ian Lee
Chair Integration Joint Board
East Renfrewshire Health and Social Care Partnership

Introduction by Chief Officer

In East Renfrewshire we have been leading the way in integrating health and care services. Our successful Community Health and Care Partnership (CHCP), between East Renfrewshire Council and NHS Greater Glasgow and Clyde, was established in 2006. Over the last nine years the CHCP integrated health and social care management and services and developed strong relationships with many different partner organisations.

From the outset of the CHCP we have focused on improving outcomes for the people of East Renfrewshire, improving health and wellbeing and reducing inequalities. Our new Health and Social Care Partnership (HSCP), under the direction of East Renfrewshire's Integration Joint Board, is able to build on this successful foundation.

The greatest influence on our Strategic Planning has been the Christie Commission report on the Future Delivery of Public Services. This report set out four objectives which must shape a programme of reform;

- Public services are built around people and communities, their needs, aspirations, capabilities and skills and work to build up their autonomy and resilience;
- Public service organisations work together effectively to achieve outcomes;
- Public service organisations prioritise prevention, reduce inequalities and promoting equality; and
- All public services constantly seek to improve performance and reduce costs and are open, transparent and accountable.

Our commitment to outcomes and public service reform is reflected in our vision and partnership statement on the following page.

Our Vision

Our partnership vision statement is **"*Working together with the people of East Renfrewshire to improve lives.*"**

We will achieve this by:

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

These 'integration touch points' will be used to guide everything we do as a partnership.

Our Partnership Commitment - Working Together

Through this Strategic Plan we make 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.

National Outcomes

The main purpose of integration is to improve the wellbeing of people who use health and social care services, particularly those whose needs are complex and involve support from health and social care at the same time. This Strategic Plan is intended to achieve the National Health and Wellbeing Outcomes prescribed by Scottish Ministers:

- People are able to look after and improve their own health and wellbeing and live in good health for longer.
- 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.
- People who use health and social care services have positive experiences of those services, and have their dignity respected.
- Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
- Health and social care services contribute to reducing health inequalities.
- 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.
- People using health and social care services are safe from harm.
- 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.
- Resources are used effectively and efficiently in the provision of health and social care services.

NHS Greater Glasgow and Clyde and East Renfrewshire Council have agreed that Children and Families Health and Social Work and Criminal Justice Social Work services and the minimum with regard to housing support should be included within functions and services to be delegated to the partnership, therefore the specific National Outcomes for Children and Criminal Justice are also included.

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; and
- We have improved the life chances for children, young people and families at risk.

The National Outcomes and Standards for Social Work Services in the Criminal Justice System are:

- Community safety and public protection;
- The reduction of re-offending; and
- Social inclusion to support desistance from offending.

East Renfrewshire Community Planning Outcomes

For 2015/16 we will honour our commitment to the East Renfrewshire Single Outcome Agreement and East Renfrewshire Council Outcome Delivery Plan. Thereafter we will work as part of East Renfrewshire Community Planning Partnership to develop our Outcome Improvement Plan and agree our contribution to stretch aims and targets.

Personal Wellbeing Outcomes

The Partnership is committed to delivering a personal outcomes approach at the heart of everything we do. For children and young people we use the Getting it Right for Every Child wellbeing outcomes (Safe, Nurtured, Achieving, Respected, Responsible and Included).

For adults we use Talking Points, which include: Seeing people, Having things to do, Living where you want, Mobility, Staying as well as you can, Being treated with respect, and Quality of life for carers.

Health and Social Care Services

This Strategic Plan relates to the following Integrated Services, over which the Integration Joint Board will have operational oversight and which will be managed locally through the Chief Officer.

Children and Families	**Older People**	**Physical / Sensory Disability**	**Learning Disability**	**Mental Health**	**Addictions**
Child and Adolescent Mental Health Health visiting School Nursing Speech and Language Therapy Social Work Services relating to ▪ Adoption and Fostering/Corporate Parenting ▪ Assessment and Planning ▪ Child Protection ▪ Children with Disabilities ▪ Intensive Service for children and families ▪ Looked After and Accommodated Children; ▪ Transition ▪ Young People and Through care ▪ Domestic Abuse	Social work District Nursing Advanced Nurse Practitioners Rehabilitation Teams Occupational Therapy Home Care Re-ablement Services Care at Home Short Breaks Adult Support and Protection Carer support	Aids and Equipment Supported Living Short Breaks	Social work Nursing Medical Supported Living Day Opportunities Local Area Co-ordination	Social work Psychiatric Nursing Psychiatry Psychology Primary Care Mental Health Supported Living	Alcohol and Drugs Treatment and Recovery services

Family Health Services GP services Community Dentals services Community Ophthalmic services Pharmacy	**Prescribing**	**Criminal Justice Social Work**	**Commissioning Planning and Health Improvement**	**Management & Admin**	**Housing** Adaptations Care and Repair

This Strategic Plan relates to the following Acute Services for which NHSGGC will be responsible for the operational oversight and management:

- Accident and Emergency services provided in a hospital.
- Inpatient hospital services relating to the following branches of medicine:
  - General medicine.
  - Geriatric medicine.
  - Rehabilitation medicine.
  - Respiratory medicine.
  - Psychiatry of learning disability.
- Palliative care services provided in a hospital.
- Services provided in a hospital in relation to an addiction or dependence on any substance.
- Mental health services provided in a hospital, except secure forensic mental health services.
- Services provided by Allied Health professionals in an outpatient department

East Renfrewshire Health and Social Care Partnership is responsible through its Chief Officer for the operational management on behalf of all the Integration Joint Boards within the Greater Glasgow and Clyde area of specialist learning disability services. This has a separate strategic plan and operational budget.

Resources of the HSCP

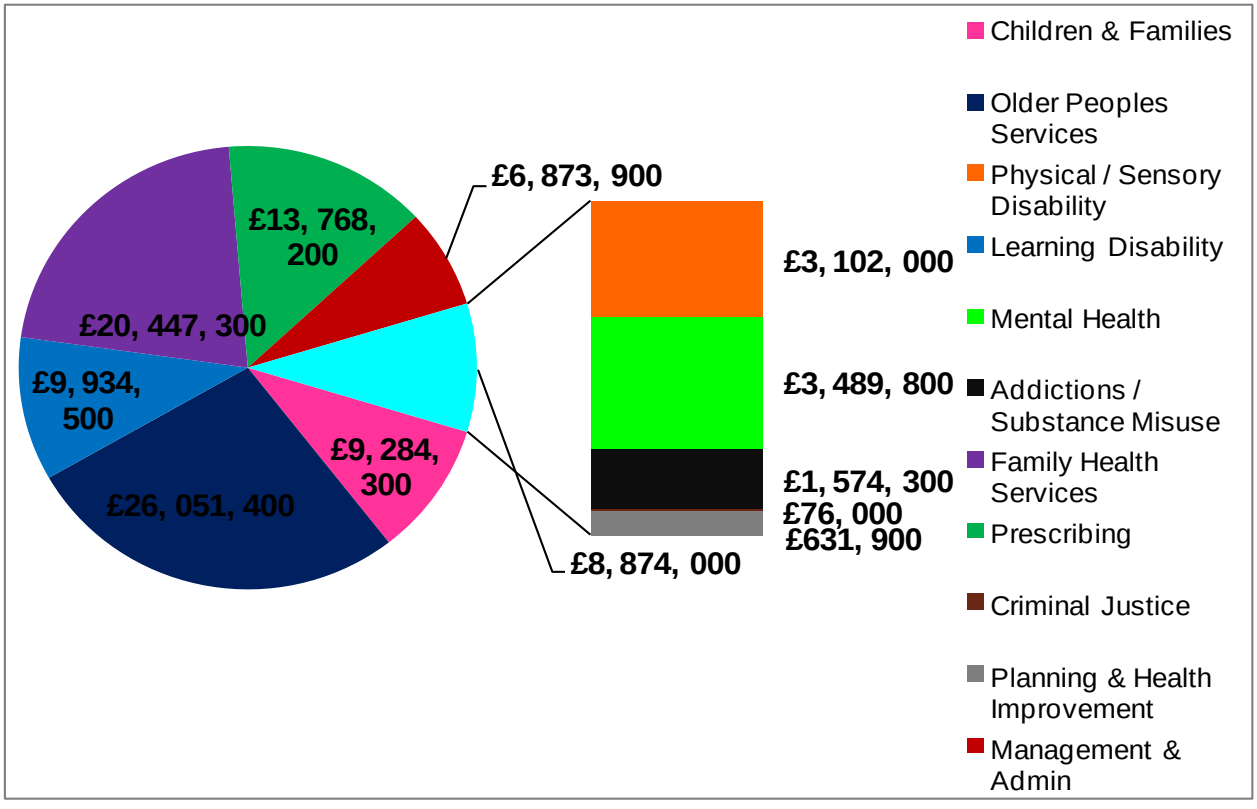
The full 2015-2016 Partnership budget for Integrated Services, over which the Integration Joint Board will have operational oversight, is detailed below.

East Renfrewshire Partnership Resources 2015-16	Total Net Resources		Delegated Resources			
			Payment	Set aside	Total	Proportion of Total Resources
	£'m		£'m	£'m	£'m	%
Community						
District Nursing	1.2		1.2		1.2	
Health Visiting	0.8		0.8		0.8	
Midwifery	-		-		-	
Child Health	0.4		0.4		0.4	
Specialist Nursing	1.1		1.1		1.1	
Clinical Psychology	-		-		-	
Community Mental Health Teams	1.9		1.9		1.9	
Community Learning Difficulties Team	0.1		0.1		0.1	
Addiction Services	0.8		0.8		0.8	
Family Planning	-		-		-	
Community AHP	0.2		0.2		0.2	
Laboratory - Direct Access/FHS Practitioners	-		-		-	
GP Out of Hours	-		-		-	
Community Dentistry	-		-		-	
Incontinence Services	-		-		-	
Home Dialysis	-		-		-	
Breast Screening	-		-		-	
Health Promotion	0.4		0.4		0.4	
Voluntary Organisations	-		-		-	
Other	1.4		1.4		1.4	
Community Total	**8.3**		**8.3**	**-**	**8.3**	**100%**
Family Health Services						
GMS	9.0		9.0		9.0	
Pharmaceutical - GP prescribing	13.8		13.8		13.8	
Pharmaceutical - Other	2.8		2.8		2.8	
General Dental Services	6.8		6.8		6.8	
General Ophthalmic Services	1.5		1.5		1.5	
FHS total	**33.9**		**33.9**	**0**	**33.9**	**100%**
Resource Transfer	**5.5**		**5.5**		5.5	**100%**
Total Health Board Expenditure	**47.69**		**47.69**	**-**	**47.69**	**100%**

Social Work Expenditure						
Older Persons	22.0		22.0		22.0	
Adults with physical or sensory disabilities	2.8		2.8		2.8	
Adults with learning disabilities	6.4		6.4		6.4	
Adults with mental health needs	1.6		1.6		1.6	
Service Strategy	0.9		0.9		0.9	
Children's Panel	0.0		0.0		0.0	
Children & Families	8.1		8.1		8.1	
Criminal Justice	0.1		0.1		0.1	
Adults with other needs	0.2		0.2		0.2	
Other	4.9		4.9		4.9	
Total Social Work	**47.1**		**47.1**	**0.0**	**47.1**	**100%**
Total Health & Social Care Expenditure	**94.8**		**94.8**	**0.0**	**94.8**	**100%**

As the Strategic Plan will be put in place mid-year, the Integration Joint Board will take responsibility for its pro-rata budget proportion.

The following diagram, based on the Partnership budget for 2014-15 shows the proportion of combined health and care expenditure in service areas. The greatest area of resource use is in older peoples' services and family health services.



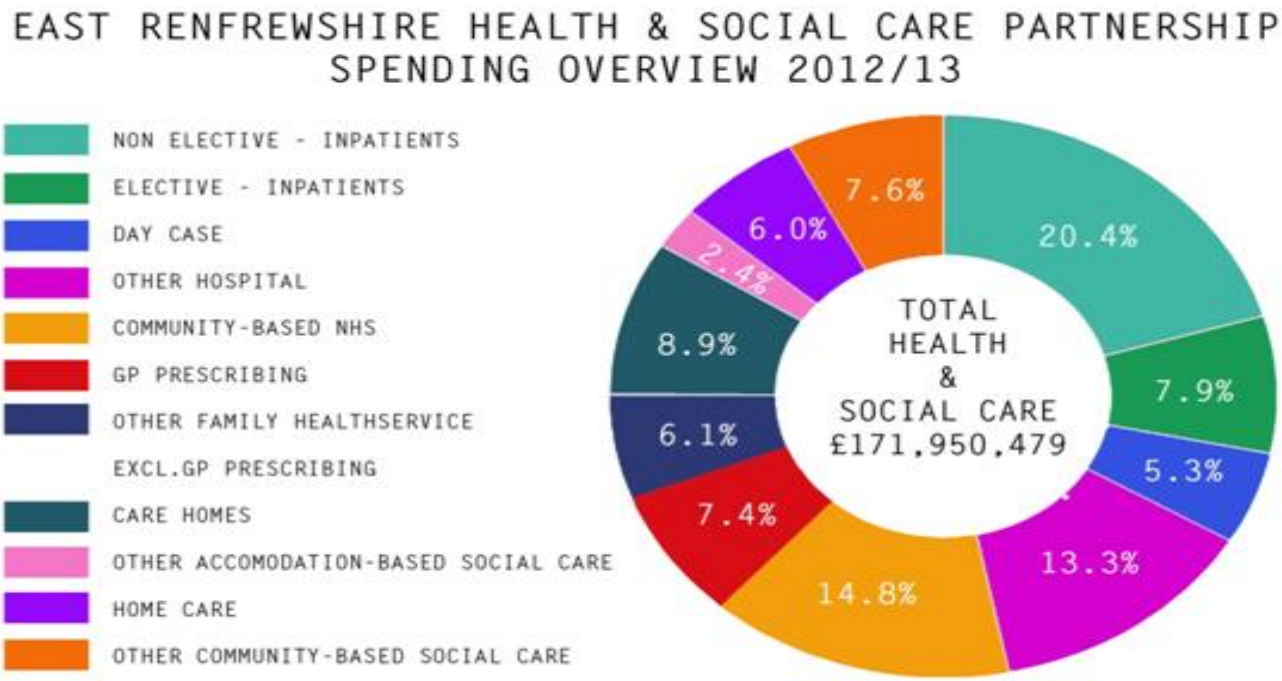
Integrated Resource Framework

The Integrated Joint Board has responsibility for planning for hospital services.

NHS Expenditure will be calculated for the following Hospital Services

- Unplanned inpatients
- Elective inpatients and day cases
- Outpatients – Accident & Emergency
- Outpatients – Other
- Day patients
- Other

The information presented below is taken from the Integrated Resource Framework (IRF). It provides an overview of our total resource use in 2012/13. This differs from our budget, as it includes resource used in acute hospitals, but excludes Children and Families and Criminal Justice Social Work Services.



From this information we can see that over 45% of resource used was on hospital care, with less than a third of this on planned care. One of our challenges is to better understand our use of unplanned care. For example, some initial work undertaken by NHS Greater Glasgow and Clyde indicates that people aged over 85 are

particularly high users of hospital beds. East Renfrewshire has a higher over 85 population on average when compared with the rest of Scotland.

We will be working with Information Services Division (ISD) and National Services Scotland (NSS) to join-up our health and care information and link this to costs based on the use of resources.

Over the coming years we hope to undertake work to better understand our spending in relation to our locality areas, which are described in subsequent sections.

One of our biggest challenges will be to look at how we ensure the most effective supports are available for people across all of life's stages. Recognising the pressures on public sector finances we will need to explore areas to decommission or disinvest in, in order to commission and invest in our agreed priority areas.

We will continue our work with service providers and people who use services on how we can achieve best value with the resources we have, to improve health and wellbeing in East Renfrewshire.

Understanding East Renfrewshire

Our strategic needs assessment[1] raises a number of important points about our population and their communities.

This information will guide how we plan, prioritise and personalise the future of our services. A snapshot of our population and their needs can be found on our health and social care integration page on the East Renfrewshire Council website, which will be added to over the course of our journey in developing the Strategic Plan. In summary, our findings so far tell us that we have:

- An **ageing population** with increasing life expectancy. The most marked population increase will be in our 80 - 84 and over 85 age groups. These oldest residents are most likely to experience increased ill-health and disability, coupled with issues around mental health and isolation. As a result of this they are the greatest users of health and social care services.
- Growing numbers of people living with **disabilities and long term conditions**, many of whom are also older people. Many people have more than one long condition sometimes referred to as 'multi-morbidity'. It is important that support and treatment is centred round the individual rather than their conditions.
- One of the most **ethnically and culturally diverse** areas, with growing numbers and proportions of people of ethnic minorities**,** and correspondingly rising numbers of people who identify with specific minority religions, such as Islam and Hinduism. The diverse needs of our population reinforce the value of a personalised approach.
- Whilst East Renfrewshire is seen as an affluent area, in small pockets of our community we have high concentrations of **deprivation.** People in our more deprived communities experience significant health inequalities both in terms of poor health and shorter life expectancy than people in our more affluent areas. We are committed to narrowing this gap in health outcomes.
- Differences in life experiences for **children and families**. This is apparent from the earliest stages, where there are some differences in outcomes for mothers and babies in different areas of East Renfrewshire. We have prioritised the Early Years as a stage at which we can make the greatest difference to health and wellbeing.

[1] Joint Strategic Needs Assessment
http://www.eastrenfrewshire.gov.uk/CHttpHandler.ashx?id=14290&p=0

Integration Planning Principles

The integration planning and delivery principles are the lens through which all integration activity should be focused to achieve the national health and wellbeing outcomes. They set the ethos for delivering a radically reformed way of working and inform how services should be planned and delivered in the future.

The main purpose of the integration planning and delivery principles is to improve the wellbeing of service-users and to ensure that those services are provided in a way which:

- Are integrated from the point of view of service-users.
- 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.
- Respects the rights of service-users.
- Take account of the dignity of service-users.
- Take account of the participation by service-users in the community in which service-users live.
- Protects and improves the safety of service-users.
- Improves the quality of the service.
- Are planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care).
- Best anticipates needs and prevents them arising.
- Makes the best use of the available facilities, people and other resources.

Our Approach to Localities, Local Areas and Communities

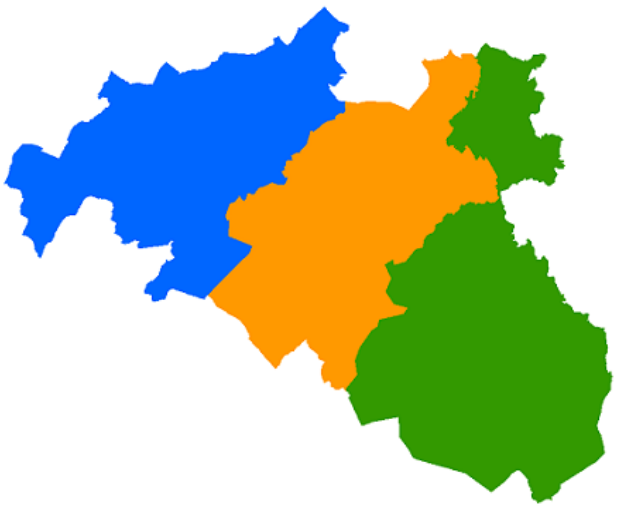
Localities, and locality planning, provide a key mechanism for strong local clinical, professional and community leadership, ensuring that services are planned and led locally in a way that is engaged with the community. We have consulted widely on our approach and have developed an approach that combines:

- Close alignment of health and care services with GP practices in **localities** based on GP practice populations;
- A focus on the different health and wellbeing outcomes in different **local areas** of East Renfrewshire; and
- Strong links and engagement with different **communities** within East Renfrewshire.

The following table and map shows how our localities relate to local areas and communities:

Locality	Local Area	Communities
Levern Valley	A	Barrhead, Neilston and Uplawmoor
Eastwood 2	B	Giffnock and Thornliebank (part of Giffnock)
	C	Newton Mearns
Eastwood 1	D	Netherlee, Stamperland, Clarkston, Busby, Eaglesham and Waterfoot (including majority of Giffnock)

Three Localities



Four Local Areas

Localities

In our localities we will be looking at health and social care service use, experiences and expenditure. The data we are using covers: emergency admissions, readmissions, A&E attendance, delayed discharge, alcohol and drug related hospital stays, hospital episodes by speciality, and percentage of the last six months of life for those aged 75+ spent outside of hospital. Linking to this, data from GP's Quality Outcome Framework (QOF) registers on long term conditions will also be presented in these three areas, as will data on prescriptions of drugs for anxiety, depression or psychosis, and social care data such as use of care at home services.

We deliver a number of health and care services in the localities which are based on clusters of GP practices. Our locality services include:

- Social work assessment and care management for older people and people with a physical disability
- Rehabilitation teams
- District nurses
- Occupational therapy

On occasion we will combine information for Eastwood 1 and 2 for example in discussing links to the Queen Elizabeth Hospital, we will use the two broad housing areas of Eastwood and Levern Valley.

Each locality has a lead link GP, whose role is to support us in looking at the data for the locality, working with colleagues to identify clinical priorities for the area and represent their locality perspective within our strategic planning group.

All locality stakeholders will be brought together to discuss locality priorities though sessions modelled on our Lets take Time to talk events. These are facilitated workshops that allow a range of local stakeholders to work with GPs to prioritise and plan.

We trialled this approach of three locality conversations with interactive group exercises at our last Lets take time to talk event earlier this year. Over 150 people participated, including GPs, health and social work managers and practitioners, third sector representation and service user representatives from our Public Partnership Forum.

The locality topics included 'Eastwood 1 – Child Protection: Identifying significant harm'; 'Eastwood 2 – Working collaboratively to care for people in the community' and 'Levern Valley – Rehabilitation and Enablement Service: Journey to date and how to improve.' Participants found the locality discussions to be interesting and enjoyable, as well as strengthening positive working relationships. The diverse mix

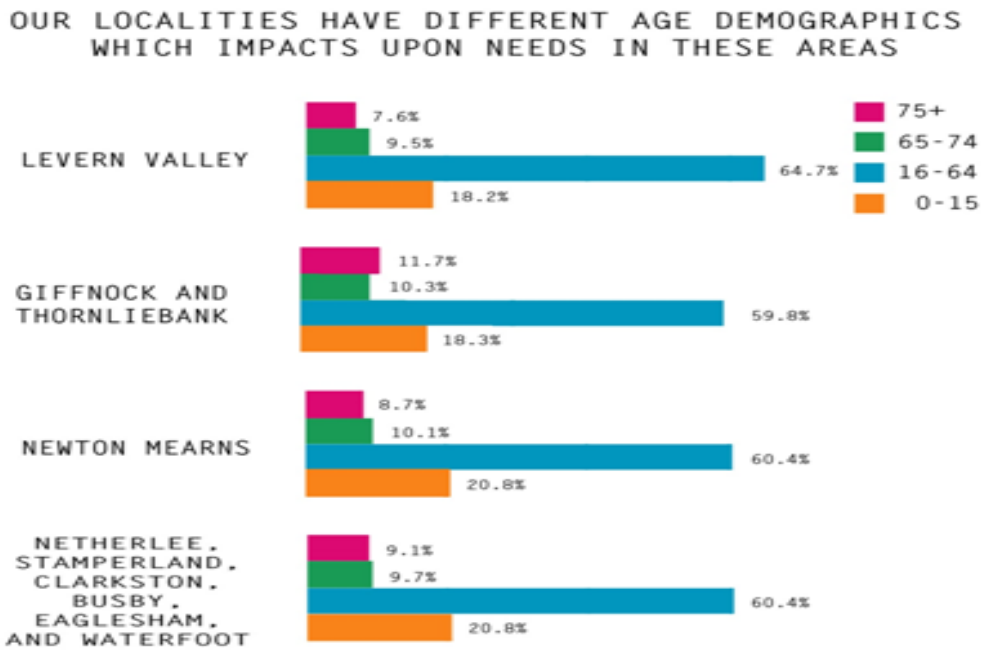
of participants also helped everyone to see that a whole systems approach is crucial for developing solutions that work well across the whole customer journey.

Local Areas

Our four local areas which reflect natural communities were identified in partnership with our Community Planning partners. These are our main data 'building blocks' for the analysis of health outcomes and indicators, and in engaging local communities in conversations about health and wellbeing.

These local areas will be used in presenting population information such as: population trends, demographics of age, gender, ethnicity and religion, and figures on deprivation, benefit claimants, and child poverty. In addition to this, high level public health information will be provided for these four areas, such as smoking prevalence and data around pregnancy and breast feeding. This information is intended to give a broad overview of the populations of the different areas of East Renfrewshire, and has been presented in these areas to reflect natural communities. Much of the information included in the needs assessment can also be analysed at a smaller area level where the need arises.

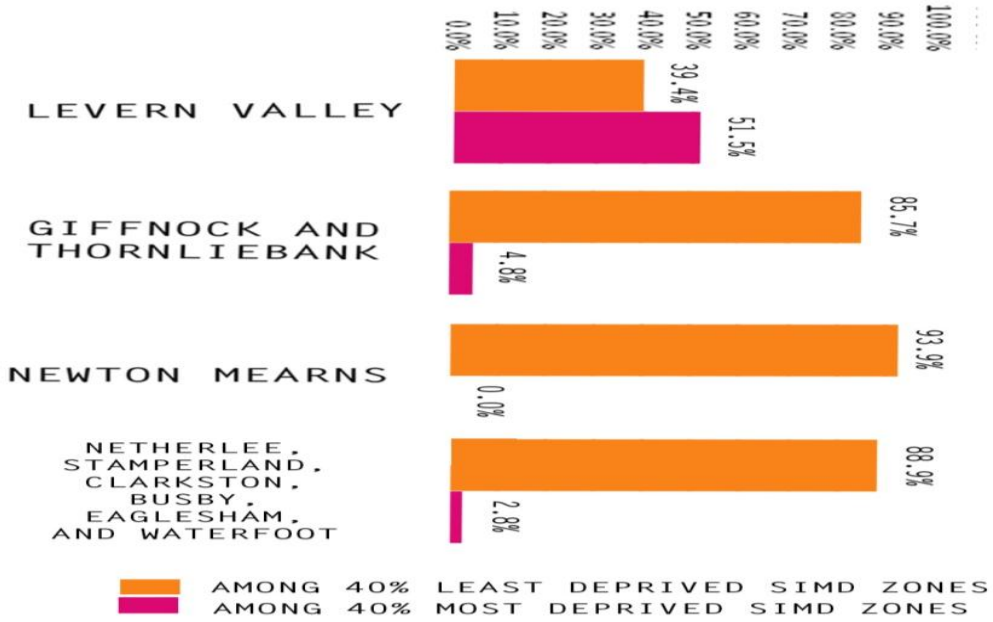
While health outcomes in East Renfrewshire are generally better than the Scottish average, closely linked to the relative level of affluence of our area, this picture is not universal.



Giffnock and Thornliebank has the highest percentage of older (65-74) and 'older older' (75+) population.

Some localities have far higher proportions of ‘data zones’ among the most deprived in Scotland, which are linked to health outcomes.

Deprivation by Local Area



Levern Valley tends to stand out from the ‘average’ picture of East Renfrewshire, as there are concentrated areas of deprivation within this locality. This is true across indicators for health, education, employment, income, housing, crime and access: each of the seven domains measured by the Scottish Index of Multiple Deprivation (SIMD).

This has an impact on needs, as Levern Valley has significantly poorer outcomes than other parts of East Renfrewshire across a number of health indicators such as emergency admissions, alcohol and drug related admissions, low weight births and breastfeeding exclusively at 6-8 weeks.

This trend is reversed in relation to some measures such as delayed discharges. Giffnock and Thornliebank stands out as having significantly higher rates of delayed discharge bed days, while Levern Valley has the lowest.

This could be linked to the age demographics of the different localities, as Giffnock and Thornliebank have the highest proportions of older people. We know that older people are more likely to have emergency admissions to hospital, and are particularly likely to stay in hospital for longer.

People over 75 are much more likely to have their discharge delayed after they have been assessed as fit to be discharged. This is linked to the increased support needs

associated with ageing, which can require linking in with other services prior to discharge.

Taking into consideration the differences between areas of East Renfrewshire will be vital to planning for the future of our health and social care services.

Throughout our journey over the coming year in developing our Strategic Plan, we will be analysing and sharing information, as well as engaging with local people about their experiences. This will ensure that local needs can be reflected in local planning. Further locality level information is available as Appendix 5.

Strategic Planning Conversations

Our Approach

Our strategic planning group has placed great emphasis and priority on meaningful engagement. We have listened to our partners, our staff, the people who use services and their carers, who have told us the best methods to engage with them.

These include being transparent about aims and intentions, avoiding the use of jargon and using plain English, using a variety of approaches to sharing information, and providing locally relevant examples so people can relate and contribute.

Based on this feedback and standards for community engagement, we set our consultation within the commitment to a long term conversation. We used a mixed approach in consulting on the draft Strategic Plan (see Appendix 1) including:

- Online and physical publication of Strategic Plan and associated materials
- Use of social media and technology
- Face to face planned and drop-in sessions

Conversation timeline

The image below highlights some of the conversations we have had on the strategic plan ‘conversation document’ in 2015-16 so far.

Feedback to date

We have had many interesting conversations with people, demonstrating a keen interest to working together in shaping health and social care in East Renfrewshire.

The consistent messages from everyone who engaged with the Strategic Plan conversation document included:

- Overwhelming support for the vision and values from service users, carers and health and social care staff;
- An interest in knowing more about health and social care in East Renfrewshire;
- Support of the partnership's strategic priorities; and
- The Strategic Plan conversation document was accessible and easy to read and engage with.

Specific comments included:

"*I agree with the vision and values as they aim to make life better for the people of East Renfrewshire. This is to be achieved be better working with other key partners and by listening more to people who use services and responding to their needs. There is also a strong focus on prevention."* [health and social care staff]

"*The strategic plan conversation document was accessible and easy to read*." [service user, staff member, carer]

"*Plan is a good size with clear information...Really useful to see a breakdown of the localities and their specific circumstances.*" [Public Partnership Forum]

"*There will always be conflict over priorities however I think these strategic priorities will benefit the majority.*" [carer]

"*Really useful to see what the changes around integration mean in practice*." [health and social care staff]

"*I think the equalities characteristics have been looked at in a fair and unbiased manner*." [carer]

"*The priorities are likely to have a positive impact in relation to the equalities characteristics*." [health and social care staff]

"*We are supportive of the prevention and early intervention, it is very interesting to know about the changing demographics and it is clear 'more of the same' in terms of service responses is not sustainable. We will be engaging with our community for them to tell us what their priorities are, and we look forward to working with partners to help improve the health and wellbeing*." [Greenbank Parish Church]

"*I'd like to commend the inclusion of your work on sensory impairment...as a carer of my husband who has dementia, it is very relevant and good to see as a priority area*." [carer of person living with Dementia]

"*There are opportunities to address the health issues created by the built environment – would be interested in working together to develop greenspace project work with health outcomes built in*." [Council staff member]

"*Helpful to have the partnership's strategic direction in one document, and we would like more carer themed discussions in the future.*" [East Renfrewshire Carers Centre Board Annual General Meeting]

"*We are keen to get involved in improving health and wellbeing in our community, the data is very interesting and helps us better understand the challenges and opportunities*." [local resident, volunteer at Greenbank Parish Church]

"*This has helped me think about our locality areas where there may be different needs, and the services that we provide. We will look at raising awareness in areas where we haven't had the anticipated uptake and look at why people may not be engaging*." [Third sector service provider]

"*These discussions have helped us to plan and engage with our communities to improve health and wellbeing."* [Muslim Care]

"*We have started our own parents peer support group on children with additional support needs and found this to be extremely helpful for us in sharing information and accessing support...there is so much value of people who have experienced the same issues sharing their expert knowledge*." [carers group]

Actions and changes to the plan following consultation

Following our conversation with carers we have updated our strategic plan to include an outline of our partnership aspirations on supporting people living with Dementia and their carers. We linked an interested carer with a newly established Dementia Strategy Group to help design local opportunities on shaping Dementia services.

In our discussions about employment which included the Carers Centre, we discussed the benefits of volunteering as a gateway into meaningful employment through confidence building, and the range of supports Voluntary Action and the Carers Centre can provide. We will strengthen our links with pathways to employment

We were asked to include more information about housing. The plan has subsequently been updated to include additional housing services references including a new section on housing needs in the joint strategic needs assessment.

Other messages included identifying with the potential negative impacts of resource cuts including potential closures of care facilities, which is a concern shared with most public sector organisations across Scotland.

Future Engagement

In-line with our commitment to engage in ways that people say they would most engage with, we asked people to let us know how they would prefer to participate in future consultation and engagement opportunities, responses included (in order of most popular):

- Online surveys
- Focus groups with mixed groups of participants
- Information sessions with Q&A opportunities
- On-going working groups
- Focus groups you are already involved with

We will use this feedback to plan for future engagement opportunities and look at ways we can explore and reflect conversations with all stakeholders as we continue our work over 2015-16.

An info-graphic format has been used for our needs assessment information in order to use it as a resource for engaging in meaningful local conversations. The overall feedback to date has been that this approach makes the data accessible and interesting to engage with. This has been part of our journey to meaningfully engage with partners by telling a story about East Renfrewshire that is both interesting and meaningful to them.

Strategic Priorities

Our strategic priorities are taken from the national health and wellbeing outcomes and those for children and young people. These outcomes have been added in italics to show the links more clearly.

People are able to look after and improve their own health and wellbeing and live in good health for longer.

Health and social care services contribute to reducing health inequalities.

Improving Health and Wellbeing through Prevention

We will work with people and our wider communities to ensure that people are more motivated to manage their health and wellbeing, access appropriate services and are supported to overcome barriers to improve their health.

A key part of our work is to ensure communities are able to build on their own assets and have the capacity to engage and co-produce actions to reduce health inequalities and improve health and wellbeing across all of life's stages. For example, we will work in partnership to support healthy parenting and healthy babies through activities such as breastfeeding peer support, *childsmile, and play, talk and read*.

Reducing Health Inequalities

Health inequalities are differences in health between individuals or groups because of differences in their circumstances or characteristics. We understand the importance of understanding these differences so we can improve health and wellbeing for those with the poorest outcomes. In addition to undertaking an Equalities Impact Assessment of our Strategic Plan, we will continue to take into consideration how our plans may impact upon different groups within our communities.

We are committed to fully accessible and equitable services, ensuring that any disadvantage experienced is mitigated through targeted support. We will increase understanding of equalities issues among staff across our partnership through training and other opportunities.

Our children have the best start in life and are ready to succeed;

We have improved the life chances for children, young people and families at risk

Increasing Wellbeing of Children and Young People

Our Integrated Children and Young Peoples Services Plan outlines our vision for children, young people, and families: "*We will work together to get it right for all East Renfrewshire's children and young people*." Our plan focuses exclusively on partnership work to improve outcomes beyond traditional departmental and agency boundaries, and has been informed by what children, young people and families have told us about their needs and experiences.

We have adopted the Getting it right for every child *'Safe, Healthy, Active, Nurtured, Achieving, Respected/Responsible, Included'* wellbeing framework to measure progress in achieving outcomes for children and young people.

Our *Early Years Strategy* focuses on the youngest members of our population and their families in order to address these inequalities at the earliest stage of life. Our focus is on developing positive ways of engaging with communities, families and individuals that build on their strengths.

Some examples include our current two year pilot of 'Family First' workers who support vulnerable families to thrive independently of services. We have also trained staff in a preventative evidence-based programme called 'Enjoy your baby.'

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.

Supporting People with Long-Term Conditions

We will continue to develop our strategy for supporting people with a long-term condition in managing their condition. In promoting self-management we will encourage people to access information and peer support opportunities in their community, so that they can live fuller lives whilst dealing with the reality of living with a long-term condition.

Our partnership has a range of approaches to support people with long-term conditions to remain in their own homes for as long as is possible. This includes *Advanced Nurse Practitioners*, who help people manage their conditions and plan ahead for changes, preventing unnecessary admissions to hospital. We will develop

their role to provide expert clinical leadership to our district nursing teams linking closely with local GPs.

We are working closely with Housing services particularly around aids and adaptations. This has an important role in supporting people with long-term conditions and disabilities in their own homes.

We will promote the use of technology as an appropriate and complementary support to the management of long-term conditions. We are a committed partner in the innovative European SmartCare and UnitedForHealth *telecare and telehealth* programmes and have attracted more funding for technology enabled care over the next three years.

We will support our staff to be aware of *sensory impairment* and develop the ability to support simple solutions for everyday problems. We will review how we currently provide sensory impairment services and will work with partners to ensure all children and adults with sensory impairment have access to outcomes focused assessment, care and support.

Staying at Home

Our aim is to help people to continue to live independent lives and live in their own homes for as long as is possible enabled by the most appropriate supports. We will ensure that our work on future housing needs contributes to the Local Development Plan and Housing Strategy.

We are redesigning our home care service to make sure that our skilled staff are available at the time people need them. We will continue to develop our home care reablement service to support people to get back their independence after illness or a stay in hospital.

We have put in place a range of supports to ensure that people can return to their home promptly following periods in hospital. In partnership with the independent sector we will develop and test ways of providing intermediate care (short term extra support). Voluntary Action is leading an exciting *Better by Design* project to explore and test how local communities and volunteers can play a greater role in supporting people back home.

Many local people have unplanned admissions to hospital as a result of an accident or sudden deterioration in their health. Some people have high levels of readmission and repeated unplanned admissions to hospital. Over the next year we will work to understand more about these people and their health and care experiences, so that we can support them better. As well as looking at local services we will be working with other areas in Greater Glasgow and Clyde and colleagues in Acute services to develop our plans for hospital care, building on the Clinical Services Review and Clinical Services Strategy.

Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services

Quality of Life

At any stage in adult life people can find that they need advice or support. We know that quite often these needs emerge unexpectedly. Our *Rehabilitation and Enablement* Service has social work, nursing, occupational therapy and rehabilitation staff based in teams working alongside groups of GP practices, providing a more integrated service for service users. Our aim is to get the right professional - or group of professionals - involved as early as possible with people who need support. We will review how well this service is working and make further improvements based on feedback.

Our Mental Health services include a range of early-intervention and preventative approaches as well specialist support services. One of our key areas of development is in reducing the stigma and 'taboo' that can exist around mental health, and normalising the fact that many people will experience mild to moderate mental health difficulties in their lives. We will redesign community-based adult mental health towards a recovery and wellbeing oriented system of care, working with people who use our services and those who care for them.

We have a comprehensive range of integrated services designed to meet the specific needs of people with alcohol and drug problems, including children and young people, their families and carers. Our new service which has a greater focus on recovery and prevention was developed by people who use the service and staff. We will continue to look at ways we can improve our service, building on our work to date.

Our Dementia services provide person centred support for persons with Dementia and their carers. The numbers of people with dementia will increase in the coming years as our population ages. We will build a cross-sector alliance to take forward the recommendations from the National Dementia Strategy, working in partnership with people with Dementia and their carers to design effective local opportunities.

Good Lives

Recently we have been working with young people with a learning disability, supporting them and their families to think about what will be a good life when they leave school. From this work we have seen that we need to increase opportunities for people with a learning disability through developing social enterprises, training and leisure options. We also need to change the way we provide support to people with a learning disability so that they can live the lives they choose. This will include having more health specialist staff as part of our local learning disability team.

We are working with our communities to support people to develop local activities such as reminiscence groups, special interest activity groups, walking groups and inter-generational projects[2] in our schools. We will continue to raise awareness of the benefits of volunteering across East Renfrewshire. We will build on our positive experiences in building the capacity in local communities, as tested through our *Reshaping Care for Older People* programme**.**

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

Positive Experiences

We will continue to focus on the personal outcomes that matter most to people and support them to find ways of meeting those outcomes. As part of our *Self-Directed Support* approach we are extending choice and control for people who require support. In partnership with the third and independent sector, a new initiative *My Life, My Way* will explore the role of Self Directed Support for people traditionally assessed as requiring residential care.

Dignity at the End of Life

We will ensure that people have care and support options at the end of their life. Whether in a care home or in their own home we will work together across primary care, nursing and social care services to support each person and their family in the way they prefer.

People using health and social care services are safe from harm.

Community safety and public protection; The reduction of re-offending; and

Social inclusion to support desistance from offending

Safe from Harm

Our services should support people to feel safe and secure in all aspects of life, to enjoy safety but not to be over-protected. Whilst making sure vulnerable people are free from exploitation and abuse, we will support people to take control of their own lives, including their own decisions on risk. We will do this by helping the person think about what could go wrong and how we can work together to manage this.

[2] http://generationsworkingtogether.org/news/old-and-young-teaming-up-for-a-battle-of-wits-19-12-2014

The aim of Criminal Justice social work services is to improve community safety and public protection. Changes at a national level mean responsibilities for local strategic planning and delivery of Criminal Justice services will be coming to Community Planning Partnerships. Work will progress over 2015 to support the first community justice plan.

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.

Supporting Unpaid Carers

Our aim is that carers in East Renfrewshire are valued, recognised and supported as partners in care. We will review our progress on our Carers Strategy in the light of the new Carers legislation. We want to make sure we provide carers with the time and space to reflect on their life and what personal outcomes are most important to them. Through working together with carers we will build on their skills and coping strategies and support them to identify what further support they might need to meet their personal outcomes. We will continue to raise awareness amongst HSP and general practice staff on the impact of the caring role and how we can do more together to support improved health and wellbeing.

We are developing our plans to introduce a Trusted Assessor model to support the carers assessment process. As part of this work we will be looking at enlisting the support of carers, supporting them through training, to fully support their role within the planning work with individuals. The partnership is also looking at developing through our carers information monies a range of approaches to support both young and adult carers by supporting specific initiatives that carers are leading upon locally.

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

Supporting our Workforce

We will be reviewing past experiences and asking staff for feedback to develop further opportunities to engage, equip and inspire our workforce. Workforce development will focus on the whole health and social care workforce exploring cross-sector opportunities for learning and development.

'Life of a carer,' a locally designed drama commissioned by East Renfrewshire Carers' Centre, which explored the impact of life as a carer is an example of a different shared approach to learning. Staff shared ideas on themes for the theatre company to cover, and the actors met with local carers to hear about their experiences and reflected these back to our workforce in short vignettes, making the stories very powerful. We aspire to explore more tailored opportunities over the coming years.

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

Using our resources effectively

We have worked hard to make sure that we have efficient and effective local services. In facing rising demands with reducing public resources it is vital that we use our money wisely on the agreed shared priorities. We believe that there is still more we can improve on by working together.

In East Renfrewshire we recognise our greatest strength is our people, who we view as assets. An asset can be described as something that is useful or has value, and we design our supports round focusing on the strengths of the individual first and foremost. We consider the individuals family or carer as assets too, and importantly we all live in communities, which are one of our biggest assets.

Taking all of these into consideration, there are many things we can work on together to help improve people's lives. For many people, this is a big change in thinking, and we're working to help change our culture to recognise and maximise the use of our assets to achieve improved outcomes for individuals, families and communities.

Implementation Plan

Many of our actions to improve health and wellbeing for 2015-16 flow from our commitments to East Renfrewshire's Outcome Delivery Plan and NHCGGC Local Delivery. These are in their final year of completion having been areas of development for the Community Health and Care Partnership in previous years. These will be reported for 2015-16 in Organisational Performance Report

We will work with partners to identify new areas of development for 2016-17 and beyond in line with integration planning principles. These will be set out in an annual implementation plan.

Performance Reporting

In order to record progress against the new Health and Wellbeing Outcomes, the Scottish Government has developed a core suite of integration indicators for partnerships to report on. The Integration Joint Board will publish an annual performance report which will set out progress towards the National Health and Wellbeing Outcomes. The report will include information about the core suite of indicators, supported by local measures and contextualising data to provide a broader picture of local performance.

A list of these indicators and measures is being collated along with information on the data gathering and reporting requirements for performance targets and improvement measures in a Performance Directory.

The first set of national indicators are based on survey feedback from existing surveys, to reflect the importance of personal outcomes and user feedback.

1. Percentage of adults able to look after their health very well or quite well.
2. Percentage of adults supported at home who agree that they are supported to live as independently as possible.
3. Percentage of adults supported at home who agree that they had a say in how their help, care or support was provided.
4. Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated.
5. Percentage of adults receiving any care or support who rate it as excellent or good
6. Percentage of people with positive experience of care at their GP practice.
7. Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.
8. Percentage of carers who feel supported to continue in their caring role.
9. Percentage of adults supported at home who agree they felt safe.
10. Percentage of staff who say they would recommend their workplace as a good place to work.*

The second set of indicators are derived from organisational/system data most of which are already collected for other reasons.

11. Premature mortality rate.
12. Rate of emergency admissions for adults.*
13. Rate of emergency bed days for adults.*
14. Readmissions to hospital within 28 days of discharge.*
15. Proportion of last 6 months of life spent at home or in community setting.
16. Falls rate per 1,000 population in over 65s.*
17. Proportion of care services graded ‘good’ (4) or better in Care Inspectorate Inspections.
18. Percentage of adults with intensive needs receiving care at home.
19. Number of days people spend in hospital when they are ready to be discharged.
20. Percentage of total health and care spend on hospital stays where the patient was admitted in an emergency.

21. Percentage of people admitted from home to hospital during the year, who are discharged to a care home.*
22. Percentage of people who are discharged from hospital within 72 hours of being ready.*
23. Expenditure on end of life care.*

*The Scottish Government has highlighted these indicators are under development.

More information on these indicators is available at: http://www.gov.scot/Resource/0047/00473516.pdf

Governance

Strategic Planning Group

Each Health and Social Care Partnership is required to have a Strategic Planning Group and our Strategic Planning Group has been established since December 2014. To date the group has focused on developing and consulting on the Strategic Plan and considering the approach to Locality Planning. Moving forward it will:

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- Oversee the development of the Strategic Plan through a focus on each of the strategic priorities;
- Support the development of locality planning and engagement ; and
- Ensure alignment between the Strategic Plan and the plans of each of six health and social care partnerships within the Greater Glasgow area.

Membership of the Strategic Planning Group is in line with the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014. A complete list of the Strategic Planning Group membership is included in Appendix 6.

Health and Care Governance Group

The CHCP had a Care Governance sub-committee that was one of the examples of good practice reviewed in developing national guidance for integration on health and care governance requires. The role of the Clinical and Care Governance Group will be to consider matters relating to Strategic Plan development, governance, risk management, service user feedback and complaints, standards, education, learning, continuous improvement and inspection. It will:

- Provide assurance to the IJB, the Council and NHS, via the Chief Officer, that the Professional standards of staff working in Integrated Services are maintained and that appropriate professional leadership is in place.
- Review significant and adverse events and ensure learning is applied.
- Support staff in continuously improving the quality and safety of care.
- Ensure that service user/patient views on their health and care experiences are actively sought and listened to by services.

The membership of the group will include the Clinical Director; the Professional Nurse Advisor the Lead from the Allied Health Professions; Chief Social Work Officer; service user and carer representatives; Third Sector and Independent Sector representatives and senior management of the HSCP.

Performance and Audit

The Integration Joint Board will establish a Performance and Audit Committee. It is envisaged that the key functions of this Committee will be:

- To ensure effective performance management systems are in place to evidence delivery of the organisation's key objectives, including the Strategic Plan.
- To act as a focus for best value and service improvement.
- To establish and review information governance & risk management arrangements,
- To review the annual work programme of internal and external audit.
- To ensure appropriate action is taken in response to audit findings.

Future Planning

Our Strategic Plan will continue to be a living, dynamic plan. The information we have used to help plan ahead will evolve over time, and so too will the contents of the plan. It will be in place for three years and be reviewed each year.

Over 2015-16 we will work in partnership to develop our priorities and ensure that our resources best meet the needs of our locality areas. We will do this in a flexible way, involving local people, professionals and service providers.