AGENDA ITEM No. 9

Meeting of East Renfrewshire Health and Social Care Partnership	Integration Joint Board
Held on	28 June 2023
Agenda Item	9
Title	Annual Performance Report 2022/23

Summary

This report provides members of the Integration Joint Board with the Annual Performance Report for the Health and Social Care Partnership for 2022-23. This is our seventh Annual Performance Report and outlines performance in relation to the delivery of our Strategic Plan 2022-25. The Annual Performance Report is a high level, public facing report. It summarises the performance of the HSCP with specific focus on the delivery of services and supports as we recover from the Covid-19 pandemic.

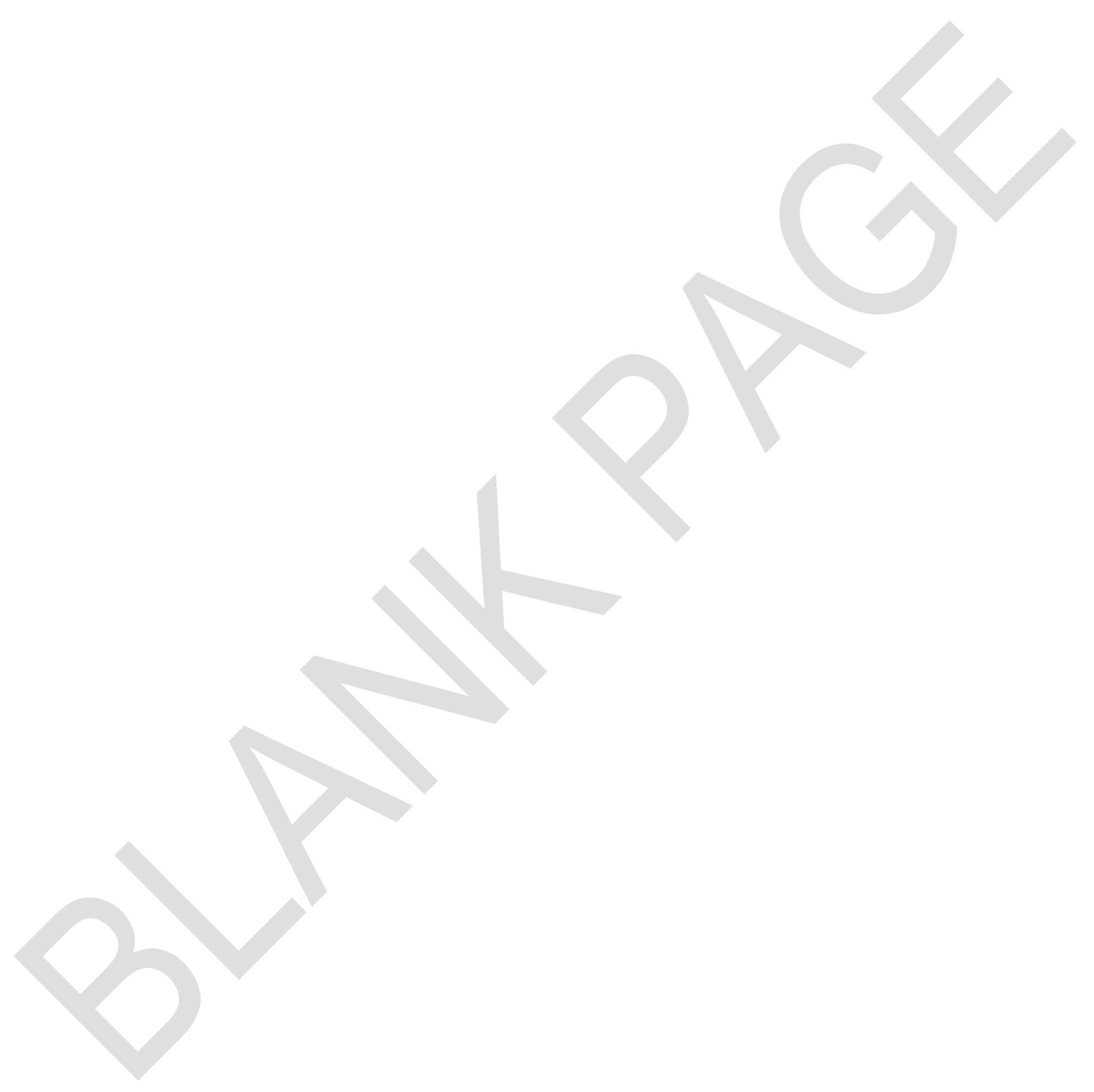
Presented by	Steven Reid Policy, Planning and Performance Manager

Action Required

The Integration Joint Board is asked to:

- Approve the report and its submission to the Scottish Government by the revised deadline of 31 July 2023.
- Agree that the Policy, Planning and Performance Team will work with the Communications Team to consider a range of media to engage with the public, illustrate performance and publish the Performance Report on our website and through social media.

Directions	**Implications**	
☒ No Directions Required	☒ Finance	☐ Risk
☐ Directions to East Renfrewshire Council (ERC)	☐ Policy	☒ Legal
☐ Directions to NHS Greater Glasgow and Clyde (NHSGGC)	☒ Workforce	☐ Infrastructure
☐ Directions to both ERC and NHSGGC	☒ Equalities	☐ Fairer Scotland Duty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EAST RENFREWSHIRE INTEGRATION JOINT BOARD

28 JUNE 2023

Report by Chief Officer

ANNUAL PERFORMANCE REPORT 2022/23

PURPOSE OF REPORT

1. This report advises the members of the Annual Performance Report for the Health and Social Care Partnership for 2022-23.

RECOMMENDATIONS

2. The Integration Joint Board is asked to:
    - Approve the report and its submission to the Scottish Government by the revised deadline of 31 July 2023.
    - Agree that the Policy, Planning and Performance Team will work with the Communications Team to consider a range of media to engage with the public, illustrate performance and publish the Performance Report on our website and through social media.

BACKGROUND

3. 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. The 2014 Act requires publication of the report within 4 months of the end of the financial year being reported on, therefore by 31 July each year.

4. During the Covid-19 pandemic the Coronavirus (Scotland) Act 2020 was enacted, which allowed for an extension for the publication of Annual Performance Reports through to November each year. This provision is no longer applicable and we are returning to the July publication deadline for the first time since 2019.

5. The Public Bodies (Joint Working) (Scotland) 2014 Act requires that publication of the report should include making the report available online, and should ensure that the Report is as accessible as possible to the public. Guidance suggests that partnerships may wish to consider a range of media to engage with the public, illustrate performance and disseminate the Performance Report. The Integration Joint Board must also provide a copy of this report to each constituent authority (NHS Greater Glasgow & Clyde and East Renfrewshire Council).

6. 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 Scottish Government has issued guidance for the preparation of performance reports:
    - 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.

7. Subject to approval of the report by the Integration Joint Board, the report will be published on our website by 31 July and promoted through appropriate media channels.

REPORT

8. The Annual Performance Report sets out how we delivered on our vision and commitments over 2022-23 recognising the continuing challenges in the aftermath of the Covid-19 pandemic, its impact of our ways of working and potential disruption to performance trends. This is our seventh Annual Performance Report. We review our performance against agreed local and national performance indicators and against the commitments set out in our Strategic Plan for 2022-23. 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.

9. 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 and meet the challenges of the pandemic over the past 12 months; our financial performance; and detailed performance information illustrating data trends against key performance indicators.

10. The report meets the requirements of the national statutory guidance and is a static 'backward looking' review of activities and performance during the previous financial year. We continue work with the Performance and Audit Committee to look at our in-year reporting to ensure we are looking at forward actions to improve performance as well as a retrospective.

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

12. 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. The respondents have not necessarily used HSCP services. The survey was last carried out in 2021. The HSCP collects local data relating to 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 HSCP.

13. 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. The updated indicators may not represent the full end year position as some of the data completion rates are not yet 100% but will be the most up-to-date data available at the statutory deadline. We have identified 'provisional' figures in the report.

14. The remaining performance information in the report relates to the key local indicators and targets developed to monitor progress against our Strategic Plan 2022-23. 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.

15. In addition to activity and performance in relation to the nine strategic priorities the report includes sections on our hosted Specialist Learning Disability Service.

Recovery from the pandemic

16. During 2022-23 the partnership has experience significant challenges from increased demand pressures and higher levels of complexity often relating to the continuing impacts from the pandemic. Throughout the period, we have continued to maintain and deliver safe and effective services to our residents. During the year, the HSCP and our partner organisations experienced increased staff absence with resulting pressures within the health and social care system. This year we have also seen continuing recruitment and retention challenges in the sector impacting on our performance.

17. The data shows that despite the continuing pressures, there has been strong performance across service areas. Throughout the period we have seen excellent collaboration across the HSCP and with our independent, third and community sector partners. And we are seeing positive signs of recovery across many of our performance indicators as discussed below.

18. Headline performance information by service area are given below.

Supporting children and families

- % starting CAMHS treatment within 18 weeks – 86% (year average) up significantly from 55% in 21/22. Average longest wait (monthly) was 24 weeks down from 41 weeks in the previous year.
- Care experienced children – excellent performance on permanence – No children in East Renfrewshire with 3 or more placements
- 91% of care experienced children supported in community rather than a residential setting (21/22 figure) – a high rate but has reduced due to the impact of the pandemic
- 82% care experienced children waiting no longer than 6 months for a review – down from 94% in previous year
- Child protection - 100% of child protection cases with increased safety (up from 84% in 21/22)
- Slightly reduction in % of children subject to child protection offered advocacy – 61% (62% in 21/22)

Supporting people to maintain their independence at home

- 64.4% of people aged 65+ with intensive care needs (plus 10 hours) receiving care at home (up from 62% in previous year).
- 65% of adults (18+) receiving personal care at home or direct payments for personal care, as a percentage of the total number of adults needing care.
- 80.4% of adults supported at home who agreed that they are supported to live as independently as possible
- 89% reporting 'living where you/as you want to live'

- 48% of people with reduced care need following re-ablement / rehabilitation (down from 60% for 21/22 but up from 31% for 20/21)

Supporting mental health and wellbeing and supporting recovery from addiction
- Mental health hospital admissions remain low (at 1.4 admissions per 1,000 population)
- 75% waiting no longer than 18 weeks for access to psychological therapies (av. 2021-22)
- 96% accessing recovery-focused treatment for drug/alcohol within 3 weeks – up from 95% in 21/22 and 69% in 20/21
- 5% of people moving from treatment to recovery services in the year – down from 9% in 21/22
- 173 alcohol brief interventions undertaken in 22/23 – up from 0 last year, reflecting increased resourcing for this activity.

Meeting healthcare needs and reducing unplanned hospital care
- Discharge without delay – averaged 8 delays for 22/23 – up from 7 for 21/22 (and 3 for 20/21)
- Adult bed days lost to delayed discharge – 4,652 for 22/23 (up slightly from 4,546 for 21/22 but significantly higher than 2,342 in 20/21)
- Adult A&E attendances – 17,355 - up from 16,877 in 21/22 but ahead of target
- Adult Emergency admissions – 6,564 - down from 6,772 in 21/22 and ahead of target
- Emergency admission rate (per 100,000 pop) – 9,036 down from 9,414 for 21/22
- Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges) – 67, down from 77 in 21/22 (and 98 in 20/21)

Supporting unpaid carers
- 80% of those asked reported that their 'quality of life ' needs were being met – down from 92% in 21/22
- % carers who feel supported to continue in their caring role – 28.4% (21/22) down from 35.3% (19/20)

Supporting people through criminal justice pathways
- 86% Community Payback Orders (CPOs) commencing within 7 days – significantly up from 58% in 21/22
- 83% of unpaid work placement completions within Court timescale – up from 81%
- Positive employability and volunteering outcomes for people with convictions – 64% up from 56% in 21/22
- 100% of people reported that their order had helped address their offending

Tackling health inequalities and improving life chances
- Our premature mortality rate remains significantly below the national average at 334 per 100,000 (Scotland 457)
- 17.9% of infants in our most deprived areas (SIMD 1) were exclusively breastfed at the 6-8 weeks – significantly up from 7.5% for the previous year (2020-21 figure)
- 92% of adults report they are able to look after their health very well or quite well (Scottish average is 91%)
- Male life expectancy at birth in our 15% most deprived communities is 74.7 compared to 72.1 for Scotland.
- Female life expectancy at birth in our 15% most deprived communities is 79.8 compared to 77.5 for Scotland.

Supporting staff resilience and wellbeing

- 85% of staff agreed that “My manager cares about my health and wellbeing” – down from 88% in previous iMatter staff survey
- 71% agreed that "I feel involved in decisions in relation to my job" – consistent with 72% in previous survey
- 74% agree that “I am given the time and resources to support my learning growth” – consistent with 75% in previous survey

Protecting people from harm

- Improvement in domestic abuse outcomes women – 90% increased by 3% from 21/22 - target met.
- Improvement in domestic abuse outcomes children – 82% decreased by 2% - target met.
- People agreed to be at risk of harm and requiring a protection plan have one in place – continues to be 100% of cases

19. Following any comments from either the Performance and Audit Committee or the Integration Joint Board in June 2023, we will use the remaining weeks until the publication date to enhance any content and make presentational changes.

CONSULTATION AND PARTNERSHIP WORKING

20. The Annual Performance Report reflects the work of the Health and Social Care Partnership throughout 2022-23. The East Renfrewshire HSCP Participation and Engagement Strategy 2020-23 sets the following objectives for the ways in which we work with our communities:
    - Our communities, our partners, our staff and those who receive support will be engaged with, involved and participate in ways that are meaningful to them.
    - We will deliver a strategy that supports and resources new ways of engagement, and embraces digital platforms.
    - We will deliver a strategy that has a focus on prevention, choice and stronger communities and people will be enabled to share their views.
    - We will have a coordinated approach to community engagement and participation.

21. There are multiple examples of these commitments in action throughout the report.

22. The Participation and Engagement Strategy is being delivered and developed through our local multi-agency Participation and Engagement Network. Partners in the network have been engaged with in the drafting of the Annual Performance Report.

IMPLICATIONS OF THE PROPOSALS

Finance

23. The Annual Performance Report incorporates relevant financial end of year performance information in Chapter 3. A separate Annual Accounts Report has also been produced and will be presented at the IJB in June.

Workforce

24. One of the strategic priorities in the HSCP Strategic Plan 2022-25 is "Working together with staff across the partnership to support resilience and wellbeing". There is a section in the report outlining how we are delivering on this priority.

Legal

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

Equalities and Fairer Scotland Duty

26. 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.
27. There are examples of this throughout the report.

28. There are no policy, infrastructure or risk implications.

DIRECTIONS

29. There are no directions arising as a result of this report.

CONCLUSIONS

30. The Annual Performance Report is the seventh 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, recognising the significant pressures being faced by HSCPs across Scotland.

31. The report demonstrates the exceptional work undertaken by the partnership as we recover from the pandemic and the continued progress in the delivery of our priority outcomes. It shows that despite the continuing challenges we are facing in terms of demand pressures and increased levels of complexity, we have continued to support our most vulnerable residents and have performed well against many of our outcome-focused performance indicators. Through our recovery and renewal planning and the continuing delivery of our Strategic Plan for 2022-25 we will ensure that our priorities and approaches meet the changing needs of our population.

RECOMMENDATION

32. The Integration Joint Board is asked to:
    - Approve the report and its submission to the Scottish Government by the revised deadline of 31 July 2023.
    - Agree that the Policy, Planning and Performance Team will work with the Communications Team to consider a range of media to engage with the public, illustrate performance and publish the Performance Report on our website and through social media.

REPORT AUTHOR AND PERSON TO CONTACT

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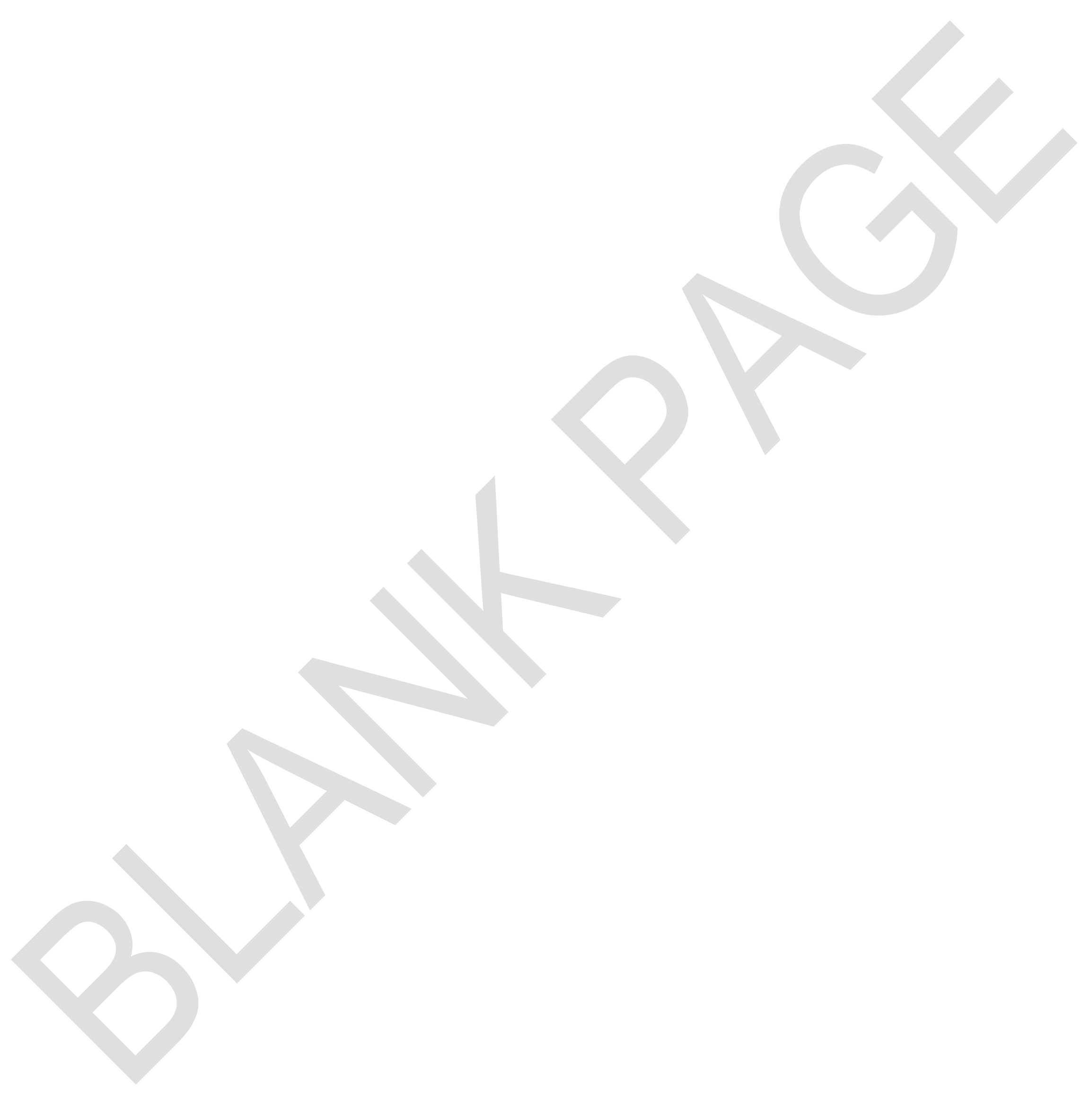
June 2023
Chief Officer, IJB: Julie Murray

BACKGROUND PAPERS

East Renfrewshire HSCP Annual Performance Report 2019/20

East Renfrewshire HSCP Annual Performance Report 2020/21

East Renfrewshire HSCP Annual Performance Report 2021/22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Working Together for East Renfrewshire

East Renfrewshire Health and Social Care Partnership (HSCP) Annual Performance Report 2022-23

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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 seventh report for the East Renfrewshire Integration Joint Board. It sets out how we delivered on our vision and commitments over 2022-23. As required, we review our performance against agreed local and national performance indicators and against the commitments set out in our 2022-25 Strategic Plan.

The HSCP provides care, support and protection for people of all ages, to enhance their wellbeing and improve outcomes for them as children, young people, families and adults. Over the course of 2022-23, our teams in collaboration with our partners and communities have continued to deliver this work in despite significant pressures. This has involved responding to higher demands for support, supporting individuals with higher levels of emotional distress, complex needs and limited informal support networks. Our teams have responded compassionately, creatively and with an unwavering commitment to improve outcomes for the individuals and families we support.

This report looks at our performance during another challenging 12 month period where we continue to see impacts for health and social care provision following the Covid-19 pandemic. The main elements of the report set out:

- the established 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 and additional activity to meet the challenges of the pandemic;
- our financial performance; and,
- detailed performance information illustrating data trends against key performance indicators.

The performance data shows that despite the continuing pressures of the pandemic there has been strong performance across service areas. We have continued to support our most vulnerable residents and have performed well against many of our outcome-focused performance indicators. Throughout the period we have seen excellent collaboration across the HSCP and with our independent, third and community sector partners. And we are seeing positive signs of recovery across many of our performance indicators as discussed below.

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 continues to grow and reached 96,580 in 2021. 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 ageing population. By 2043, almost one quarter of East Renfrewshire is projected to be aged 65 or over (23.8%). There has been a 26% increase

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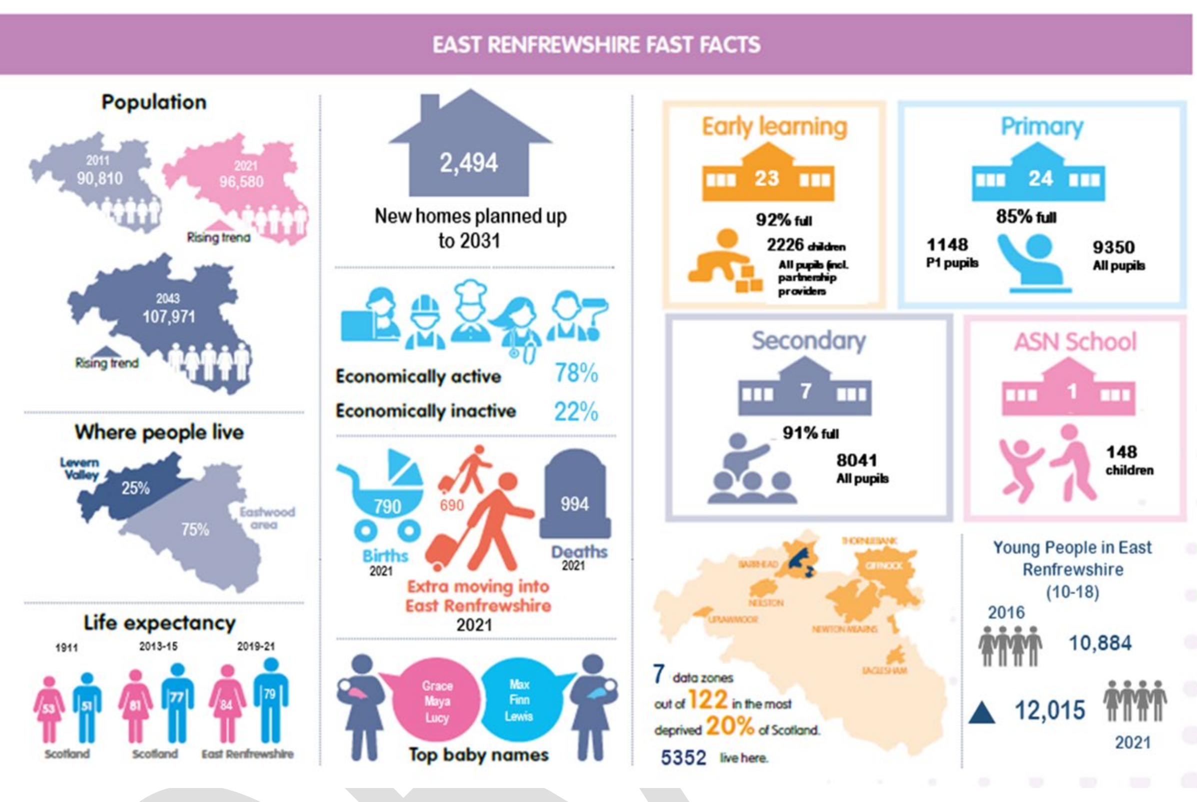
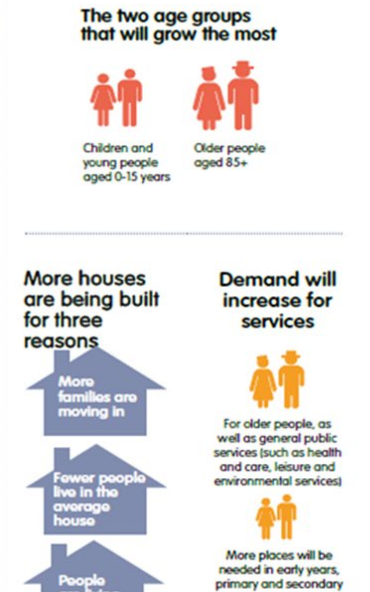
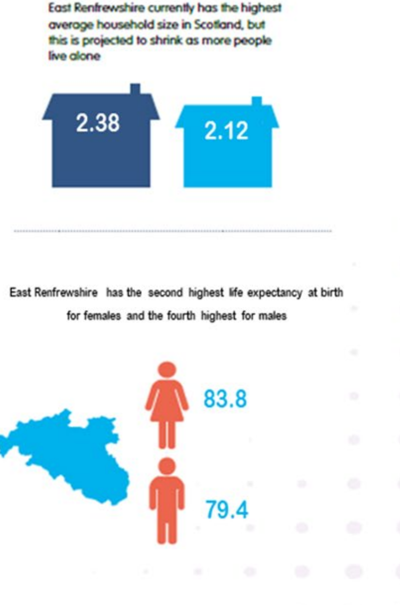
in the number of residents aged 85 years and over during the last decade. People over 80 are the greatest users of hospital and community health and social care services.

Overall, East Renfrewshire is one of the least deprived local authority areas in Scotland. However, this masks the notable differences that we see across the area with some neighbourhoods experiencing significant disadvantage. All of East Renfrewshire's neighbourhoods that are among the 20% most deprived are concentrated in the Barrhead locality with a quarter of the population living in these data zones.







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 17 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.

The integrated management team directly manages over 900 health and care staff, this includes 52 social workers who are trained and appointed as council officers. ER HSCP has long established relationships with third and independent sectors to achieve our strategic aims around early intervention and prevention. In addition, the HSCP hosts the Specialist Learning Disability Inpatient Services, Autism Service on behalf of the six HSCPs in NHSGGC and the Scottish Centre of Technology for the Communication Impaired (SCTCI) which provides specialist support for Alternative and Augmentative Communication to 12 Scottish Health Boards. The services within East Renfrewshire are community based with the exception of the inpatient wards for people with learning disabilities. There are no acute hospital sites or prisons in East Renfrewshire

1.3 Our Strategic 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 HSCP builds on this secure foundation. Throughout our integration journey during the last 17 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.

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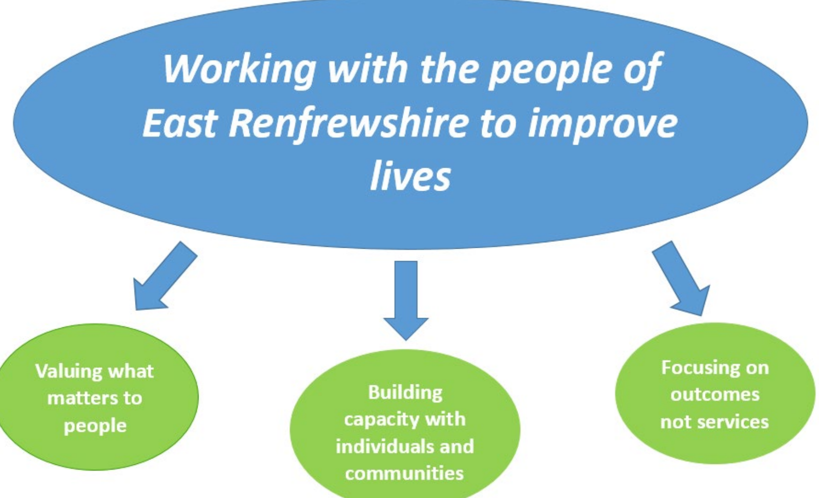
We developed integration touchstones to progress this vision. These touchstones, which are set out below, are used to guide everything we do as a partnership.

- *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.

Our second Strategic Plan covering 2018-21 recognised that the partnership must extend beyond traditional health and care services to a wide partnership with local people and carers, volunteers and community organisations, providers and community planning partners. The plan placed 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.

Recognising the challenges of undertaking planning activity at the height of the Covid-19 pandemic, and in line with the approach of other HSCPs in Scotland, it was agreed that we would establish a one-year 'bridging' plan for 2021-22 reflecting priorities during our continuing response and recovery from the pandemic.

Our third 'full' Strategic Plan covers 2022-25. The plan was developed in consultation with stakeholders and East Renfrewshire residents, despite the continuing challenges we faced from the pandemic. This included a highly participative engagement process coproduced with wider partners through our Participation and Engagement Network and a comprehensive strategic needs assessment.

The consultation found that people were supportive of our strategic priorities and the key areas of focus set out in the plan. Many people emphasised the crucial importance of partnership and collaborative working and there was a focus on ensuring the necessary support is in place for our staff and for local unpaid carers. Key changes we made to our strategic plan in light of the consultation included:

- Strengthening the emphasis in the plan on safety, preventing harm and addressing rising incidence of violence against women and girls following the pandemic.
- Reference to the practical supports available for digital solutions; and recognition to the role of peer support in recovery and supporting independence.
- More emphasis on how we are working to enhance mental health support through primary care; and local initiatives using the Community Mental Health and Wellbeing Fund.
- More recognition of the impact of the pandemic on unpaid carers and increased pressures for carers including increased caring requirement.
- In our existing discussion of health inequalities, greater reference to the wider impacts of poverty and focus on supporting people with protected characteristics.
- For our priority supporting staff wellbeing recognition our intention to be a 'listening' partnership; and outlining activities including wellbeing group, plan and appointment of wellbeing lead.

Our headline planning priorities build on those set out in our previous strategic plans. We extended our priority for mental health to include mental health and wellbeing across our communities. We changed the emphasis of our priorities relating to health inequalities and primary and community-based healthcare and we introduced a new strategic priority focusing on the crucial role of the workforce across the partnership. For the 2022-25 plan we also added a distinct priority focusing on protecting people from harm, reflecting the cross-cutting and multi-agency nature of this activity. For each priority we set out the contributing outcomes that we will work to, key activities for the next three years and accompanying performance measures. Our strategic priorities for 2022-25 are:

- Working together with **children, young people and their families** to improve mental and emotional wellbeing;
- Working together with people to maintain their **independence at home** and in their local community;
- Working together to support **mental health and wellbeing**;
- Working together to meet people's **healthcare needs** by providing support in the right way, by the right person at the right time;
- Working together with **people who care for someone** ensuring they are able to exercise choice and control in relation to their caring activities;
- Working together with our community planning partners on new **community justice pathways** that support people to stop offending and rebuild lives;
- Working together with individuals and communities to tackle **health inequalities** and improve life chances;
- Working together with **staff across the partnership** to support resilience and wellbeing; and,
- Protecting people from **harm**.

The plan illustrates how the HSCP will contribute to the priorities established in the East Renfrewshire Community Plan and Fairer East Ren. Under our strategic priorities we set out our key activities and critical indicators that link to the HSCP contribution to East Renfrewshire Council's Outcome Delivery Plan. The plan also links to relevant recovery/remobilisation planning at NHSGGC Board level, including the priorities set out in Moving Forward Together, and commitments reflected in the Five Year Strategy for Adult Mental Health Services, the Public Health Strategy: Turning the Tide through Prevention and the Joint Unscheduled Care Commissioning Plan. The plan fully recognises the implications from the Independent Review of Adult Social Care and planned National Care Service.

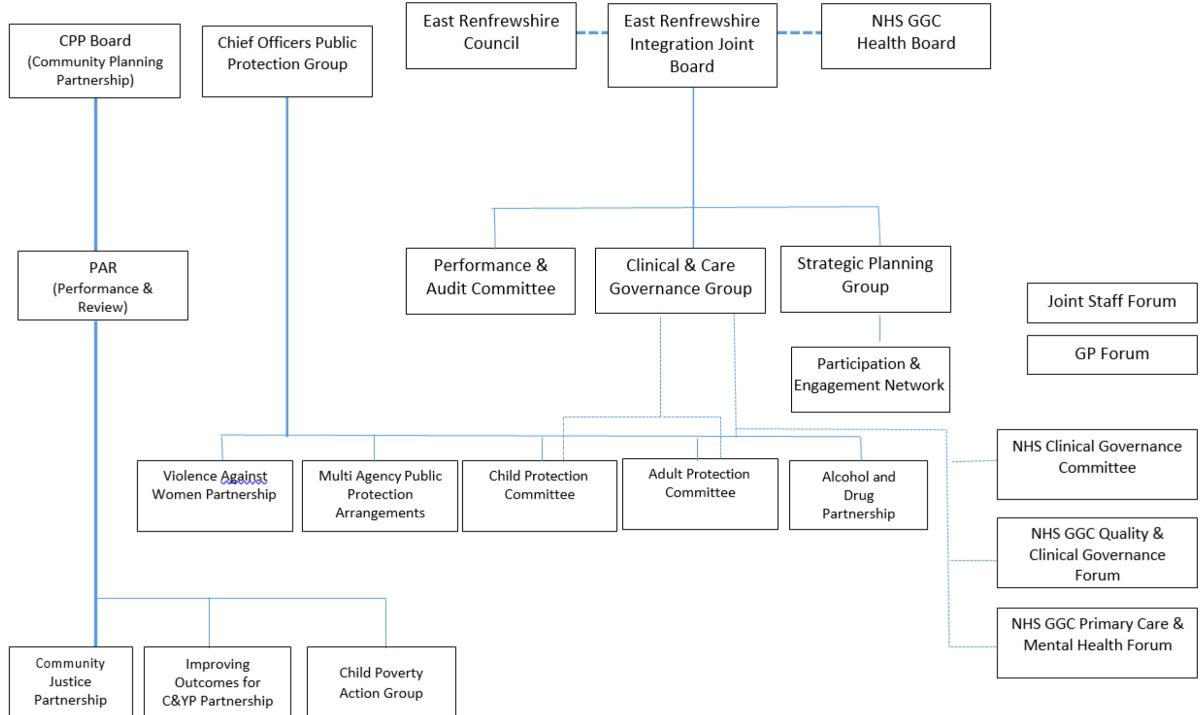
1.3.2 Locality planning in East Renfrewshire

Our previous 2018-21 Strategic Plan reduced our locality planning areas from three to two localities – one for Eastwood and another for Barrhead. This allowed us to coordinate our approach with our local GP clusters while also reflecting the natural communities in East Renfrewshire.

Our locality areas 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. Our management and service structure is designed around our localities. Our locality planning arrangements continue to develop and will be supported by planning and market facilitation posts and financial reporting at a locality level.

The IJB continues to deliver integrated health and care services within East Renfrewshire in our valued partnership working with community, the third, voluntary and independent sectors, facilitating the successful operation of the HSCP.

The chart below shows the governance, relationships and links with partners which form the IJB business environment.



1.3.3 Our integrated performance management framework

We have a commitment to integrated performance management. Our performance management framework is structured around our Strategic Plan, with all performance measures and key activities clearly demonstrating their contribution to each of our nine 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 Strategic Plan. Working with key stakeholders in our Strategic Planning Group, 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 Public Health 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 feedback from people who use services 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 people who use our integrated health and social care centres. We monitor feedback from residents through the recently established Care Opinion system. 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 local Mental Health Carers Group, where carers are able to raise issues about their needs and the support they receive. We continue to develop our approach to engagement through our multi-agency Participation and Engagement Network, strengthening our methods in drawing in residents' views to our evaluation processes.

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2 Delivering our key priorities

2.1 Introduction

This section looks at the progress we made over 2022-23 to deliver the key priorities set out in our Strategic Plan and how we are performing in relation to the National Health and Wellbeing Outcomes. 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 experience from local people engaging with our services. Our intention is to illustrate the wide range of activity taking place across the partnership during the pandemic.

A full performance assessment covering the period 2016-17 to 2022-23 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 aims and priorities during 2022-23

Improving the mental and emotional wellbeing of children and young people continues to be one of the highest priorities for East Renfrewshire HSCP. Our multi-agency approach to supporting the needs of children and young people in East Renfrewshire is set out in our Children and Young People's Services Plan 2020-2023. Together all partners in East Renfrewshire are building an approach to mental health support for children, young people and families that will ensure they receive the right care and interventions at the right time and in the right place.

Following the Covid-19 pandemic we have seen a significant rise in the number of children, young people and families experiencing challenges with their mental health and wellbeing. We aim to provide a holistic range of appropriate supports through our multi-stakeholder Healthier Minds Service which works alongside our Family Wellbeing Service and links to GP practices and the Child and Adolescent Mental Health Service (CAMHS).

An emerging area of increasing need is from children and young people with a neurodevelopmental diagnosis (including autism) or suspected diagnosis. In partnership with the Council and other partners we work to ensure service responses are effective and the workforce is sufficiently equipped to help children and their families in the right way. We continue to support our care experienced children and young people and are committed to fully implementing the findings of the national Independent Care Review report "The Promise".

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

- Protecting our most vulnerable children, young people and families
- Delivering on our corporate parenting responsibilities to our care experienced children and young people by fully implementing The Promise

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- Responding to the mental and emotional health and wellbeing needs of children and young people
- Ensuring children and young people with complex needs are supported to overcome barriers to inclusion at home and in their communities

2.2.2 The progress we made in 2022-23

During 2022-23 our children's services have continued to see increasing demand and increasing levels of complexity among referrals. We continue to work with an increasing number of children with diagnosed neurodevelopmental disorders and a high prevalence of families in crisis. CAMHS continues to experience high demand and a significant level of urgent referrals. However, we have been able to significantly reduce waiting times for children requiring support through the CAMHS service through the development of alternative (Tier 2) services: Healthier Minds and the Family Wellbeing service.

Headline performance data includes:

- % starting CAMHS treatment within 18 weeks – 86% (year average) up significantly from 55% in 21/22. Average longest wait (monthly) was 24 weeks down from 41 weeks in the previous year.
- Care experienced children – excellent performance on permanence – No children in East Renfrewshire with 3 or more placements
- 91% of care experienced children supported in community rather than a residential setting (21/22 figure) – a high rate but has reduced due to the impact of the pandemic
- 82% care experienced children waiting no longer than 6 months for a review – down from 94% in previous year
- Child protection - 100% of child protection cases with increased safety (up from 84% in 21/22)
- Slightly reduction in % of children subject to child protection offered advocacy – 61% (62% in 21/22)

2.2.3 The support we provided in 2022-23

East Renfrewshire HSCP and our partners recognise the extent of mental health concerns among the children's population, and in our multi-agency Children and Young Peoples Services Plan 2020-2023 we have agreed mental and emotional wellbeing as a key priority. The impact of the Covid-19 pandemic has exacerbated the circumstances of many children, young people and families, and we have seen a significant rise in the number of those experiencing challenges with their mental health and wellbeing and this also includes those who have a neurodevelopmental diagnosis.

Over the past few years we have been working to alleviate pressure on **CAMHS** by establishing appropriate (Tier 2) alternatives that work with young people and families to support recovery and minimise crisis. As a result of this, during 2022-23 we have seen significant alleviation of the pressures at the CAMHS 'front door' bringing down the proportion of people having to wait more than 18 weeks.

In August 2022, CAMHS achieved and has maintained performance ahead of the national **waiting time target** (90% of people starting treatment within 18 weeks). And from September to the end of the financial year the service has consistently achieved 97% and above.

In response to growing demand during the pandemic a multi-stakeholder **Healthier Minds Service** approach aligned to school communities was developed to identify and ensure delivery of mental wellbeing support to promote children and families' recovery.

Healthier Minds referrals continue to primarily come from schools and other agencies including GPs, CAMHS, Social Work, RAMH, Woman's Aid and Children 1st and more importantly includes self-referrals from young people. A total of 1006 children and young people have been referred to the screening hub (as at 18th April 2023), which meets weekly, resulting in children, young people and their families being supported timeously. An extensive calendar of sessions and training has been planned for the new school year. Training has also been created and developed to respond to the increased presentations of self-harm. The training has evaluated well and will be delivered throughout the authority. The Healthier Minds team continue to see positive outcomes for children, young people and their families.

Healthier Minds Hub

In recognition of the identified increase in mental health concerns for children and young people, the partnership invested in multi-agency mental health provision. The Healthier Minds Hub is East Renfrewshire's framework for supporting and nurturing the mental health and wellbeing of children, young people and families. It is also a resource for staff.

The hub has representatives from CAMHS, Social Work, RAMH Youth Counselling, Educational Psychology, Community Learning & Development and the Children 1st Family Wellbeing Service. Hub members meet weekly to consider referrals, the needs of the child or young person determine the route for provision of the optimal support.

A multi-agency recovery team known as the Healthier Minds team, was developed and aligned to school communities to identify and ensure delivery of mental wellbeing supports that promote children and families' recovery.

The three key elements of the service are: strategic mapping and support to maximise school community capacity to be trauma responsive, provision of direct services to children and families to build on strengths and improve social, emotional and mental wellbeing and strengthening of the existing school counselling model.

93% children and young people supported by the Healthier Minds Team report improved mental health and wellbeing. One young person described how the trusting relationship with the staff had supported them to overcome many challenges such as not attending school, difficult relationships at home and an eating disorder. The young person detailed how this support impacted positively on their wellbeing.

The Healthier Minds Service gathers data effectively to evaluate and improve its work. 1040 referrals were received between 25 November 2020 and 19 May 2023. The highest proportion 40% were referred on to RAMH Youth Counselling Service, 33% were referred to Healthier Minds Team, with others continuing support with existing services, supported by school or had sufficient supports in place. 63% of referrals were for females and 33% were for males. 166 re-referrals were received in this period.

The top three reasons for referral are anxiety, low mood and emotional regulation.

East Renfrewshire's **Family Wellbeing Service** supports children and young people who present with a range of significant mental and emotional wellbeing concerns. The services 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.

"I hadn't even thought about, those kind of concepts before in my life. So, those ones, they were interesting because I hadn't realised that all contributes to how you're coping as a family.'' –***Parent, Family First Family Wellbeing Scale***

"I liked opening up and talking in an environment that I felt safe in and that a I felt like I was actually being listened to" ***Healthier Minds Feedback***

We can't thank you enough, you have been such a support to us. He doesn't trust people easily, and said he felt so supported yesterday. **School Nursing Feedback**

Our **Intensive Family Support Team (IFST)** welcomed a health visitor as part of the team in November 2021 to provide an **Intensive Health Visiting Service**. Over the course of the past year the health visitor has worked with the families who need this support most. Families are able to have lots of time with the health visitor, to build relationships and get support which benefits their family's life now and in the future. Examples of this are:

- The health visitor supports carers and parents with practical tasks such as breast feeding, sleeping and weaning, as well as support to promote bonding and understanding baby's cues.
- Previously, universal health visiting support would have gone with the child to the kinship or foster home. We are now able to offer health visiting to mums and dads, who do not have care of their children and are working with us to get them home. This includes offering the service at the pre-birth stage, providing early and intensive support to the mums-to-be who need it most.
- Promotes good working relationships with other health services, such as infant mental health services.
- Helps the voice of the infant to be heard when decisions are being made.

Case Example

The health visitor worked alongside social workers from Intensive Family Support Team and the Community Team to support a family with two young children, who had been placed in foster care. The family had no extended family support in Scotland and mum often experienced poor mental health, so it was important to be able to build and maintain trusting relationships. The children were returned to their family's care, but unfortunately soon after mum experienced a significant mental health episode, which required her to stay in hospital for a prolonged period. The team worked together with dad to make sure he had what he needed to look after the children and keep them at home, where they wanted to be. Twelve months later, the family are all living together at home, compulsory measures of supervision have been removed and the family continue to work with the health visitor and social workers on a voluntary basis.

Supporting disabilities and complex cases

One third of families open to the Community Children's Services team require an assessment of their needs in relation to one or more children in the family unit who have a disability. As a direct consequence of the pandemic and the social isolation experienced by families caring for children with additional support needs we have seen an increased demand for services and a higher degree of complexity within these families.

Post pandemic, the needs of children with a disability appear to be more complex in nature due to a number of factors these have included difficulties accessing personal assistance support, increasing demands on a variety of support services in the community and more complex presentations. As a result of this, services have required to adapt and become more creative in how we can support families to use self-directed support to meet the child's needs.

The Community Children's Services team continues to work together with the multi-agency partners to signpost, and creatively support families through strength based person centred planning. Effective multi agency working is key to reducing and removing barriers to inclusion at home, school and in the community. This involves close collaboration between health, social care, education and third sector organisations within East Renfrewshire.

A multi-agency consultation group has been established to develop the creative use of self-directed support and to review what is working well for families. By assessing the needs and strengths of children and focusing on the views of the child, their parents and the people who know them best we continue to develop strategies and partner with commissioned services to support families to remain together and tailor personalised plans, which allows for flexibly and choice.

Our **Inclusive Support Service (ISS)** continues to provide three distinct services: holiday provisions, out of school activity clubs and individualised support services. Providing a range of targeted supports for children and young people aged 5-18 years. All of the children and young people who access the service have either complex health or behavioural support needs, with a significant number having limited verbal communication.

In East Renfrewshire **Youth Intensive Support Service (YISS)** is the lead service for all looked after young people aged 12 – 26 years, recognising that more intensive interventions are required to improve recovery from trauma, neglect and abuse. The service aims to successfully engage the most hard to reach young people in East Renfrewshire and has the following shared aims across social work and health services:

- To reduce the number of young people looked after and accommodated and at risk of hospitalisation and custody.
- To reduce the impact of historical trauma and abuse for young people.
- To ensure that the transition into adulthood achieves better long term outcomes.
- Maximise social capital.
- To keep whenever safe to do so a connection to their local communities.

Over 2022-23 we have continued the development of the **Signs of Safety** model, led by the Chief Social Work Officer and the Head of Education Services (Equality and Equity). The model supports practice improvement, with a particular focus on developing relational interventions with children, young people, their families and carers in order to reduce risk and improve children's wellbeing. It is the most effective framework to assess and manage risk for children and young people while supporting families. The approach recognises the need to define harm, outline danger and identify safety goals. Implementation of the Signs of Safety model is overseen by a multi-agency implementation group consisting of key partners. As a result, one assessment framework/paperwork is being used across a variety of statutory and non-statuary work including Child Protection assessments, disability/Section 23 assessments, Child in Need and SCRA assessments. The recent joint inspection undertaken by the Care Inspectorate (focusing on children at risk of harm) highlighted Signs of Safety whole system implementation as a good practice example.

During the year we have continued to work in partnership with children, young people, and families/carers to implement **The Promise**. We secured Corra Foundation investment which

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has allowed us to improve the process for Pathway Planning for Care Leavers from age 16-26 years. The enhanced pathway process will ensure that outcomes are improved for young people in transition. In addition a further successful application to Corra has enabled us to undertake a co-production project on local housing provision for vulnerable young people. Procedures are now embedded in Children and Family Services to ensure and enable sibling contact where it is in the best interests of the child, as in line with legislation and national policy.

We continue our work to implement the new **Scottish Child Interview Model (SCIM)**, alongside key partner agencies, ensuring trauma-informed support children who have experienced abuse. Since January 2022, all children and young people referred to the Child Interview Team have had their interview conducted under the Scottish Child Interview Model. To ensure service needs are met, the Recovery Support Team increased their workforce with an additional two posts in October and November 2022.

North Strathclyde Child Interview Team

East Renfrewshire are part of a partnership, which went live with joint investigating interviews (JII) on the 10th August 2020. Children and young people in East Renfrewshire are now interviewed and supported by Police and Social Work who are highly skilled, utilising proven techniques to achieve best evidence. In addition, the child / young person and their non-abusing care giver will have access to trauma informed support and advice throughout the JII process from the Children 1st recovery and participation workers who provide the child / young person and their families an opportunity to express their views, needs and concerns.

A critical aim is to ensure that all interviews take place in a safe child friendly, age appropriate way with consideration given to any developmental or additional needs. All children and their families will receive the practical and emotional support they require to recover.

Headline data / achievements:

- East Renfrewshire as one of 4 Local Authorities within the North Strathclyde Partnership were successful in winning the award for Excellence in Children's Services at the Scottish Social Services Awards Ceremony in November 2022.
- Children 1st were successful in securing funding that allowed the development of the Wee Bairns Hoose, which is set to have a summer 2023 opening here in East Renfrewshire. There will be a virtual link to Court, purposefully built to ensure the required expectations from Crown Office and Procurator Fiscal are met to challenge any requirement for children to be in the environment of an adult courtroom.
- Total 334 referrals received to the team during this reporting period where 73% progressed to an interview (243). For ERC, 83% (36) referrals progressed to a JII.
- Overall disclosure rate, 76%, which suggests that children / young people in East Renfrewshire feel safe and supported to speak despite their traumatic experiences.

Young people who have been in contact with the team made the following comments:

- *"I don't want to leave, I want to stay"*
- *"I felt that no-one was going to listen to me, but you have listened to me and you have made me feel better"*
- *"The interview went super smoothly and the interviewers were amazing"*

Participation and engagement activities take place across the service, however our **Champions Board** and **Mini-Champs** are active groups of young people and children who meet regularly and inform strategy and practice. 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. The Champions Board offers looked after young people leadership opportunities 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. The Champions Board's recent thematic work has been in relation to housing and mental health. The Champions Board recently helped to plan and support a visit from the First Minister to showcase the work of both groups to celebrate Care Day. The Champions Board is planning a refresher event in the coming months to highlight the groups' role in supporting East Renfrewshire to fulfil our corporate parenting responsibilities.

Supporting children and families through Health Visiting

Some key achievements of our health visiting service during 2022-23 include:

- Full implementation of the Universal Pathway now in place since July 2022
- UNICEF Gold Reaccreditation achieved in November 2022 with a Commendation.
- East Renfrewshire has average breastfeeding rates when compared to Scotland and Greater Glasgow and as a whole, with 73.8% of babies reported to have ever breastfed and 45.3% exclusively breastfed at primary visit (CHSP Pre-school August 2022 Public Health Scotland).
- Dunterlie Breast feeding group commenced in June 2022 in Barrhead within an area of higher deprivation within the HSCP. To date 113 mums have attended this group with weekly attendance noting to rise from 1 to 9
- Introduction of 2 Nursery Nurses to the team to support with neurodiversity in 2022 which is highly supportive to parents with children that are waiting for autism diagnosis
- East Renfrewshire was one of the first HSCPs to introduce the Ages and Stages Questionnaire(ASQ) in November 2022 to effectively assess child development and offer early intervention
- Introduction of the new My World Triangle (MWT) Assessment tool in 2022 which is resulting in improved assessments to allow for better-quality sharing with other agencies resulting in improved outcomes for children
- Record keeping audit in March 2023 – highlighted good results associated with new MWT assessment
- Test of change in relation to poverty has been taking place in ER which has led to an increase in referrals to MART from our most deprived neighbourhoods areas. This is now being implemented within other HSCPs within GGC
- The highest referrals are from the G78 postcode area whereby 104 referrals have been made since October 2022- Jan 2023 compared to the lowest of 3 referrals from G77 area.

The HSCP provides support to **unaccompanied asylum seeking children** arriving in the local authority area. Of the 17 arrivals to the area since 2017, 12 have arrived since May 2022. The average frequency of contact for all arrivals is twice per week and newly arrived young people are supported 7 days per week for the first few weeks. We have well established links with the Equality Development Officer for faith and culture groups; and additional support is provided to young people by Aberlour Guardianship Service.

2.3 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

2.3.1 Our strategic aims and priorities during 2022-23

Ensuring as many East Renfrewshire residents as possible can maintain their independence at home remains a priority of the partnership and a key area of focus as we move through and beyond the Covid-19 pandemic. Our approaches are person-centred and focused on the rights of individuals to exercise choice and control. We are able to deliver on this priority thanks to the enthusiasm and commitment of our partner providers and community support organisations and will continue to promote collaborative approaches.

We work to minimise isolation and engage with those in need through approaches such as befriending, peer support and the work of our Kindness Collaborative and Talking Points, linking people to local supports. We will continue to build on this collaborative working going forward to increase the community supports and opportunities available. We will make best use of technology and health monitoring systems to support independence and self-management. We are committed to increasing choice and control and delivering the full potential of Self-directed Support. As more people live longer with more complex conditions it is important that we work collaboratively with housing providers to support independent living in our communities.

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

- Ensuring more people stay independent and avoid crisis though early intervention work
- Ensuring the people we work with have choice and control over their lives and the support they receive.

In the aftermath of the Covid-19 pandemic restrictions we continue to see increased frailty and social isolation particularly among older people. Across our services we have seen increased demand and higher levels of complexity among the people we support. Although we are facing significant challenges, the response to the pandemic demonstrated the resilience of our community-based supports with teams of volunteers and staff keeping touch with the most vulnerable and isolated, notably through the Community Hub.

2.3.2 The progress we made in 2022-23

Over 2022-23 we have continued to support people to live independently and well at home, despite additional demand pressures on our services due to more people seeking support at home as well as increased levels of frailty and complexity. During 2022-23 we have seen continuing pressure on our Care at Home service with increased referrals and reducing capacity among partner providers. While these challenges have impacted on some of our performance measures such as our capacity to support reablement, we perform well on the overall balance of care delivered in our communities.

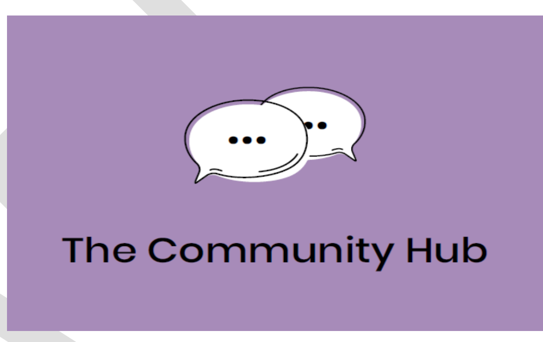
Headline performance data includes:

- 64.4% of people aged 65+ with intensive care needs (plus 10 hours) receiving care at home (up from 62% in previous year).
- 65% of adults (18+) receiving personal care at home or direct payments for personal care, as a percentage of the total number of adults needing care.
- 80.4% of adults supported at home who agreed that they are supported to live as independently as possible
- 89% reporting 'living where you/as you want to live'
- 48% of people with reduced care need following reablement / rehabilitation (down from 60% for 21/22 but up from 31% for 20/21)

2.3.3 How we delivered in 2022-23

The HSCP remains committed to promoting Community Led Support which emphasises more local, personalised and flexible services. Through strong local partnerships our teams are responding to the challenges we face following the pandemic with great innovation and greater collaborative working in support of our communities.

In East Renfrewshire our local **Community Hub** was developed to coordinate the community response to the Covid-19 pandemic. The Community Hub is a partnership between Voluntary Action East Renfrewshire, HSCP Talking Points and East Renfrewshire Council Communities and Strategic teams. It supports residents to access information and signposted to local community supports as well as establishing new shopping and prescription delivery service.



During 2022-23 the Community Hub has developed its website to focus the online directory away from Covid emergency response to promoting social activities, community supports and information. The success of directory reflects the work of on-going collaboration between local partners. The Community Hub website now has information on where to access support and information relating to The Cost of Living, promoting warm and welcome spaces, support services and access to both local and national resources. At the end of March 2023 the website had 2,435 users with 7,651 page views.

The Community Hub is working to establish a data sharing platform to help plan and development new community activities. The relaunch of our Wellbeing Network is the first step to supporting our partners to create a data sharing platform, agree how and what data and information we need to share and begin to build a picture of need for 2023-24.

Talking Points continues to be the main route for residents to get advice and support around their health and social care as well as information surrounding accessing community supports. The services has a membership of over 60 local and national organisations that work together to offer the correct support and information as early as possible. This preventative approach is person-centred and is integral in our delivery of Talking Points. During 2022/23 Talking Points have supported 690 calls/referrals with the most frequent reason for referral being loneliness/Befriending or looking for group activities within East Renfrewshire. The Talking

Points service also supported the development of three new older adult community groups, which work with 120 older residents weekly.

During 2022-23 we have been working to develop greater choice and innovation across community-based supports available in East Renfrewshire. This means **developing our local market** and supporting our existing **community infrastructure**. As we moved beyond the pandemic, the first half 2022-23 saw a steady return of local groups, community activities and support services. However, as the year progressed it was clear that many groups and organisations were facing financial difficulties and required support. The range of supports provided by Voluntary Action East Renfrewshire (VAER) during the year (including through virtual supports) consisted of organisational support and group training to 14 social enterprises (SE) and 36 third sector/community groups (non SE).

Over the year, the HSCP has been working with communities, third sector organisations and our independent sector providers to develop our approaches to **collaborative and ethical commissioning** of services and supports. HSCP have held a series of collaborative commissioning events from June 2022 with external partners/providers. Working groups and key actions are in place to develop more collaborative opportunities. A period of engagement has been implemented from March 2023 on the HSCP draft Strategic Commissioning Plan that describes current provision, identifies gaps and future intentions.

Our partnership is working to support the development of community-led activities across East Renfrewshire through the **Kindness Collaborative** led by VAER. In its first year of development, the Collaborative has developed a range of promotion materials and dedicated website space. A network has been established and key areas activity have included: identification of gaps in service provision; understanding what additionality can be brought by community-led approaches; development of collaborative approach with local organisations and groups; development of volunteering roles.

The Kindness Collaborative has coordinated a number of community call outs for help and support. As ever, we are delighted with the amazingly positive response from our community groups, third/public sector partners and residents. The collaborative undertook **Cost of Living engagement** which has paved the way for an ERC-led Warm and Welcome Spaces initiative. This provided funding for safe and comfortable environments for local activities during the winter months. The Cost of Living collaborative work involved more than 70 participants over two days. The work focused on the following themes:

- Warm & Welcoming spaces
- Networking & Outreach
- Information, Training and Data exchange
- Food Dignity & Sustainability

East Renfrewshire HSCP's **Care at Home** service provides Care at Home to around 500 East Renfrewshire residents covering on average 10,500 visits and 3434 hours of care per month. There have been significant capacity issues within Care at Home both locally and across Scotland with the situation locally reaching crisis point in early December 2022.

Increasing complexity of people being supported against a backdrop of recruitment challenges has led to significant pressures. Locally there has been a 49% reduction in the amount of service that commissioned providers are able to deliver since 2020. This has led to significant pressure on the HSCP's in house care at home service. The service is has continued to experience significant absence rates during the year, reaching 35% in January/February, principally affecting frontline carer and organiser roles.

Promoting digital opportunities that support independence

East Renfrewshire Digital Inclusion Partnership continues to meet and collaborate on providing fair and equal access to digital supports across East Renfrewshire. There is a digital inclusion action plan with 4 main activity areas all focused on increasing our local communities' confidence in using/accessing digital technology. This partnership is made up of Council, HSCP, 3rd and community sector partners all supporting our most vulnerable residents to be more digitally included.

Design, develop and deliver a community-led Digital support programme:

- **Digital Champions development**
  - All partners have been given access to and training for Digital Champion volunteers, offering support for and with Digital technology and well as being active promoters of the benefits of using technology to enhance independent living. Currently VAER support the delivery of two digital drop-ins offering support for anyone looking to increase their digital confidence. These drop-ins are delivered within the two Market Place venues in Barrhead and The Avenue. Our Digital Champions range from between 30-60yrs old with a mixture of ethnic backgrounds.
  - The Market Place also offers:
    - two Conversational English drop-ins for anyone with English as a second language, the volunteer lead for this is also linked in with our digital champions.
    - Type2 Diabetes digital support programme, this is predominantly people referred via the Diabetic Centre at the RAH. However, we are supporting a small peer support group to offer wider health and wellbeing supports as well as digital support for the My Diabetes My Way web programme.
    - VAER have access to Volunteer Translators when needed to support anyone to access our Digital Supports.

The Digital Partnership have agreed a programme of activity to gather and share information about where and how to access Wi-Fi across East Renfrewshire, this will be linked with when and where the digital supports are available.

The HSCP has been working on the huge task of transferring our **Telecare Service** from an analogue to a digital service - and we are the first HSCP in Scotland to have an end-to-end digital telecare service (although this is only in place for those who have had digital alarm units installed already, but work is ongoing on this). The national switch-off of analogue lines in 2025 has meant this piece of work is essential in ensuring our residents continue to be able to access their Telecare service. The installation of Digital Alarm Units within homes is expected to continue until 2025.

We have been supporting national Tests of Change which are identifying the benefit of pro-active calling to telecare users by call-handlers. Benefits include a reduced number of responder visits required, reduced numbers of ambulances being called and reduced numbers of telecare customers being hospitalised. Proactive calling is being considered as a potential next step for East Ren's Telecare Service.

We are in the process of implementing a new national **telehealth** solution (to replace Florence) which will be accessible to more people as it can be accessed via a telephone keypad, mobile

phones, tablets, laptops or desktops. The system has only just gone live and we already have three GP practices signed up to the service.

Just over a year ago we recruited a **TEC Implementation Officer**, whose main focus was the upskilling of the workforce (within our own service, the acute sector and the voluntary sector) to understand what types of Technology Enable Care (digital solutions etc) are available to our people and to consider TEC as the first potential solution to their care needs. In addition, our TIO is also involved in identifying new TEC which could benefit our citizens and in the roll-out of the new telehealth service.

East Renfrewshire HSCP are supporting the local delivery of the **Improving the Cancer Journey**, funded and supported by Macmillan Cancer Support (Scotland) and the Scottish Government. The new partnership will offer support to anyone affected by cancer across East Renfrewshire, by offering a Holistic Needs Assessment (HNA) to help identify and address all physical, psychological, social, financial and practical needs.

Macmillan Improving the Cancer Journey (MICJ) – East Renfrewshire

In partnership, Macmillan and the HSCP will work with local health providers, the local authority, third sector, communities and people affected by cancer (including family members and carers), with the aim of ensuring everyone affected by cancer can easily access the support they need as soon as they need it to enable them to live as well and as independently as possible.

East Renfrewshire has a cancer incidence rate of approximately 590 per 100,000, equating to approximately 540 people being diagnosed with cancer annually. The incidence of cancer is also anticipated to increase by 33% over the next 5-10 years. There were 2,888 cancers (excluding non-melanoma skin cancer) diagnosed in East Renfrewshire in the five years from 2016 to 2020. These were evenly split across genders. Across the two localities, Eastwood has the most diagnoses of cancer with 74.4% of cases compared to Barrhead with 25.6%.

At the end of 2019, 3,853 people in East Renfrewshire were living with a diagnosis of cancer and had been diagnosed within the previous 20 years. This equates to 4.01% of the population. This is higher than the national figure of 3.74%. It would be safe to assume that people living with cancer is expected to rise to circa 5900 by 2030. This number is increased significantly when you begin to consider the support needs of loved ones associated with a cancer diagnosis. Cancer mortality is consistently considerably lower in East Renfrewshire than it is in Scotland, with 46 fewer deaths per 100,000 occurring in 2018-20. The most common types of cancer in East Renfrewshire for both sexes combined (in order) were, female breast cancer, prostate cancer, lung cancer, colorectal cancer, malignant melanoma of the skin and kidney. These 6 cancers account for two thirds of all cancer diagnoses in the East Renfrewshire area.

Building on learning from MICJ in the other partnerships within NHS Greater Glasgow and Clyde, MICJ provides a framework and evidence base to support improving patient outcomes and experience.

Macmillan ICJ in East Renfrewshire sets out to:

- Invite all with a cancer diagnosis in East Renfrewshire to complete a Holistic Needs Assessment (HNA) and develop an individual care plan that includes carers and family members.
- Provide the dedicated support of a named ‘Link Worker’ to everyone in East Renfrewshire with a cancer diagnosis, and to his or her carer or family.

- Facilitate the delivery of effective and integrated Health and Social Care support solutions, based on their needs.
- Demonstrate through outcomes the case for longer term sustainability of the service and the potential model for personalised care for other long term conditions.

2.4 Working together to support mental health and 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

2.4.1 Our strategic aims and priorities during 2022-23

During the pandemic we adapted our approaches across services to support the mental wellbeing of the people we work with. As we move forward we will continue to focus on good mental wellbeing, and on ensuring that the right help and support is available whenever it is needed. We recognise that different types of mental health need will continue to emerge as time passes and that we will need to continually adapt our approach to reflect this. We are focused on close collaboration with primary care, and further enhancing the mental health and wellbeing supports within primary care settings. We will work with GPs, third sector partners and people with lived experience to develop our approach to ensure people get the right service, in the right place at the right time. We are enhancing our approach to minimising drug-related harms and deaths and improving overall wellbeing amongst people with harmful drug or alcohol use and their families.

We will continue to work in partnership with people who use services, carers and staff to influence the Greater Glasgow and Clyde Five Year Strategy for Adult Mental Health Services and contribute to its delivery to ensure the needs of East Renfrewshire residents are met. We will ensure a particular focus on prevention, early intervention and harm reduction; high quality evidence-based care; and compassionate, recovery-oriented care recognising the importance of trauma and adversity and their influence on well-being.

We will continue to support the promotion of positive attitudes on mental health, reduce stigma and support targeted action to improve wellbeing among specific groups.

Our aim is to **support people to look after and improve their own mental health and wellbeing**, by:

- Ensuring individuals can access a range of supports on their journey to recovery from mental health and alcohol and drugs harms
- Ensuring wellbeing is enhanced through a strong partnership approach to prevention and early intervention
- Helping staff and volunteers to have the skills, knowledge and resilience to support individuals and communities

2.4.2 The progress we made in 2022-23

During 2022-23 our teams have continued to deal with increased demand across mental health and addiction services due to increases in complexity. There have been high demand across all teams (Community Addictions Team, Adult Mental Health Team, Primary Care Mental Health Team, Older Adult Team). For older people we are seeing overall wellbeing impacted by issues such as isolation and reduction in mobility.

Headline performance data includes:

- Mental health hospital admissions remain low (at 1.4 admissions per 1,000 population)

- 75% waiting no longer than 18 weeks for access to psychological therapies (av. 2021-22)
- 96% accessing recovery-focused treatment for drug/alcohol within 3 weeks – up from 95% in 21/22 and 69% in 20/21
- 5% of people moving from treatment to recovery services in the year – down from 9% in 21/22
- 173 alcohol brief interventions undertaken in 22/23 – up from 0 last year, reflecting increased resourcing for this activity.

2.4.3 How we delivered in 2022-23

Our teams continue to deal with a significant increase in demand across mental health and addiction services due to increases in complexity. We are building on the new approaches and ways of working that were developed during the pandemic to help meet the demands on us going forward as we support good mental health and wellbeing, help people manage their own mental health, and build their emotional resilience.

The partnership is taking a holistic approach to promoting mental health and wellbeing including promote physical activity linked to mental wellbeing, in partnership with VAER, funded by Paths 4 All and NHSGGC.

Work with our communities to promote positive mental health and wellbeing

Health Walks
Currently, there are 12 Community Health Walks running across East Renfrewshire on a weekly basis, two of which are Dementia and Cancer Friendly Walks. Walker numbers have continued to rise each month as we move into spring season. March 2023 saw an average of 89 walkers attend weekly. Due to demand / interest from the community, two new walks commenced in April. An additional health walk also runs weekly from Cowan park, and is facilitated by a staff member from our Addictions team. This is a closed group, specifically for individuals in active recovery.

Strength & Balance Class
Currently, there are 6 Community Strength and Balance classes running across East Renfrewshire. In March, classes saw an average of 60 attendees per week with demand for classes growing due to the reduction in Covid restrictions. Participants can then be signposted on to East Renfrewshire Culture and Leisure Trust activities.

A number of **wellbeing inputs** to community groups and organisations have been delivered including the delivery of Health & Wellbeing sessions for RAMH Recovery College summer programme. Three NHSGG&C Healthier Minds sessions were delivered:

- Sleep & Mental Health
- Loneliness & Isolation
- Resilience

The HSCP has commissioned 12 month pilot programme with Glasgow Council on Alcohol (GCA) focusing on community outreach to deliver **Alcohol Brief Interventions**, alcohol counselling sessions and training on the delivery of ABIs to staff across the HSCP and partners. 173 ABIs have been delivered to date and 8 alcohol counselling sessions. Outreach events have taken place in leisure centres, libraries, Voluntary Action market places, community centres and food banks. Staff training on the delivery of ABIs is being scheduled during April – October.

We have continued to support to roll out the **Community Mental Health and Wellbeing Fund** in partnership with VAER. Two years of funding from the Scottish Government has been fully distributed to local grassroots Third/Community sector organisations and groups. HSCP staff participated in the panel for the year 1 allocations with applications encouraged from specific target groups. The Year 1 grant awards were made at the end of 2021-22 with the majority of delivery in spring/summer 2022 and onwards. Around half of the 19 applications focused on older people as their main target groups. Other target groups include minority ethnic communities and people who are neurodivergent.

Programmes such as the **RAMH Recovery College** had a wide reach across communities with a diverse programme of mental health and wellbeing courses on offer with 38 people completing courses. A wellbeing tool was used to capture pre- and post-participation wellbeing scores and this showed an average improvement of 21% in wellbeing. Individual students met employability goals: 3 gained paid work during the pilot period and cited their increased confidence to involvement in Recovery College was a significant contributing factor. five individuals have taken on volunteer roles with RAMH.

The partnership works to deliver the priorities set out in the Greater Glasgow and Clyde Mental Health Strategy. East Renfrewshire HSCP commissions the **peer support services** across mental health and alcohol and drugs settings to support the recovery workstream and aims of the NHSGGC Strategy. Peer support is where people with similar life experiences offer each other support, especially as they move through difficult or challenging experiences. The service received its first referrals in 2020, initially offering opportunities to meet face-to-face, within the restrictions at that time.

The peer support is currently supporting over 70 people. The majority are supported on a 1-1 basis however a schedule of group activities is also in place. The peer support service works with individuals already engaged with services in East Renfrewshire, with referrals made by Health and Social Care Partnership adult mental health and alcohol and drugs services, as well as RAMH and RCA Trust. It is an additional, complementary support to help individuals identify their personal goals for recovery.

Supporting skills, knowledge and resilience across our partnership

A key priority in delivering our strategy to support better mental health and wellbeing is to ensure staff and volunteers across the wider partnership have the skills, knowledge and resilience to support individuals and communities. Examples of training delivered during the year include:

- Scottish Mental Health First Aid: 30 staff / partners attended including HSCP, partners and community representatives
- Mental Health Awareness (Tailored to Community Policing Teams): 18 Police colleagues attended
- Heart Start training: 40 staff/partners
- ASIST (57 participants) and self-harm training (60 participants)

A training sub-group is being established as part of the HSCP Suicide Prevention Strategy and Action Plan. Training opportunities for courses such as ASIST and SMHFA have been targeted to staff who are working with people at risk. This has included social work staff, School Nursing staff and Teachers.

Awareness raising of online training such as webinars, online modules and awareness raising session have continued. Training opportunities are communicated via the weekly Health and Wellbeing email bulletin and other mechanisms to ensure the right opportunities are offered to the appropriate staff and teams. NHSGG&C Mental Health Team and Public Health Scotland produce monthly bulletins with new training, resources etc. and these are

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widely shared across HSCP and partners such as VAER, RAMH, East Renfrewshire Culture and Leisure Trust.

Locally we now have three staff trained in peer support. For the last year the Health and Wellbeing Lead has supported around 25 staff with their mental health and wellbeing via peer support. In 2023 we began the promotion of the peer service across the HSCP where staff / managers can contact the peer supporters direct to arrange 1-1 support.

As we move beyond the Covid-19 pandemic we are focused on building on innovative approaches that were developed during the pandemic period, including **digital solutions** to support people. Over 30 devices were issued to people as part of Connecting Scotland programmes during 2020 and 2021. As more groups and activities have returned to in-person basis, people are able to participate in recovery activities in communities. The Community Addictions Service continue to provide access to mobile phones and SIM cards on an adhoc basis to those experiencing digital exclusion and a small number of mobile phones have been issued in the past year. We continue to engage with lived experience networks about the needs of those in recovery and develop actions in response.

Delivering wellbeing inputs to community groups and third sector organisations

Our data shows men are less likely to access mental health services such as primary care mental health team and GP community link workers, higher numbers of suicides amongst males. Following discussions with the group, we delivered Health & Wellbeing Awareness Sessions to Mens Shed, Barrhead (55 male members). Sessions included :

- Physical activity session
- Dementia Awareness
- Cancer Awareness
- NHSGG&C Healthier Minds Sessions: loneliness & isolation / Long Term conditions/ Loss & Grief/ Sleep & Resilience.

Delivery of Health & Wellbeing sessions for RAMH Recovery College summer programme. Three NHSGG&C Healthier Minds sessions were delivered including :

- Sleep & Mental Health
- Loneliness & Isolation
- Resilience

During 2022-23, the partnership has continued to focus on **suicide prevention** activities. Following the publication of the National Suicide Prevention Strategy & Action Plan in September 2022, two Suicide Prevention workshops were delivered locally with 65 staff and partners attending from across wide range of groups and organisations in East Renfrewshire. Workshops involved awareness raising, training, consultation and networking. Following the workshops, a Suicide Prevention Working group with wide representation has been established (first meeting February 2023) with the aim of developing and delivering a two-year suicide prevention action plan. Partners include HSCP, Council, Police, British Transport Police, VAER, East Renfrewshire Carers, ER Culture & Leisure and Barrhead Housing Association.

We continue to implement the **East Renfrewshire Alcohol and Drugs Strategy** and Delivery Plan with a wide range of actions including:

- Working with people with lived and living experience to enhance and develop recovery community activity
- Strengthen links between community addictions and children and families services
- Increase awareness of services including family support

During 2022-23, progress has been made in the following areas:

- **Lived and living experience involvement** in the work of the Alcohol and Drugs Partnership continues to evolve and expand. The peer research group has grown to six members and has just completed the second research study – a community needs assessment of those affected by alcohol and drugs. The study reached 24 people with lived and living experience and 47 professionals. The ADP will consider the findings of the needs assessment and develop an action plan to enhance supports and services.
- Resources have been identified to deliver **whole family support** activities. These will be co-designed with families affected by a loved one's alcohol or drug use. Community Addictions Service and children and families services are beginning work to engage family members to identify the priorities for this funding with a view to delivering the additional supports in the second half of 2023-24.

The HSCP continues to work to implement the **Medication Assisted Treatment (MAT) Standards** and ensure fast, appropriate access to treatment. The MAT standards enable people to access same-day prescribing for opioid use disorder, facilitating low barrier access to assessment and treatment.

Delivering the Medication Assisted Treatment (MAT) Standards in East Renfrewshire

The Medication Assisted Treatment (MAT) Standards Implementation Plan is available here and sets out a wide range of actions including:

- Implementation of rapid access to opiate substitution treatment Monday to Friday
- Tests of change in near fatal overdose pathways and assertive outreach approaches
- Enhancing access to harm reduction interventions for people at risk

The Plan is well advanced with the majority of actions to deliver standards 1-5 now complete.

All staffing roles to support the delivery of Medication Assisted Treatment are now in place, funded by the national support funding. This includes a full time Pharmacy Independent Prescriber who, alongside the team medical officer, enables prescribing to be available 5 days per week, The Community Addictions Service have implemented a Standard Operating Procedure for rapid access to MAT and there are examples of individuals being able to access a prescription on the same day they present to the service.

The Turning Point overdose response team has provided harm reduction advice and support to almost 40 individuals since the service began operating in September 2021. Interventions include Naloxone training and provision, overdose awareness training.

The Alcohol and Drugs Partnership has worked with Turning Point to implement the Mobile Harm Reduction Service, an outreach service to target individuals who may not be accessing treatment. The service is now in place every fortnight on a Thursday in the Barrhead community – providing injecting equipment, Naloxone, blood borne virus testing and wound care. The days/times/locations remain under review based on uptake of the service and the service will rotate around different communities based on identified need. Awareness raising sessions with key stakeholders were held in January in Barrhead and Eastwood where partners had the opportunity to view the vans and hear about the provision of the harm reduction interventions. The service is promoted through communications to

services and community networks as well as outreach work by van staff when working in the area. Uptake is low at this early stage and additional promotion is being planned.

The Community Addictions Service has also enhanced existing harm reduction provision through increasing Blood Borne Virus testing, and ensuring Injecting Equipment Provision is available at service sites.

2.5 Working together to meet people's healthcare needs by providing support in the right way, by the right person at the right time.

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

2.5.1 Our strategic aims and priorities during 2022-23

The vision set out by NHSGGC in its recovery and remobilisation planning is to have in place a whole system of health and social care enabled by the delivery of key primary care and community health and social care services. HSCPs are working in partnership to ensure effective communications, a consistent approach, shared information and the alignment of planning processes.

Primary care is the cornerstone of the NHS with the vast majority of healthcare delivered in primary care settings in the heart of our local communities. It is vital in promoting good health self-care and supporting people with long term health needs and as a result reducing demands on the rest of the health and social care system. Through our Primary Care Improvement activity we have been expanding primary care teams with new staff and roles to support more patients in the community.

Significant investment in winter 2022 helped add resilience to our health and care response. We have strengthened the capacity of our Care at Home Responder Service, Community Nursing and Community Rehabilitation teams and have established an intensive support service at our in-house care home for a multidisciplinary ‘step-up’, ‘step-down’ approach. This is supporting rehabilitation and reablement and timely discharge to home/homely settings. Additional resources are being used to address the accelerated demand pressures we have seen for Care at Home services, with increased frontline staff as well as management and support, and increased capacity for the Home First model and Technology Enabled Care.

We continue to work together with HSCPs across Glasgow, primary and acute services to support people in the community, and develop alternatives to hospital care. In partnership we support the development and delivery of the joint strategic commissioning plan which outlines improvements for patients to be implemented over the next five years.

Our aim is to **ensure people’s healthcare needs are met (in the right way, by the right person at the right time)**, by:

- Early intervention and prevention of admission to hospital to better support people in the community
- Improved hospital discharge and better support for people to transfer from acute care to community supports
- Improved primary / secondary care interface to better manage patient care in the most appropriate setting.

2.5.2 The progress we made in 2022-23

Patterns of accident and emergency use and unplanned hospital admissions were significantly altered by the pandemic; but some measures have moved above pre-pandemic levels during

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the year. Despite increased activity we remain ahead of target for emergency admissions and A&E attendances and available data suggests unplanned attendances and admissions have been at a stable rate over the year. During the reporting period we saw an increase in discharges with delay. This is being driven by the pressure on care at home services which is restricting access. Our Hospital to Home team work to deliver timely and appropriate discharges from hospital. Our performance for delays remains among the best in Scotland. We continue to support the hospital discharge efforts by promoting the use of intermediate care beds where a care at home package cannot be immediately accommodated. We are also seeing improved performance on emergency readmissions, reflecting the positive support we have in place in the community.

Headline performance data includes:

- Discharge without delay – averaged 8 delays for 22/23 – up from 7 for 21/22 (and 3 for 20/21)
- Adult bed days lost to delayed discharge – 4,652 for 22/23 (up slightly from 4,546 for 21/22 but significantly higher than 2,342 in 20/21)
- Adult A&E attendances – 17,355 - up from 16,877 in 21/22 but ahead of target
- Adult Emergency admissions – 6,564 - down from 6,772 in 21/22 and ahead of target
- Emergency admission rate (per 100,000 pop) – 9,036 down from 9,414 for 21/22
- Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges) – 67, down from 77 in 21/22 (and 98 in 20/21)

2.5.3 How we delivered in 2022-23

During 2022-23 the HSCP has continued to work with other partnerships and acute services in the Glasgow area to develop new services and pathways that will continue as we move into recovery.

Our **Hospital to Home team** (which facilitates complex hospital discharges) was supplemented last year by the creation of a new team focussing on the appropriate and effective use of intermediate care beds. This supports timely hospital discharge where the required homecare package is not immediately available and delivers improved outcomes from assessment activity carried out in this setting (versus hospital). The targeted work by the team includes requests for intermediate care beds, care home liaison, occupancy tracking, data collation, arranging interventions / reablement and carrying out outcome-focussed reviews and care planning. The collaborative working between these teams has ensured that delays in hospital discharges have been minimised and kept within manageable levels.

We continue to develop **enhanced community support** and **intermediate care models** in partnership with HSCPs across Glasgow. To support timely discharge from hospital through intermediate (‘step-down’) provision, we provide a 6-bed unit in Bonnyton Residential Home and block, or ‘spot’ purchase additional beds for intermediate care in local Care Homes. Ongoing use of the 6 intermediate beds in Bonnyton is supported by partnership working across social work, community nursing, Reablement and Rehab services, and primary care services.

Supporting people through interim care models Improved performance around interim care in 2022-23 57 people have been in interim care in East Renfrewshire between 1 April 22- 31 March 2023 (20 went on to require permanent care). 53% of people returned home

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2,140 days in interim care/bed days saved. (Improved performance on hospital bed days saved, contributed in part to interim care performance)

We are also working to implement our **discharge to assess** protocol to help minimise discharges with delay. There has been ongoing joint working between Acute Services and Hospital to Home Team, Intermediate Care and Rehab Service to support individuals to be discharged home or to alternative community setting to ensure safe discharge without delay and ongoing assessment.

Despite our proactive activity to support discharge from hospital, the HSCP is still challenged with delays resulting from **Adults with Incapacity (AWI)** and family choice/indecision and delays due to Power of Attorney (PoA) not being in place. New AWI Procedures were implemented on the 1st July 2022. These incorporated recommendations from the Mental Welfare Commissions Authority to Discharge Report 2021. Having a dedicated **Mental Health Officer (MHO)** within the Home from Hospital Team ensures a rapid and responsive service to individuals requiring a legal framework to facilitate hospital discharge.

Our **Community Rehabilitation Teams** continue to experience increased pressures due to the ongoing impacts and consequences of the pandemic on the older population, with an increase in frailty and frailty related falls. Average weekly referals into the service have increase by approximately 50% since the start of the pandemic. Due to increased complexity of need and deconditioning, the service is finding that people are requiring longer and more frequent inputs, adding to demand pressures.

The partnership has seen increased **falls/frailty** presentations due to unintended consequences of Covid-19 lockdown restrictions on individuals' health including deconditioning, reduced social supports, implications of the pausing, ceased or phased remobilisation of NHS and community services and groups. There remains increased pressure on HSCP community assessment and rehabilitation teams to deliver assessment, intervention, and rehabilitation but without some of the wider supports previously available.

During 2022/23 we have continued our work to implement frailty pathways and support initiatives to address frailty in our communities. There has been ongoing development of **Home First Response/Frailty service** including appointment of Frailty Practitioner and further development of various community falls and frailty pathways across HSCP to identify and provide appropriate guidance, support and interventions. As well as improved use of data (frailty scores), a 'frailty matrix' has been developed detailing appropriate services across the frailty pathway. We have established community pathways with Scottish Ambulance Service in relation to falls/ frailty and work with primary care colleagues to identify test of change opportunities for proactive identification of frailty.

To prevent crisis and emergency use of acute services, we continue to work to improve the quality and quantity of **Anticipatory Care Plans (ACPs)**. The number of ACPs recorded on the NHS Clinical Portal system for East Renfrewshire HSCP has now exceeded target. Training in anticipatory care planning has been delivered across HSCP services and **ACP Champions** have been identified in Community Nursing and Rehab Services.

Supporting local care homes

Our partnership with local care home providers has continued to develop and strengthen following the pandemic. Commissioning and contracts staff continued to support homes with twice-weekly welfare calls to homes, or more often if needed. Every week we hold

multidisciplinary Care Home Assurance Meetings and there is a four-weekly Care Home Managers Forums with managers. Regular support meetings take place with care homes experiencing any issues/risks. The HSCP adult support and protection team has worked closely with homes advising and investigating to keep the most vulnerable individuals safe from harm. Bespoke support is offered to care homes particularly affected during the pandemic and the wellbeing of staff and residents continues to be a high HSCP priority. The Commissioning and Contracts team also supports the Care Home Assurance visits, alongside with the clinical nursing team and senior manager for communities and wellbeing. The team is also providing input at various internal and external meetings, such as the weekly vaccination meeting, and Greater Glasgow care home assurance group.

During the year, we completed the full implementation of East Renfrewshire's **Primary Care Improvement Plan (PCIP)**. The plan set out a wide range of activity in line with six Memorandum of Understanding (MOU) priority areas, including:

- enhanced models for vaccination through the Vaccination Transformation Programme (VTP);
- Pharmacotherapy Services – a new medicines management system with more pharmacists and pharmacy technicians working within GP practices;
- Community Treatment and Care Services (CTAC) providing support to General Practice for minor injuries, chronic disease monitoring and other services suitable for delivery within the community;
- Urgent Care (Advanced Practitioners) with the creation and implementation of 3.0 wte Advanced Nurse Practitioners (ANP) to work across three GP clusters within Eastwood and Barrhead localities;
- Additional NHSGGC Advanced Practice Physiotherapists (APP) and musculoskeletal (MSK) Physiotherapists working across GP practices;
- Community Link Workers (CLW) based in GP practices to signpost people to community-based supports. The service reflected shared awareness of the impact of a significant cohort of patients who sought recurring and regular support from GPs, for what were often issues associated with loneliness, social isolation, and lack of community connectedness and associated 'social' issues.

We will review the effectiveness of these new approaches and we are continuing a series of 'deep dives' into MOU services at the PCIP Oversight Group meeting.

The Advanced Nurse Practitioner has played a very valuable role in the practice which has facilitated a reduction in GP workload

The Advanced Practice Physiotherapist has very effectively complemented our clinical skill-mix and feedback from patients continues to be extremely positive

Community Link Workers are an extremely valuable resource

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2.6 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

2.6.1 Our strategic aims and priorities during 2022-23

Unpaid carers are essential to our social care system and the daily efforts of families and loved ones to support those in need is fully recognised by the partnership. Carers have been significantly impacted by the pandemic and changes to a range of supports available to those providing care. Unpaid carers have also taken on increased caring during over the past few years and have faced additional pressures. As we move beyond the pandemic we must ensure that the right supports and services are in place for carers. The ongoing work of the East Renfrewshire Care Collective has demonstrated the need to maintain and strengthen our approach to involving carers throughout the planning process in identifying the outcomes that matter to them and by ensuring carers voices are valued and reflected within our strategic planning work.

Our Carers Strategy sets out how we will work together with partners to improve the lives of East Renfrewshire's carers. Through our local engagement and discussion we know that we need to develop our workforce, pathways and supports for carers. We have committed to working together with East Renfrewshire Carers Centre (ER Carers) to improve access to accurate, timely information. We will continue to encourage collaboration between support providers for advice, information and support for carers ensuring local provision that best meets carers needs. We will provide information and training to raise awareness of the impact of caring responsibilities. We will continue to support the expansion of personalised support planning in collaboration with our unpaid carers and ensure that self-directed support options are offered to all adult carers who have been identified as eligible for support.

We will work collaboratively with providers to develop flexible and innovative approaches to the provision of breaks from caring; and we will make sure that carers are aware of and have access to these. Peer support and having the opportunity to share experiences is highly valued by our carers but has been disrupted during the pandemic. As a wider partnership we will ensure that these informal supports that enable people to continue in their caring role are re-established and strengthened going forward.

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.
- Ensuring more carers are being involved in planning the services that affect them and in strategic planning

2.6.2 The progress we made in 2022-23

Working with East Renfrewshire Carers Centre, we have continued to ensure that carers have had access to guidance and support throughout the year. Training and awareness-raising on

the issues affecting carers have been delivered. Work has continued on the development and promotion of support planning for carers and the partnership continues to develop approaches to short breaks for carers.

Headline performance data includes:

- 80% of those asked reported that their 'quality of life ' needs were being met – down from 92% in 21/22
- % carers who feel supported to continue in their caring role – 28.4% (21/22) down from 35.3% (19/20)

2.6.3 How we delivered in 2022-23

The pandemic has impacted significantly on carers, with potentially restricted access to support, resources and activities away from caring.

Throughout the year we have maintained our positive partnership working with the **East Renfrewshire Carers' Centre (ER Carers)**, continuing to deliver community-based integrated support for carers in East Renfrewshire including access to tailored advice, support, planning and community activities.

In partnership with the ER Carers we ensure **information and training** is available to raise awareness of the impact of caring and requirements of Carers Act. The Equal Partners in Care (EPIC) Training Programme has been under review during the year and relaunched at the end of March 2023. EPIC will be included in the induction training for new staff and will be supplemented by input from carers, the East Renfrewshire Carers Lead and Self-directed Support (SDS) lead. 27 carer aware sessions have been delivered across HSCP and third sector partners in the last year. Drop-in appointments for staff were piloted in January 2023 in partnership with SDS Forum although there was limited uptake. Further training and drop-in sessions will be developed to meet the requirements of the HSCP's new Supporting People Framework and review of adult carer support plans.

During the year we have continued to work in partnership to ensure carers are being involved in **planning services** that affect them. Following the success of the Dementia Walking Buddies we are planning to develop a carers network specifically in relation to dementia support. The Carers Collective continue to meet monthly with further specific engagement events held in relation to:

- HSCP Budget
- Strategy development
- Short Breaks
- Day Centres/Day opportunities
- Hospital Discharge
- Autism

Carers Rights information is provided to every carer refered to the Centre. This information is supplemented by group sessions on Carers Rights and Introduction to Caring sessions.

We continue to implement **carers' support planning** including planning for emergencies with individual carers. Following introduction of the Supporting People Framework and the new Personalisation & Assessment Workstream a working group has been established to create a process for carers that reflects these changes and develops a revised process for Adult Carer Support Plans. The new process will incorporate Emergency plans with an increased focus on promoting Anticipatory Care Plans (ACP) for both carers and the people they support. Carers Centre staff have undertaken training to promote Anticipatory Care Plans and there is a new Carers Pathway for ACP with links to the Community Nursing Team. An **abbreviated Adult Carer Support Plan** (ACSP) has been introduced for carers with no support

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requirements from HSCP. This is used by the Centre to record support plans for all carers referred for support.

The current **East Renfrewshire Carers' Strategy** has four strategic carer outcomes that are fully in line with the principles of the Carers (Scotland) Act 2016, the National Health and Wellbeing Outcomes and East Renfrewshire HSCPs Strategic Plan.

- Carers are identified, valued and involved
- Carers have choice, control and a life alongside caring
- Carers are living full lives and able to support their health and wellbeing
- Caring is a positive experience

The Carers Strategy is currently being revised and updated to reflect the introduction of the Supporting People Framework. A programme of engagement with carers, young carers, stakeholders and community groups has been undertaken and the strategy will go to IJB for approval in Summer 23. A programme of awareness raising and engagement will follow.

East Renfrewshire's **Short Breaks Statement** was developed in collaboration with carers and other stakeholders. It establishes guiding principles for planning short breaks and these remain key to short break provision. These are:

- Carers will be recognised and valued as equal partners in planning for Short Breaks.
- Planning and assessment will be outcomes focused to ensure that we focus on what both the carer and the cared for person wants to happen.
- By using our eligibility framework we will have an equitable and transparent system for determining eligibility for funding Short Breaks that is consistent and easily understood.
- There will be timely decision making.
- Planning a short break will be a safe, respectful and inclusive process with every carer treated equally.
- When planning a Short Break questions about needs and outcomes will have a clear purpose for carers, not just to inform the support system.
- Prevention will be key. Planning and assessments for support should prevent deterioration in the carer's health or the caring relationship.

The **Short Breaks Working Group** includes the HSCP, Carers Centre and carers and has informed development of our local **Promoting Variety Project**. The Promoting Variety Project is now underway to develop a time-banking initiative for short breaks. A Project Co-ordinator has been recruited and carer engagement and volunteer recruitment has started.

Short Breaks is now a pilot initiative in the HSCP's collaborative commissioning work, testing the potential for direct payment grant support to carers.

Supporting East Renfrewshire's minority ethnic carers

The HSCP and Carers Centre secured funding to appoint a dedicated ethnic minority worker. The Centre has been able to sustain this post into their core funding. The Centre ensures that all activities are open to all carers; the post continues to lead on support dedicated to carers from ethnic minority communities including promoting ACSPs to carers and providing emotional and practical support such as information sessions, training and peer support.

Among the ethnic minority carers known to the Carers Centre there is a high prevalence of parent carers supporting children on the Autism Spectrum or Neuro-developmental condition. To support this the Centre has facilitated training including CYGNET and four workshops delivered by the Autistic Collective and the Scottish Minority Ethnic Autistic. The

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carers have also had regular meetings with senior managers from HSCP and Education Department to share their views on services and support required.

The Centre promotes short breaks to ethnic minority carers and in addition to peer support responding to carers' feedback has facilitated day trips, swimming lessons and activities such as weekly badminton sessions and bowling trips.

The Carers' Centre is working in partnership with the Centre of Therapy to offer ethnic minority carers access to counselling and Cognitive Behavioural Therapy.

Learning from the pandemic has highlighted the importance of online support. The Centre's website and online information incorporates software that translates all information to any required language.

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2.7 Working together with our community planning partners on new community justice pathways that support people to stop offending and rebuild lives

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

2.7.1 Our strategic aims and priorities during 2022-23

We will continue to work together with our multi-agency partners to ensure there are strong pathways to recovery and rehabilitation following a criminal conviction.

Through the East Renfrewshire Community Justice Outcome Improvement Plan we are committed to a range of actions with community planning partners. We are working together to support communities to improve their understanding and participation in community justice. As an HSCP our justice service will continue to promote the range of community justice services that we deliver and, in response to the challenges posed by the pandemic period, will continue to identify and build on opportunities for the unpaid work element of community payback orders to meet the needs of the local community and reduce the risk of further offending. We will build on the innovative approaches that have been developed during the pandemic and ensure we have the capacity to support people to complete unpaid work.

We will continue to strengthen our links with community services and programmes to provide greater access and support for people to stop offending. In the context of our recovery from the pandemic we will work to ensure that people moving through the justice system have access to the services they require, including welfare, health and wellbeing, housing and employability.

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

- People have improved access to through-care
- People have access to a comprehensive range of recovery services
- Trauma-informed practice is embedded across justice services
- Structured deferred sentence and bail supervision is implemented
- The risk of offending is reduced though high quality person centred interventions

2.7.2 The progress we made in 2022-23

The provision of unpaid work was significantly impacted by the pandemic with Community Payback Orders (CPOs) suspended on 23rd March 2020 and this continues to have an impact on unpaid work provision. There were 5,874 hours backlog at end March 2023, spread over 71 individuals subject to Unpaid Work. This denotes a return to pre-Covid levels of Unpaid Work Orders.

Headline performance data includes:

- 86% Community Payback Orders (CPOs) commencing within 7 days – significantly up from 58% in 21/22
- 83% of unpaid work placement completions within Court timescale – up from 81%
- Positive employability and volunteering outcomes for people with convictions – 64% up from 56% in 21/22

- 100% of people reported that their order had helped address their offending

2.7.3 How we delivered in 2022-23

The HSCP delivers accredited programmes aimed at reducing reoffending. During 2022-23 we continued to deliver **Moving Forward, Making Changes** in a groupwork capacity. To complement the three staff currently trained, a further three staff have been identified and nominated for training. The programme is being converted to the Moving Forward 2 Change (MF2C) programme; staff will be trained when this is in place.

The criminal justice service uses appropriate **risk assessment tools** to identify need and reduce the risk of further offending. Justice Social Workers have undertaken training in the Throughcare Assessment Release Licence (TARL) process which will strengthen collaborative risk assessments between community-based and prison-based Social Work. All Justice staff are now trained in this approach.

New staff have accessed **Trauma Informed Practice training** as it has become available. This has been complemented by all staff undertaking a range of training including supporting young people's mental health.

The HSCP works to deliver a whole systems approach to diverting both **young people and women** from custody. Women and young people continue to be clear priorities in the use of **Structured Deferred Sentences**. The Structured Deferred Sentence is a low-tariff intervention providing structured social work intervention for offenders post-conviction but prior to sentencing. It is a sentencing option in all court reports for people under 25 and women who are appearing for sentencing. It is also intended for offenders with underlying problems such as drug or alcohol dependency, mental health or learning difficulties or unemployment that might be addressed through social work intervention. This outcome is promoted whenever appropriate within Criminal Justice Social Work Reports.

We aim to ensure that people subject to statutory and voluntary supervision including licence have early **access to community mental health, alcohol and drug recovery services**. Staff continue to refer people with any identified needs to the associated ERCAT or Community Care teams. This includes regular contact with Adult Services to seek advice on possible referrals and potential interventions. Justice Social work and East Renfrewshire Alcohol and Drug Service have revised local policies for Drug Treatment and Testing Orders to better meet the current needs of those requiring this service. Justice staff are now trained in the administering of opioid overdose prevention medication Naloxone.

It is important that people are able to find positive alternatives to offending. Criminal Justice staff closely with the East Renfrewshire Employability Partnership, utilising the existing pipeline to refer people for assistance with **employability-related supports** and those for further **education/training**. We have sought to draw upon a wide-range of employability services to accomplish this and have connected with employability services to deliver input to our Moving Forward Making Changes programme for specialist supports. UKSPF (UK Shared Prosperity Funding) funding is in place from April 2023 for two year period, to provide a dedicated key justice employability worker support for people with convictions. This year, we have identified a three new personal **work placements**. These have complemented our existing placements which are themselves regularly reviewed for suitability.

2.8 Working together with individuals and communities to tackle health inequalities and improve life chances.

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

2.8.1 Our strategic aims and priorities during 2022-23

We are committed to the local implementation of Greater Glasgow and Clyde's Public Health Strategy: Turning the Tide through Prevention which requires a clear and effective focus on the prevention of ill-health and on the improvement of wellbeing in order to increase the healthy life expectancy of the whole population and reduce health inequalities. This includes a commitment to reduce the burden of disease through health improvement programmes and a measurable shift to prevention and reducing health inequalities through advocacy and community planning.

The significance of health inequalities has been brought into even sharper focus as a result of the Covid-19 pandemic. We will continue to work together with community planning partners to improve health and wellbeing outcomes for our most disadvantaged localities and those who have been disproportionally impacted by the pandemic. We will also work collaboratively with local and regional partners to develop our understanding of health inequalities in East Renfrewshire and changing patterns of need as we recover from the pandemic.

Longer-term, the HSCP will continue to support community planning activity that aims to tackle the root causes of health inequalities as reflected in our Community Plan (Fairer EastRen). This includes activity to address child poverty, household incomes and strengthen community resilience. We will continue to promote digital inclusion with a particular focus on supporting people to live well independently and improve health and wellbeing.

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Our aim is to **tackle health inequalities and improve life chances**, by:

- Increasing activities which support prevention and early intervention, improve outcomes and reduce inequalities;
- Reducing health inequalities will be reduced by working with communities and through targeted interventions.

2.8.2 The progress we made in 2022-23

- Our premature mortality rate remains significantly below the national average at 334 per 100,000 (Scotland 457)
- 17.9% of infants in our most deprived areas (SIMD 1) were exclusively breastfed at the 6-8 weeks – significantly up from 7.5% for the previous year (2020-21 figure)
- 92% of adults report they are able to look after their health very well or quite well (Scottish average is 91%)
- Male life expectancy at birth in our 15% most deprived communities is 74.7 compared to 72.1 for Scotland.
- Female life expectancy at birth in our 15% most deprived communities is 79.8 compared to 77.5 for Scotland.

2.8.3 How we delivered in 2022-23

We have seen significant improvement in the past year in the percentage of children exclusively breast fed within our most deprived neighbourhoods (data to 21/22). Barrhead is an area of higher deprivation within the HSCP with SIMD 1 and 2 with lower **breast feeding** rates in comparison to our Eastwood area.

Health Visitors (HV) signpost parents within Barrhead to the breastfeeding group in the Dunterlie area which is celebrating it's one year anniversary on the 9th June which will be during Scottish Breast Feeding week. To date, 114 mums have attended this group for breast feeding support.

The Barrhead HV team continue to follow an enhanced pathway in the early postnatal weeks to provide additional support for mothers within areas of SIMD 1 and 2 to provide extra support to mothers that are breast feeding. With the introduction of the antenatal pathway in June 2022, this has allowed for early discussions on breast feeding with all mothers

Promoting breast feeding across services

East Renfrewshire have been in the relatively unique position of having a Health Visitor seconded to the (Children and Families) Intensive Support Social work team since November 2021, supporting vulnerable families living within SIMD 1 and 2. This HV has delivered a **breast feeding awareness session** to the Intensive Support Work team. The Health Visitor is planning further Breast Feeding advocacy and culture sessions with other social work staff in the Request for Assistance Team, Youth Intensive Support Team followed by Children and Families social work team by June 2023. This training will help to improve the knowledge, skills and confidence of the social workers supporting mothers to breast feed.

East Renfrewshire HSCP are represented on the NHSGGC Digital Public Health Group. East Renfrewshire Health Improvement team are preparing information for frontline navigators on key developments such as **MyApp: My Mental Health** hosted by NHS Scotland Right Decision System.

Following the success of the **Digital Literacy Sessions** delivered by Public Health Resource unit and Health Improvement for 50 Library Staff, a bespoke session is in design for HSCP staff. To support frontline navigator roles and other HSCP staff, a programme of training is being collated starting with **Big Health – Digital Health**.

Health Literacy sessions are being developed in partnership with the Public Health Resource Unit. These sessions will be for HSCP staff as part of an ongoing training package that will complement the new Supporting People Framework.

Smoking cessation continues to provide telephone support to East Renfrewshire residents. The service is promoted at the Food Share in Dunterlie Resource Centre. Health Improvement have developed a targeted campaign to raise awareness of the Quit Your Way Pregnancy Service and the gift card incentive programme.

East Renfrewshire Health Improvement has supported the review and launch of the **Your Body Matters** Primary Educational Curriculum Pack. The pack will be available to all Primary Schools across East Renfrewshire May 2023.

The HSCP continues to support **physical activity programmes** in partnership with East Renfrewshire Culture and Leisure. Highlights of the HSCP/ERCL partnership – Vitality Test of Change include:

- Significant increases in occupancy rates
- Strong partnerships formed with key staff
- Baseline testing completed successfully
- Positive impacts reported from participants

VAER contract has been extended to June 30 2024 for the delivery of Community Health Walks and Strength and Balance classes. Currently 11 walks / per week with an average of 89 walkers per week (2 walks are Dementia and Cancer friendly). Seven strength and balance classes / week with an average of 60 walkers per week.

GCA (Glasgow Council on Alcohol) have been commissioned to deliver: alcohol awareness, alcohol screening, Alcohol Brief Interventions, and alcohol counselling.

- **Oct - Dec 22** - focus on mapping, promotion of service
  38 screenings
  18 Alcohol Brief Interventions
  2 Alcohol Counselling sessions
  2 referrals
- **Jan - Mar 23**
  235 screenings
  173 Alcohol Brief Interventions
  48 Alcohol Counselling sessions
  6 referrals

East Renfrewshire Health Improvement has supported development of an **Early Years Mental Health Framework**. Consultation is ongoing as to the preferred format and an equality impact assessment is underway. The framework will be ready for implementation across the HSCP by the end of summer.

East Renfrewshire HSCP has supported development of a **Relationships and Sexual Health online toolkit** for carers, families and staff supporting care experienced children and young people. We want to make sure that children and young people with care experience can access this too, and that the support they receive is right for them.

In partnership with Sandyford, the **Sexual Health Clinic for young people** will be reintroduced at Barrhead Health Centre. Health Improvement will support communications and aim to reduce barriers to booking and attending the clinic. East Renfrewshire has one the lowest rates of free condom distribution. Health Improvement are scoping opportunities for new distribution sites including leisure facilities. Communications on the new young people clinic and free condom service are included in upcoming activity.

Supporting local activity to tackle Child Poverty and mitigate its effects

Health Improvement and the Health Visiting team are working together to develop a Formula Milk Pathway following the scoping document Pathway to Support Families in Need of Emergency Formula Milk produced by NHSGGC. Formulas have increasing in price by as much as 14% and there are reports of unsafe feeding practices. This will provide guidance

on emergency provision in line with Unicef Breastfeeding Friendly standards and align to the child poverty plan.

Health Improvement are liaising with Nutrition Scotland to provide Community Nutrition Train the Trainer course for third sector and volunteers. REHIS Food Hygiene Refresher places are also on offer incorporating information on Natasha's Law.

Asset mapping for food banks, food shares & larders is complete. Health Improvement are exploring opportunities to look at free condom provision and other health needs via these assets.

Childsmile Nursery sees the highest level of engagement in East Renfrewshire with 22 out of 37 preschool and nursery establishments participating.

East Renfrewshire Health Improvement staff represent the HSCP on the NHSGGC Financial Inequalities Group.

Through the Early Years Child Poverty delivery programme priority groups engaged with services from East Renfrewshire include:

- Lone Parents - 60%
- Child Under 1 – 44%
- Family with more than 3 children – 16%
- Referrals & financial gain from the Q4 22/23 report logged 52 referrals, 30 of which were from HVs, 1 midwife totalling £11,443

The partnership continues to work to **understand the needs** of the population and address longer term impacts from the pandemic on our communities and protected characteristic groups. The NHSGGC Health & Wellbeing Survey 2022 has a total target of 1070 interviews across East Renfrewshire. To date, 844 have been carried out and 226 remain outstanding. The East Renfrewshire report is due for completion 27th October 2023. Information has been collated to assess: current health improvement programmes; condition specific information; and available support. **Scoping activity** is underway to align to the electronic Holistic Needs Assessment (eHNA) and potentially preventative input to the Supporting People Framework. East Renfrewshire Health Improvement team are members of the NHSGGC **Screening Inequalities Working Group**. Screening uptake is under review for the localities and uptake by datazone has been requested to the Public Health Programme Manager.

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2.9 Working together with staff across the partnership to support resilience and wellbeing

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

2.9.1 Our strategic aims and priorities during 2021-22

We rely on our workforce to support all aspects of health and social care and their wellbeing and resilience has never been more important. The HSCP has established a health and wellbeing 'champion' who contributes to discussions at a national level and we have appointed a dedicated Health and Wellbeing Lead Officer for the wider partnership. A local Health and Wellbeing Group has been established to support the workforce across the partnership. The group is chaired by Head of Recovery and Intensive Services who also holds the national champion role. The group have put in place a wellbeing plan entitled 'You care….We care too.'

Our activity aligns to the NHSGGC Mental Health and Wellbeing Action Plan and national objectives. We will continue to input at a national level to the health and wellbeing conversation and to the development and delivery of the NHSGGC vision to support the mental health and wellbeing of staff. This includes ensuring rest and recuperation, peer support, helping staff fully utilise their leave allowance, and ensuring working arrangements are sustainable in light of continuing constraints and reflect ongoing changes to services and pathways.

Our aim is to **support resilience and wellbeing among staff across the partnership**, by:

- Ensuring staff have access to resources and information that can improve their wellbeing;
- Ensuring staff feel connected to their team or service and we embed a health and wellbeing culture across the partnership;
- Promoting opportunities for staff to take part in physical activity, rest and relaxation;
- Ensuring staff feel safe in the work place.

2.9.2 The progress we made in 2022-23

Supporting staff wellbeing remains a key focus of the partnership especially as we experience continuing pressures following the pandemic. The way staff have been working has changed significantly with home working becoming the norm for large groups of employees. Our dedicated Health and Wellbeing Lead is in place with responsible for the implementation and delivery of wellbeing programme across the health and social care landscape. The lead has had significant success to date, with comprehensive options in place. Support is accessible to HSCP staff, Care Homes, Primary Care, Care Providers, Third and Community Sector (staff and volunteers). This role has been specifically designed to acknowledge the growing pressures and challenges upon the health and social care workforce, and to create resources, tools and services to support the health and wellbeing of all staff and volunteers who work for and support the HSCP.

Headline performance data includes:

- 85% of staff agreed that "My manager cares about my health and wellbeing" – down from 88% in previous iMatter staff survey
- 71% agreed that "I feel involved in decisions in relation to my job" – consistent with 72% in previous survey

- 74% agree that “I am given the time and resources to support my learning growth” – consistent with 75% in previous survey

2.9.3 How we delivered in 2022-23

During 2022-23 we continued to ensure that all staff have access to universal information with regard to health and wellbeing across the partnership’s services. New **wellbeing information points** have been created at both Health Centres to promote universal information sharing. Ongoing **networking** takes place through meetings such as the Scottish Government wellbeing champion meeting, Participation and Engagement Network, Community and third sector network meetings. Work is ongoing to promote wellbeing across the partnership e.g. foster and kinship carers, commissioned services, hosted services, volunteers.

There has been ongoing focused work to engage managers in forum to develop **leadership competencies** relating to wellbeing e.g. managers wellbeing forum held in March 2023 at both health centres. The next step is to hold live online forum to continue gather views/needs of managers. Managers have ongoing access to all current wellbeing offers and training opportunities, including specific team wellbeing events.

We continue to work to ensure that regular **wellbeing conversations** are taking place between staff and teams. Staff are offered 1-to-1 wellbeing conversation support and teams have the opportunity to participate in wellbeing related activities such as **focussed team wellbeing events**. As a partnership we are working to embed wellbeing conversations in team meetings and supervision.

During the year, the Health and Wellbeing Lead has been promoting **relaxation, emotional support, physical activity** opportunities and practical support across the partnership. There is also a variety of focussed work ongoing to support teams facing particular challenges, including Homecare, care homes, and GP Practices. Other services are supported as and when there is a particular challenge e.g. when a service is being inspected or if there is an investigation taking place, or if a particular service require bespoke wellbeing support.

2022-23 has also seen development of **wellbeing spaces** (indoor and outdoor) to promote positive and safe use of spaces, and to support increased participation in wellbeing related activities, and nourish a positive wellbeing environment, both practically and aesthetically. This has included:

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- Development of outside spaces at both Health Centres (ongoing), to offer wellbeing spaces for activities and promote wellness.
- Wellness rooms development at both Health Centres to support wellbeing.
- Various services e.g. Care homes and GP Practices supported to develop spaces to promote positive wellbeing.
- Development of ergonomic spaces at both Health Centres (ongoing).

2.10 Protecting people from harm

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

2.10.1 Our strategic aims and priorities during 2022-23

Fundamental to the work of the HSCP and cross-cutting the other strategic priorities set out in our Strategic Plan, is our responsibility to keep people protected and safe from harm. Everyone has the right to live in safety and be protected from neglect, abuse and harm. Our partnership has a key role in helping to keep vulnerable people in our communities safe and in preventing harm and supporting people at risk of harm. We deliver these through a variety of multi-agency public protection arrangements including: Child Protection; Adult Support and Protection; Violence Against Women Partnership; Multi-Agency Management of Offenders (MAPPA) and the Alcohol and Drugs Partnership. We also respond to new risks and vulnerabilities as these emerge, taking actions with our partners to prevent and respond and learning from each other to improve the ways we support and protect vulnerable people.

2.10.2 The progress we made in 2022-23

- Improvement in domestic abuse outcomes women – 90% increase by 3% - target met.
- Improvement in domestic abuse outcomes children – 82% decrease by 2% - target met.
- People agreed to be at risk of harm and requiring a protection plan have one in place – continues to be 100% of cases

2.10.3 How we delivered in 2022-23

As we work to protect adults at risk from harm we will continue to respond to the changing needs that have arisen as a result of the pandemic. Through the delivery of our multi-agency **Adult Protection Improvement Plan 2021-23** we continue to focus on: ensuring that adults at risk, their families and carers views are heard and help shape the way we deliver services; making best use of all our opportunities for the prevention and identification of harm; and ensuring that we offer supports and services which meet the needs of Adults at risk of harm and those who support them.

Since the start of the pandemic we have developed stronger relationships between partner agencies, promoting an approach to **adult support and protection (ASP)** that keeps all partners involved and included in discussions and planning, particularly in our routine ASP work and in the undertaking of Large Scale Investigations. We have seen increased partnership working with a focus on keeping adults and their families and carers engaged and informed.

East Renfrewshire HSCP received 1,810 ASP referrals and 1,422 adult welfare concern referrals between January 2021 and January 2023.

East Renfrewshire HSCP, over the past three years, has completed an ambitious improvement journey to ensure adults at risk of harm are supported to live safely. These improvements have been supported by the development and regular review of our ASP local operating procedures and our commitment to early intervention, prevention and supporting community capacity building.

We operate a single point of contact for all ASP and adult welfare concern referrals. Created in June 2020 the dedicated ASP team was established as a test of change to strengthen our initial response to harm during the early stages of the pandemic. This dedicated team has

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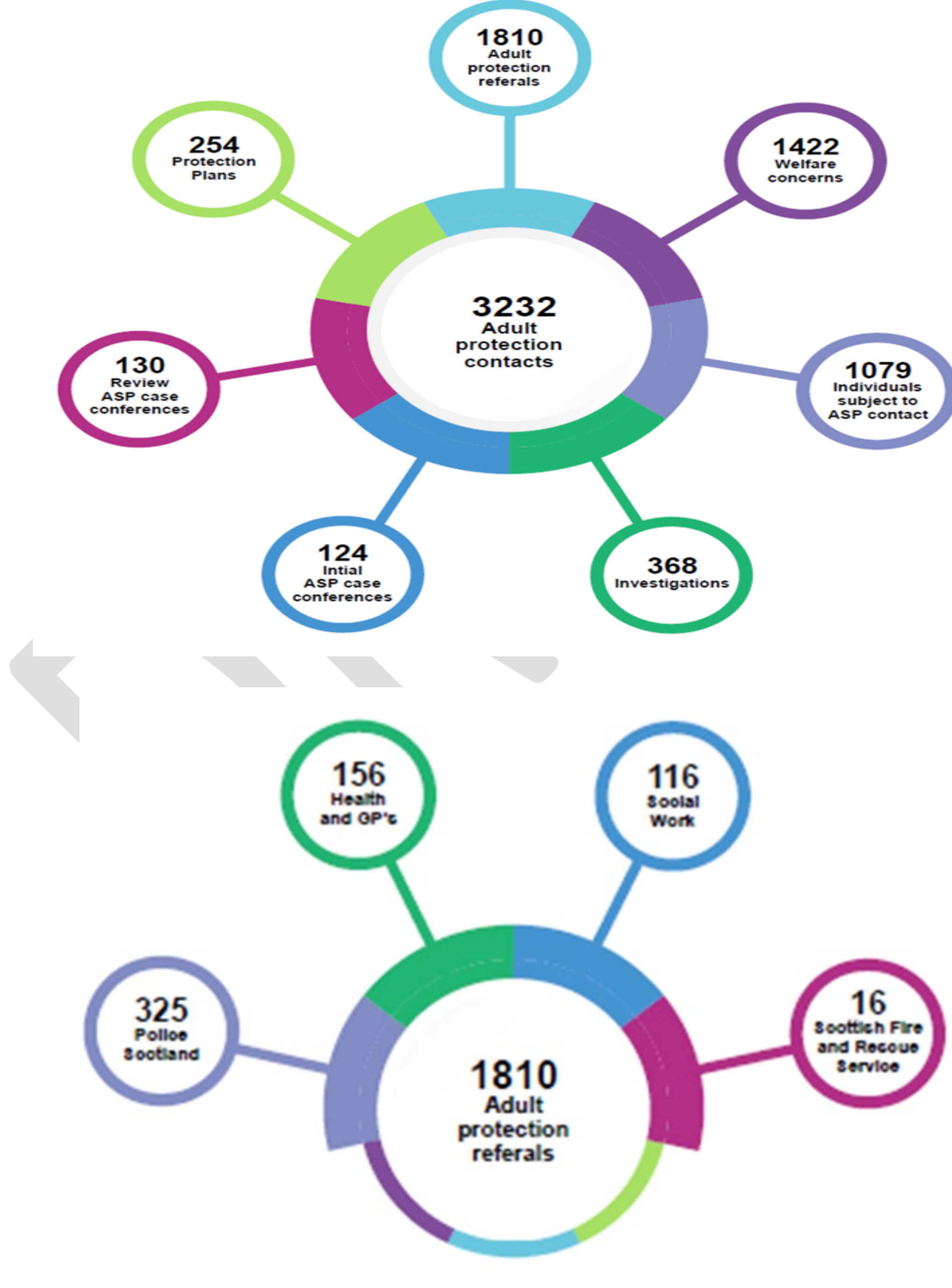
greatly strengthened our response to ASP activity locally and led improvements across the HSCP. Due to the success of this model and positive feedback from colleagues and partners across East Renfrewshire, we resourced this model on a permanent basis (funded by SG Strengthening Adult Social Work funding stream) from November 2021 onwards.

The dedicated ASP team has greatly strengthened and streamlined our approach to screening and triaging adult protection referrals and application of the 3-point test. The team have provided coaching and mentoring support to council officers across the HSCP and strengthened relationships between locality services, external partners, and Police and Fire Service colleagues. The ASP Team is supported on a rota basis by council officers and managers across the HSCP.

East Renfrewshire Adult Support and Protection in numbers - 2021- 2023[1]



[1] ASP data, 30 January 2021-30 January 2023

What we know about the adults subject to ASP inquiries:

60% were female

Average age of 70 years old

56% experienced harm in own home

32% experienced physical harm

23% were adults experiencing problems arising from infirmity due to age

Some experiences of the ASP process in East Renfrewshire

"Maggie's daughter feels that the support provided to her mother had allowed her to become happier and less distressed in her home and kept her safe, and that the regular reviews had provided her with a support structure during a difficult time."

"The framework of a protection plan helped Ron to build trusting relationships with his support team. Now Ron is often the first to raise concerns and feels safer in his home and able to ask for the support he needs"

"The ASP process allowed all involved in supporting Tracey the opportunity to share and consider information that allowed for an effective discharge plan. Tracey, to this day, is maintaining sobriety, living independently and engaging with supports in place, with no further ASP concerns being raised."

During 2022-23, the partnership received a **Joint Inspection of Adult Support and Protection** carried out by the Care Inspectorate in collaboration with Healthcare Improvement Scotland and HM Inspectorate of Constabulary in Scotland. The inspection reported in June 2023 and reported the following key strengths at the partnership:

- Adults at risk of harm experienced improvements in their circumstances because of timely, person-centred, and efficient adult support and protection interventions.
- The overall quality and effectiveness of core adult support and protection processes was a key strength for the partnership.
- Initial inquiries and investigations were highly effective and always determined the correct outcome for adults at risk of harm.
- Oversight of key processes supported staff and ensured consistent robust decision making for adults at risk of harm.
- Strategic leadership for adult support and protection was enthusiastic and focused. This supported targeted and meaningful improvements.
- The adult protection committee offered strong leadership for adult support and protection and offered effective oversight for the delivery of key processes.
- Strategic leaders promoted a culture of learning and continuous improvement which supported the development of adult support and protection services for adults at risk of harm.
- Health was a strong adult support and protection partner. Health services delivered innovative, early and effective interventions for adults at risk of harm.

The inspection set out a number of priority areas for improvement, including: improving the quality of chronologies; greater involvement of adults at risk of harm and their unpaid carers at a strategic level; enhanced multi-agency quality assurance practices; and, building on existing practice to ensure the full involvement of all key partners in relevant aspects of ASP practice going forward.

As part of our work to protect people from harm and abuse, we have established and continue to support a **Multi-Agency Risk Assessment Conference (MARAC)** in East Renfrewshire for high-risk domestic abuse victims. Since the start of the pandemic we have seen higher numbers of referrals to MARAC and greater levels of complexity in the cases being dealt with. We continue to work together with **East Renfrewshire Women's Aid Service** to provide direct support for women and children who have experienced domestic abuse.

In 2022-23 we continued to see an increase in support required as a result of domestic abuse / violence against women through MARAC. 134 victims and 195 children were discussed at MARAC - an increase of 7.2% compared with 2021-22. These discussions involved 195 children (reduction of 5% from the previous year). 32% of victims did not have children compared to 26% the previous year. Women without children were not previously visible in the domestic abuse pathway demonstrating increased awareness and risk assessment and improved pathway response.

MARAC referrals from all statutory services nationally continue to be low overall and may suggest that unless a victim in Scotland reports domestic abuse to the Police or seeks out support from a specialist domestic abuse service, they are unlikely to be referred to their local MARAC. This is not the case locally as East Renfrewshire demonstrates a higher proportion of referrals from children and families and wider statutory services (38%) compared to 10% nationally and therefore are able to capture families that might not be known to another services.

Ensuring staff are aware of the referral pathways and supports available

- We have implemented a comprehensive training programme on Domestic Abuse/MARAC and Safe and Together practice which details the referral pathway and range of supports available.
- Regular communications on domestic abuse are provided to all staff on the supports available.
- Monthly domestic abuse advice session are delivered by two senior domestic abuse practitioners and are available to any member of staff to discuss and seek advice on any aspect of domestic abuse practice
- Each year we develop and implement a comprehensive communications campaign and events/workshops targeting both public and staff on domestic abuse and gender based violence as part of the 16 days of action campaign on gender based violence. In 2021 and 2022 we supported 40 targeted events for staff.
- This included events/workshops on domestic abuse, sexual violence, honour based violence, commercial sexual exploitation, mentors in violence prevention programme, trauma enhanced practice training, embedding safe and together - creating domestic abuse informed systems, services and workforce, violence against women and mental health, violence against women and young people, coercive control in children's lives, the impact and dynamics of LGBTI people's experiences of domestic abuse, multi-agency risk assessment conference, perpetrator engagement and interviewing and responding to domestic abuse, sexual offences and stalking.

During the period, **East Renfrewshire Women's Aid Service** supported 1,086 people in 2022-23, a reduction of 11% from the previous year. This reduction primarily relates to decrease in calls to the helpline and duty which had increased significantly since the start of the pandemic. It appears that the service is now moving back towards levels of demand experienced pre-pandemic.

My support worker's first call was amazing. She calmed me as I was a total mess, and my life was in turmoil

I look forward to getting up in the morning which was not the case before I contacted Women's Aid – a life saver!

Friendliness and care have given me hope and you've never let me down. You've saved my life when I was on the floor

Providing domestic abuse induction training to all new staff

- Equally Safe at Work is an employer accreditation programme developed by Close the Gap piloted across councils across Scotland. The programme aims to support employers to improve their employment practice to advance gender equality at work, and prevent violence against women. East Renfrewshire is a shadow participant in Close the Gap Equally Safe at Work Programme.
- East Renfrewshire are one of seven areas in Scotland to participate in the national Equally Safe in Practice Workforce Pilot. This includes working collaboratively to implement and evaluate three new core e-learning modules – Together for Gender Equality, Understanding Domestic Abuse and Understanding Sexual Violence.
- The modules are aimed at staff across all levels, roles and responsibilities and intend to build a basic understanding of gender, gender inequality and the dynamics and impact of violence against women and girls. Learners are supported to consider what they can do within their role to respond to those affected, and how they can contribute to making their organization and communities safer and more equal.
- We have completed the pilot phase with over 100 staff in East Renfrewshire enrolled to complete the first e-module on gender equality. Findings from the national evaluation have been positive with the majority of learners demonstrating improved knowledge, increased confidence and clear ways to utilize the learning in their practice. From considering their interactions with colleagues or the public more carefully, to challenging assumptions and recognizing the importance of listening, believing, supporting and signposting. The next phase will seek to roll out the program and embed the e-modules as mandatory core training for all staff.

Copy of national learning report here https://womensaid.scot/equally-safe-in-practice-pilot-evaluation/

Making domestic abuse resource tools available to all staff

A wide range of domestic abuse informed resource tools are available for all staff to support their practice.

- East Renfrewshire have implemented Safe and Together gold standard child protection domestic abuse training. It is supported by an internationally recognised suite of tools and interventions which are designed to help practitioners and professionals improve their awareness and understanding of domestic abuse. Safe and Together is based on three key principles:
  - Keeping children Safe & Together with their non-abusive parent, ensuring safety, healing from trauma, stability, and nurturance.
  - Partnering with the non-abusive parent as a default position ensuring efficient, effective, and child-centred practice.
  - Intervening with the perpetrator to reduce the risk and harm
- We have implemented the Multi Agency Risk Assessment Conference (MARAC) process in East Renfrewshire. The MARAC provides a structured, partnership response to high-risk cases of domestic abuse and is embedded in our strategy and quality assurance processes.
- MARAC is underpinned by a comprehensive risk assessment. The DASH Risk checklist helps frontline practitioners to identify high risk cases of domestic abuse, stalking and 'honour'- based violence and provides a shared understanding of risk to support decision making on which cases are referred to MARAC and what other supports may be required.
- Both Safe and Together and MARAC are recognised as best practice both nationally and locally and reflected in the recent Care Inspectorate Report Inspection of services for children and young people at harm in East Renfrewshire.

Copy of report here: https://www.careinspectorate.com/index.php/news/6792-a-joint-inspection-of-services-for-children-and-young-people-at-risk-of-harm-in-east-renfrewshire

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2.11 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.

The service continued to operate fully throughout various infection control measures in the recovery phases of the Covid-19 pandemic. This often resulted in intermittent closures to admissions and disruption including challenging absence levels similar to those experienced by the wider health and social care system.

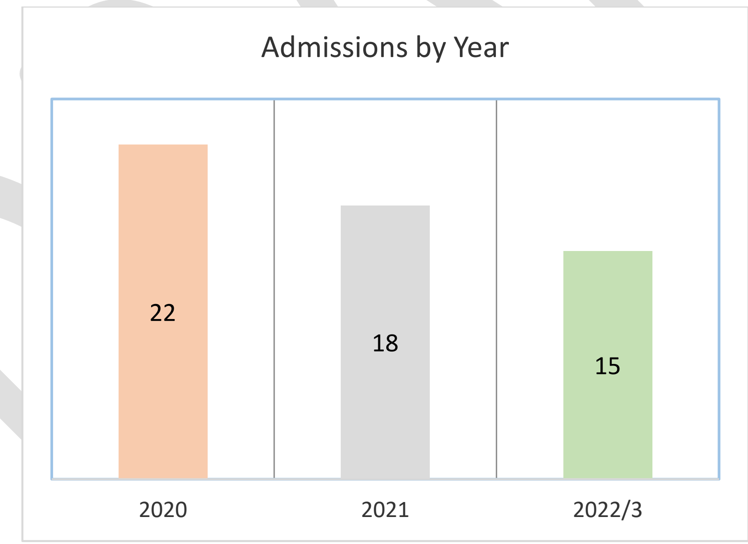
In previous year beds were mainly occupied by people who were admitted due to mental illness (58%). This year that figure dropped to 50% indicating an increase in admissions as a result of challenging behaviour which is not in keeping with the service vision.

Delayed discharge continued to create significant issues, with a number of patients having no discharge plan for a significant period of time nor a home to return to. The reasons for delay were due to no suitable accommodation and/or no providers in place and/or providers in place having real difficulty with recruitment which continues to affect current patients.

People are still more likely to be discharged within a reasonable timescale if their primary reason for admission is due to mental ill health.

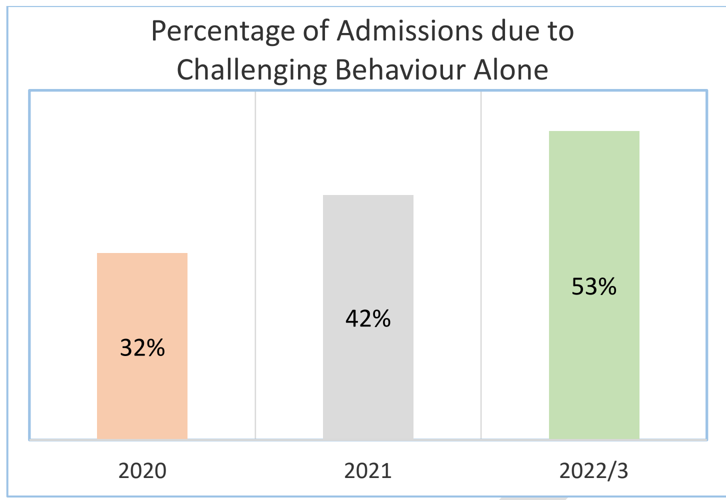
There has been an increase in the number of admissions for young males.

Admissions



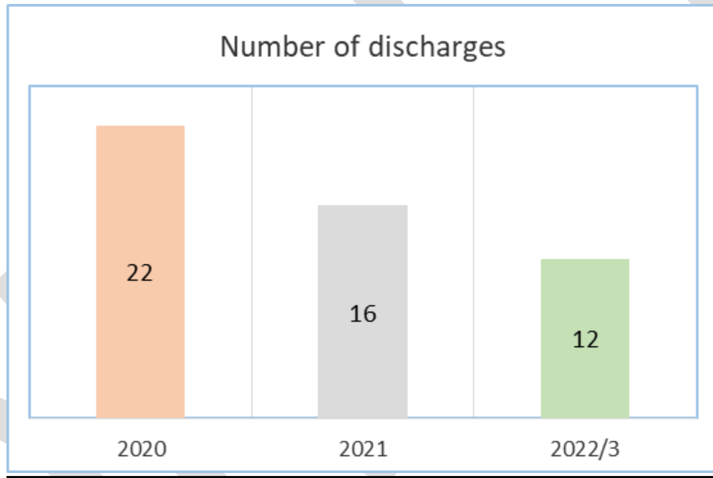
In total, 15 people were admitted to the service in 2022-23. This is a reduction of three from the previous year and relates directly to a smaller number of discharges and increasing lengths of stay / delays. However, more people were admitted than discharged due to the use of a contingency bed in Claythorn.

Of the total numbers of referrals received 10 of the patients were admitted directly to the service (76%), the remaining people were initially admitted to general adult mental health and later transferred.

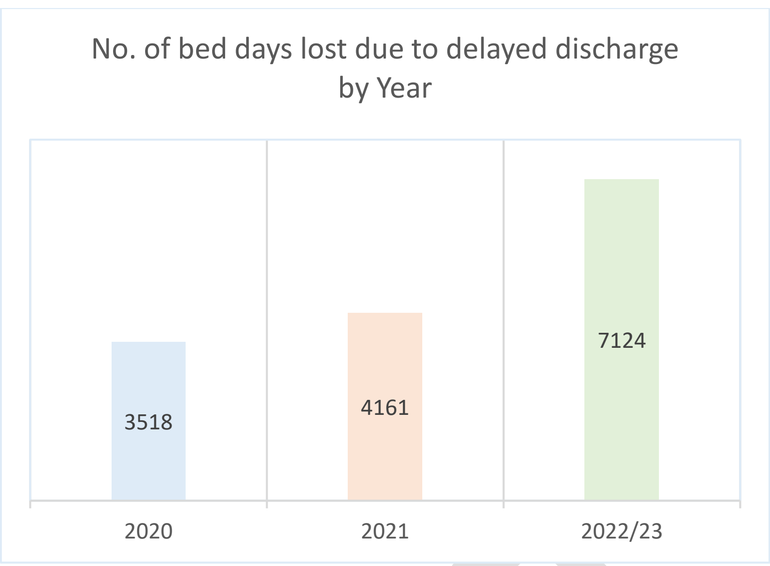


There was an increase in admissions due to challenging behaviour alone from previous years (53% compared to 42% in 2021). This is largely proving to be as a result of instability in community supports for a variety of reasons with staffing being a major concern.

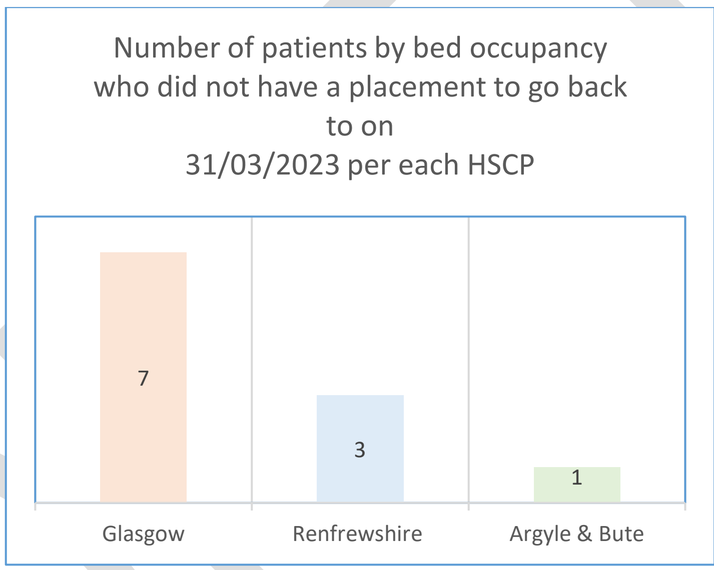
Discharges



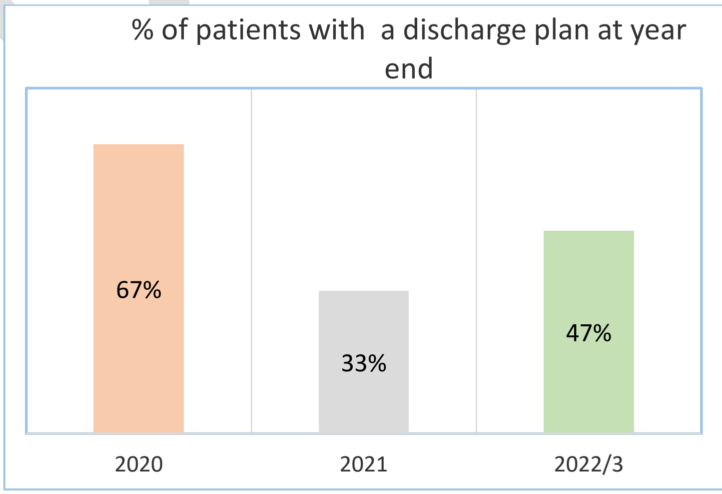
12 patients were discharged in 2022-23 and 2 people died while in our care. Discharges were lower than previous years: 16 discharges in 2021; and 22 in 2020. One person discharged was re-admitted in the same year (2021) as a result of placement breakdown. The average length of stay for those patients discharged was 240 days if the person had a home to return to. If a new home and support is required the average is 2072 days (5.6 years).



There was a 42% increase in beds days lost due to delayed discharge from 2021 to 2022/23.

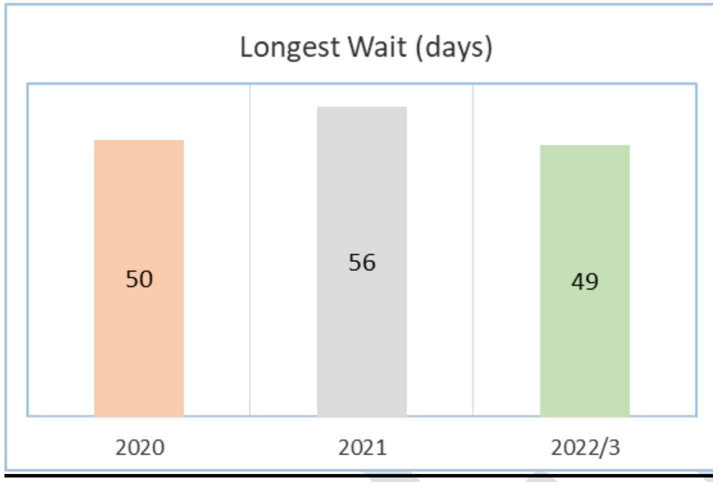


11 inpatients on 31 March 2023 did not have a discharge plan / community placement. This significantly reduces the ability of the service to successfully manage patient flow.



Only 47% of inpatients had a discharge plan on the 31 March 2023.This was a significant reduction in the number from the previous years of 67%. Some patients have been waiting a long and unacceptable time for discharge. One patient has been waiting to move out of learning disability hospital provision since March 2019.

Waiting times



The longest wait for a bed was **49** days, a reduction from the previous year. This patient went first into a mental health bed before being transferred to a Learning Disability bed.

As a result of continuous occupancy, the service is often unable to directly admit people requiring specialist learning disability assessment and treatment.

A group of people were removed from the waiting list as admission was no longer required or an alternative had been established.

Developing the Speciality Learning Disability In-patient Service

NHS GGC HSCPs had committed to working together in 2019 to take forward a **programme of redesign** of inpatient services, the emphasis being on improving our responses in the community to reduce the use of inpatient beds when not clinically required. We had highlighted a need to review and improve performance in delayed discharge and have worked positively with Scottish Government to shape the original 'Coming Home' report in 2018 – this led to the publication of the recent 'Coming Home Implementation' 2022 report.

Alongside this, the allocation of the **Community Living Change Fund** aligns to NHS GGC ambitions to redesign services for people with complex needs including learning disabilities and autism, and for people who have enduring mental health problems. East Renfrewshire is leading on this work and have established a programme board which will provide strategic leadership and governance and direct the work of the community and inpatient redesign going forward. Avoiding admission and preventing placement breakdown is a key priority to addressing delayed discharges.

Performance has deteriorated across 22/23 with fewer discharges and higher delays negatively impacting on our ability to admit directly to the LD service when this is appropriate. HSCPs and third sector organisations report significant challenges in provider recruitment, staff retention, we are seeing the negative outcomes of in terms of discharge activity. We are also seeing instability in community supports for similar reasons including

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turnover of staff having a negative impact where consistency in care and support is essential.

We have developed a **multi-agency collaborative group**, including all HSCPs, Commissioning, Third Sector and Housing colleagues. This has a delayed discharge work stream chaired by a third sector Chief Executive. The aim of this group is to encourage and influence different practice which may address some of the historical and more recent difficulties.

East Renfrewshire has also led on the Scottish Government's Implementation group with the Head of Service chairing the Dynamic Support Register sub group which will result in a **nationally agreed pathway** based on early intervention to avoid admission. This has been agreed by COSLA and Government and is to be launched to all Boards / HSCPs in May 2023.

As part of the inpatient redesign we are exploring **alternatives to inappropriate admission** and in 2022/23 the inpatient service provided day support as an alternative to admission. Due to the provider challenges the provider was unable to maintain this leading to full admissions.

We have developed a **community and inpatient redesign group**, chaired by inpatient and community colleagues. The aim of this group is to focus on local developments within the HSCPs, developing enhanced community responses and identifying the impact local developments will have on the inpatient redesign, take forward bed closure and alternatives to admission and the closure of our long stay unit.

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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 2022-23 is our statutory financial report for the year. We regularly report our financial position to the IJB throughout the year.

3.2 Financial Performance 2022/23

The annual report and accounts for the IJB covers the period 1st April 2022 to 31st March 2023.The budgets and outturns for the operational services (our management accounts) are reported regularly throughout the year to the IJB, with the final position summarised:

Service	Budget	Spend	Variance (Over) / Under	Variance (Over) / Under
	£ Million	£ Million	£ Million	%
Children & Families	14.741	14.281	0.460	3.12%
Older Peoples Services	25.619	24.085	1.534	5.99%
Physical / Sensory Disability	6.309	6.090	0.219	3.47%
Learning Disability – Community	17.902	18.629	(0.727)	(4.06%)
Learning Disability – Inpatients	9.559	9.591	(0.032)	(0.33%)
Augmentative and Alternative Communication	0.265	0.265	-	0.00%
Intensive Services	16.089	16.735	(0.646)	(4.02%)
Mental Health	5.729	5.392	0.337	5.88%
Addictions / Substance Misuse	1.626	1.543	0.083	5.10%
Family Health Services	28.923	28.921	0.002	0.01%
Prescribing	17.098	17.872	(0.774)	(4.53%)
Criminal Justice	0.029	(0.001)	0.030	103.45%
Finance and Resources	1.972	1.868	0.104	5.27%
Net Expenditure Health and Social Care	**145.861**	**145.271**	**0.590**	**0.40%**
Housing	0.486	0.486	-	-
Set Aside for Large Hospital Services	29.075	29.075	-	-
Total Integration Joint Board	**175.422**	**174.832**	**0.590**	**0.40%**

The £0.590 million operational underspend (0.40%) is marginally better than the reporting taken to the IJB during the year and this underspend will be added to our budget phasing reserve. The main variances to the budget were:

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- £0.460 million underspend in Children and Families was mainly from care package costs and some staff vacancies.
- £1.534 million underspend within Older Peoples services was mainly from purchased nursing and residential care. This reflects the ongoing trend of reduction in nursing and care home admissions but does offset the increase in community activity, particularly in Care at Home. Given this continued trend budgets have been realigned in 2023/24 to recognise this shift in type of care.
- £0.646 million overspend within Intensive Services as our care at home costs reflect that we continue to see high demand post pandemic and we had additional costs delivering the service with diminished capacity, particularly over the winter period.
- £0.726 million overspend within Learning Disability Community Services mainly from care package costs, partially offset by staff vacancies. We have recognised this cost pressure in the 2023/24 budget, which in turn has added to our funding gap and associated saving requirement.
- £0.774 million overspend in the cost of prescribing as we saw increases in the volume of items prescribed and the costs are impacted by the economic climate and supply chain issues, compounded by Brexit and the war in Ukraine. This overspend is after the £0.456 million balance of the smoothing reserve, set up to meet fluctuation, was fully used.

The financial performance table bvelow includes the £4.564 million we spent on Covid-19 activity and as this was fully funded by the Scottish Government through the ring-fenced reserve balance we brought into 2022/23. Our Covid-19 related spend of £4.564 million was reported to the Scottish Government as part of the Local Mobilisation Plan submitted by NHS Greater Glasgow and Clyde Health Board.

Our local spend was significantly less than the prior year reflecting the changes to Scottish Government guidance on financial support to adult and social care providers, testing and public health policies in relation to Covid-19 and cessation of support for unachieved savings compared to the funding provided to IJBs, at the end of financial year 2021/22. This has resulted in the Scottish Government reclaiming surplus Covid-19 reserves to be redistributed across the wider health and care sector to meet current Covid-19 priorities. For East Renfrewshire HSCP this represented a return of surplus Covid-19 reserves of £4.7 million and this was in line with the level of reserves reclaimed from other HSCPs across the country.

The IJB receives regular and detailed revenue budget monitoring throughout the year.

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

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2021/22 £000	Services Prvided to East Renfrewshire IJB by Other IJBs within NHSGGC	2022/23 £000
435	Physiotherapy	476
43	Retinal Screening	50
474	Podiatry	788
289	Primary Care Support	306
342	Continence	419
600	Sexual Health	631
990	Mental Health	1,183
789	Oral Health	978
350	Addictions	374
209	Prison Health Care	232
171	Health Care in Police Custody	156
3,846	Psychiatry	4,032
8,538	**Net Expenditure on Services Provided**	**9,625**

We also host the Specialist Learning Disability In-Patient Services and Augmentative & Alternative Communication (AAC) services on behalf of the other IJBs within the NHS Greater Glasgow & Clyde. The cost of these two hosted services are met in full by East Renfrewshire. The use by other IJBs is shown below for information.

2021/22 £000	Learning Disability In-Patient Servies Hosted by East Renfrewshire IJB	2022/23 £000
5,655	Glasgow	6,872
1,993	Renfrewshire	1,834
551	Inverclyde	521
310	West Dunbartonshire	291
-	East Dunbartonshire	-
8,509	Learning Disability In-Patients Services Provided to other IJBs	9,518
313	East Renfrewshire	73
8,822	**Total Learning Disability In-Patient Services**	**9,591**

2021/22 £000	Augmentative and Alternative Communication (AAC) Hosted by East Renfrewshire IJB	2022/23 £000
97	Glasgow	124
22	Renfrewshire	27
26	Inverclyde	32
4	West Dunbartonshire	5
22	East Dunbartonshire	27
171	AAC Services Provided to other IJBs	215
40	East Renfrewshire	50
211	**Total AAC Services**	**265**

3.3 Reserves

We used £16.420 million of reserves in year and we also added £1.714 million into earmarked reserves. The year on year movement in reserves is summarised:

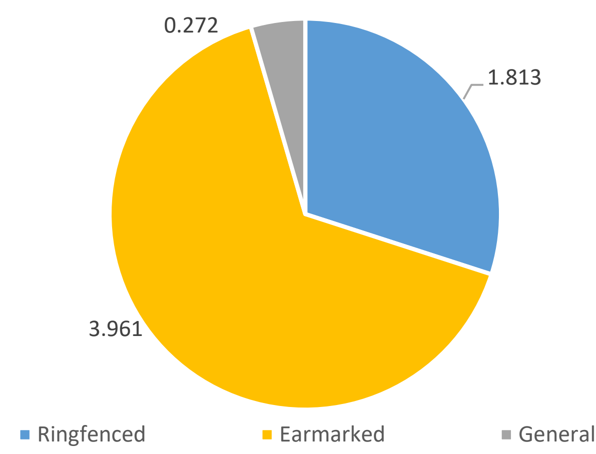
Reserves Movement	£ Million	£ Million
Reserves at 31 March 2022		20.752
Planned use of existing reserves during the year	(16.420)	
Funds added to reserves during the year	1.714	
Net reduction in reserves during the year	(14.706)	
Reserves at 31 March 2023		6.046

The purpose, use and categorisation of IJB reserves is supported by a Reserves Policy and Financial Regulations, both of which were reviewed in September 2022.

The reserves of the IJB fall into three types:

- Ring-fenced: the funding is earmarked and can only be used for that specific purpose
- Earmarked: the funding has been allocated for a specific purpose
- General: this can be used for any purpose

The current balance of £6.046 million for all reserves falls in these three reserves types:



Ring-Fenced Reserves

The majority of the reduction in reserves related to the use of specific ring-fenced funding we received from the Scottish Government and in particular the Covid-19 funding received at the end of 2021/22, as detailed above.

In addition to Covid-19 we also spent £2.64 million ring-fenced reserves during the year and the Scottish Government funding mechanisms put in place for much of these funds meant we needed to use our uncommitted balance prior to drawing any in year funding for programmes such as the Primary Care Improvement Fund and Mental Health Action 15. We have added £0.390 million to our Alcohol & Drugs Partnership reserve. In agreement with the Scottish Government the balance we take into 2023/24 will support the development of a local recovery hub and other committed costs.

The overall reduction in ring-fenced funding during 2022/23 is not unique to East Renfrewshire and mirrors the national position.

Earmarked Reserves

Our earmarked reserves are in place to support a number of projects, provide transitional funding for service redesign, provide bridging finance for in year pressures, add capacity to support service initiatives and to support longer term cost smoothing and timing of spend across multiple years.

Within our earmarked reserves we spent £4.514 million supporting savings and delivering on projects as planned, however it is important to note that our smoothing reserve for fluctuation in prescribing costs and the transition funding to support Learning Disability bed model redesign were both fully utilised in 2022/23.

We have also transferred a number of reserve balances totalling £0.567 million to our budget phasing reserve as agreed during the year by the IJB, recognising the scale of the budget savings in 2023/24. The balance relates to a number of smaller projects and initiatives.

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General Reserves
Our general reserve remains unchanged at £0.272 million and is well below the optimum level at a value of 2% of budget we would ideally hold. The general reserve is currently 0.19% of the 2022/23 revenue budget.

Given the scale of the financial challenge we have faced pre pandemic the IJB strategy to invest where possible in smoothing the impact of savings challenges has not allowed any investment into general reserves. We have recognised whilst this means we are below our policy level, the prioritisation has been on long term sustainability and minimising the impact of savings over time on those services we provide.

We received Covid-19 support for unachieved savings during the first two years of the pandemic and when this stopped we used £2.439 budget phasing reserve in 2022/23 as we work to deliver our legacy savings on a recurring basis. The use of reserves to support savings delivery was an agreed strategy pre Covid-19. Our capacity to deliver change and savings was restricted by operational pressures during 2022/23.

In the event our operational costs exceed budget in 2023/24 we may need to un-hypothecate (i.e. un-earmark) reserves to meet costs.

The use of reserves is reported to the IJB within our routine revenue reporting.

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.

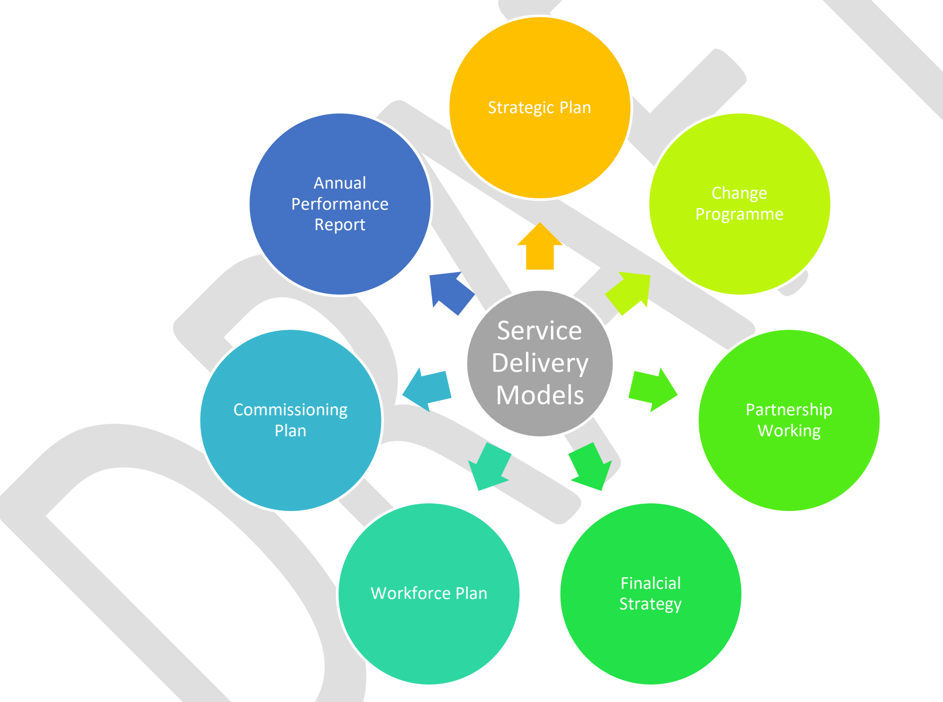
	2022/23	**2021/22**	**2020/21**	**2019/20**	**2018/19**	**2017/18**
SERVICE	**(Over) / Under £ Million**	**(Over) / Under £ Million**	**(Over) / Under £ Million**	**(Over) / Under £ Million**	**(Over) / Under £ Million**	**(Over) / Under £ Million**
Children and Families	0.460	(0.020)	0.410	0.637	0.800	0.083
Older Peoples & Intensive Services	0.888	0.189	0.327	(0.866)	(0.228)	0.153
Physical / Sensory Disability	0.219	0.031	0.099	0.030	0.056	(0.167)
Learning Disability - Community	(0.727)	0.458	(0.267)	(0.095)	(0.047)	(0.214)
Learning Disability - Inpatients	(0.032)	0	0	0.002	0.123	0
Augmentative & Alternative Communication	0	0	0	0	N/A	N/A
Mental Health	0.337	0.136	0.192	0.189	0.419	0.409
Addictions / Substance Misuse	0.083	0.021	0.052	0.013	0.032	0.018
Family Health Services	0.002	0	0	-	0.008	0
Prescribing	(0.774)	0	0	(0.311)	(0.428)	0

Criminal Justice	0.030		0.011	-	0.039	0.011
Planning and Health Improvement	**	0.005	0.065	0.098	0.074	0.001
Management and Admin / Finance & Resources	0.104	0.017	(0.056)	0.238	(0.190)	0.483
Planned Contribution to / from Reserves	0	0	0		(0.398)	(0.600)
Net Expenditure Health and Social Care	**0.590**	**0.837**	**0.833**	**(0.065)**	**0.260**	**(0.177)**

** In 2022/23 this was subsumed into the relevant adult / children services

3.5 Best Value

The IJB has a duty of Best Value and this includes ensuring continuous improvement in performance, while maintaining an appropriate balance between the quality of those services provided by the HSCP and the cost of doing so. We need to consider factors such as the economy, efficiency, effectiveness and equal opportunities. The IJB ensures this happens through its vision and leadership and this is supported and delivered by:



3.6 Future Challenges

The IJB continues to face a number of challenges, risks and uncertainties in the coming years and this is set out in our current Medium-Term Financial Plan (MTFP) for 2023/24 to 2027/28 and our Strategic Plan for 2022/23 to 2024/25. These key strategies also inform our strategic risk register and collectively support medium-term planning and decision making.

The IJB operates in a complex environment with requirements to ensure statutory obligations, legislative and policy requirements, performance targets and governance and reporting criteria are met whilst ensuring the operational oversight of the delivery of health and care services.

UK and Scottish Government legislation and policies and how they are funded can have implications on the IJB and how and where we use our funding over time.

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The most significant challenges for 2023/24 and beyond include:

- delivering a difficult range savings to ensure financial sustainability, recognising this is at odds with our historic focus on prevention
- managing the real tension between reduced service capacity as a result of savings and maintaining discharge without delay from hospital
- understanding the longer term impacts of Covid-19 on mental and physical health in the longer term
- recruitment and retention of our workforce, particularly in the current cost of living crisis
- managing prescribing demand and costs in partnership with our GPs
- supporting the physical and mental health and wellbeing of our workforce and our wider population, again further impacted by the current cost of living challenges
- meeting increased demand for universal services without funding for growth, including increased population demand and new care homes opening with the area
- we may also need to prepare for the challenges and opportunities that may arise from a national care service

For 2023/24 the cost pressures identified in our budget are of £10.34 million is offset by available funding of £3.28 million leaving a funding gap of £7.06 million; a savings programme is identified to deliver this in full, but we recognise there may be some areas where we will not achieve a full year by 31 March 2024 and this will be supported by the remaining earmarked reserves we hold.

Our Savings, Recovery and Renewal programme will continue to be reported to the IJB on a regular basis and provides detail on progress on savings, project work and service redesign. The prioritisation of care, to support those with the greatest need is required to deliver around 50% of our savings.

The funding gap in 2023/24 is £7.06 million and presents a very significant challenge particularly when taking into account the continued recovery from Covid-19, pay, inflation and capacity challenges. The funding gap results from:

	ERC £m	NHS £m	TOTAL £m
1. Cost Pressures:			
Pay Award	1.45	0.40	1.85
Inflation, Contracts and Living Wage	2.64	0.41	3.05
Demographic and Demand	2.23	0.10	2.33
Capacity	0.22	0.10	0.32
Prescribing	-	0.35	0.35
2022/23 Legacy Savings	2.44	-	2.44
Total Pressures	8.98	1.36	10.34
2. Funding available towards cost pressures	2.25	1.03	3.28
3. Unfunded Cost Pressures	6.73	0.33	7.06

The budget agreed by the IJB on 29th March 2023 sets out the detail behind each of the cost pressures and it is important to note that these include contractual and policy requirements that must be met.

The prescribing cost pressure has been limited to the level of funding uplift provided as part of the Scottish government budget settlement, although it needs to be recognised that there still remains significant volatility in both cost and demand.

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The legacy savings brought forward from 2022/23 relate to the pre-pandemic budget the IJB agreed for 2020/21, set on the cusp of the first wave of the pandemic. At that time we were clear that we would need to move to prioritisation of care, with focus on those with the greatest level of need, recognising this would have significant impact on care packages as we had exhausted all other options. For context from 2016/17 to 2019/20 (the last year pre pandemic) the HSCP savings we needed to make in social care were £8.4 million.

We subsequently received full support for unachieved savings in 2020/21 and 2021/22 from the Scottish Government as part of the Covid-19 support funding, recognising we did not have operational capacity to work on savings delivery.

The use of reserves to allow time to feed in these legacy savings was part of our reserves strategy pre pandemic and we have met the majority of this saving in 2022/23 from reserves as the Covid-19 funding to support unachieved savings ceased in March 2022.

We now need to look again at prioritisation of care to help meet the cumulative impact of both legacy and new cost pressures in 2023/24, hence the introduction of a Supporting People Framework as part of our approach to achieve required savings:

	ERC £m	NHS £m	TOTAL £m
Summary of Savings to Close Funding Gap:			
Service Savings including structure proposals	2.85	0.33	3.18
Additional pay award funding post budget	0.26	-	0.26
Limit use of support services to contain cost pressures	0.22	-	0.22
Supporting People Framework	3.40	-	3.40
Total of Identified Savings	6.73	0.33	7.06

Whilst the scale of this challenge is significant to East Renfrewshire, particularly as one the smaller HSCPs this is not unique; the national position across all public sector services shows a challenging financial outlook and a report compiled on a the position of 29 of the 31 IJB's at the beginning of 2023/24 showed a collective financial gap of £305 million which is 3.6% of the respective total budgets; however within individual IJBs this gap ranges from 1% to 9%. For East Renfrewshire HSCP the total gap is 4.7%, which equates to 10% against the East Renfrewshire Council contribution and 0.4% against the NHS Greater Glasgow and Clyde contribution.

The 2023/24 budget recognises that we may require to invoke financial recovery planning if we cannot close our funding gap on a recurring basis.

Our partner East Renfrewshire Council has agreed just over £0.75 million non-recurring support in 2023/24 for the HSCP to deliver a number of initiatives related to Covid-19 recovery:

- Increasing our Talking points capacity to support the development of more community groups
- Extend the warm spaces and community cafe initiatives in our Health & Care centres
- Additional staffing cover to help meet pressures over the winter months
- Wellbeing and recovery support along with "go bags" to support domestic abuse survivors
- Financial support for foster carers, recognising the cost of living challenges
- Support to extend the staff and our partners wellbeing programme within the HSCP
- Provide additional materials to support community justice work
- Provide additional wellbeing support for vulnerable individuals, particularly those with additional support needs

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- Housing and mental health support for our young people
- Funding to work with older children as they transition into adult services
- support work for young people affected by drugs and alcohol

Looking forward to 2024/25 and beyond in any one year the modelled cost pressure could range from £9.0 million to £3.4 million depending on the combination of factors, recognising the next 2 years are likely to be particularly challenging before we see economic recovery.

Similarly the resulting potential unfunded gap, as modelled, could range from £5.9 million to £2.3 million. However this will ultimately be determined by the Scottish Government budget settlement each year.

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 the number of children with complex needs resulting in an increase in demand for services.

The wider economic challenges are significant as we are seeing continued increasing inflation across a number of goods and services and in particular prescribed drugs on a global level, impacting nationally. The war in Ukraine has also impacted on supply of goods. For the UK economy current intelligence suggests that the cost of fuel and utilities may begin to reduce during this year, however this is only one element of the cost of living crisis. Our population and households are not impacted equally by cost of living and those with lower income are disproportionately affected.

Any changes relating to the National Care Service will be analysed and reflected in our future plans.

We have successfully operated integrated services for almost 20 years so we have faced a number of challenges and opportunities over the years. 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 will not only rise in line with population increases but is also subject to many other factors. This area is so volatile it is difficult to accurately predict and the post Covid-19 impact could continue to be significant. The IJB previously held a reserve to help manage fluctuation in cost and demand, but this has now been fully utilised. Without intervention this could be a £2m overspend in 2023/24 with no funding available to offset this and this is an area difficult to predict in the longer term. Work is ongoing locally, across NHS Greater Glasgow and Clyde and at a national level to monitor this area of pressure.

Maintaining Discharge without Delay performance is a key issue for us. In order to achieve the target we continue to require more community based provision and this is dependent on availability of care. 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 through an Unscheduled Care Commissioning Plan.

We are in a period now where we are learning to live with Covid-19, its legacy impact and the continued circulation of the virus in our communities. With the exception of a modest sum of £2k to provide PPE to carers the support from the Scottish Government has ended, both for the HSCP and for partner organisations. There is still a risk that should any outbreak occur within a team or a health and care setting there could be impact on capacity and therefore on

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service delivery. There may also be associated additional costs of staff cover and infection control.

We continue to use learning from how we delivered services during the pandemic to shape and inform future service models.

The longer term impact on the on the sustainability of our partner care provider market in the post Covid-19 pandemic and current economic climate is a significant issue. Our Strategic Commissioning plan sets out the detail on how we will work with our partners in the third and independent sectors in the coming years. The way we commission services may be impacted by the creation of a national care service. There is an increasing tension between cost expectations from care providers including those on national procurement frameworks and contracts and the funding, or more specifically the lack of that IJBs have to meet any additional increases

We intend to develop our performance and financial reporting in more detail at a locality level to allow fuller reporting and understanding of future trends and service demands and include Covid-19 implications and scenarios. We were not able to progress this work during 2022/23 as capacity did not allow this.

We plan to deal with these challenges in the following ways:

- Our Savings, Recovery and Renewal Programme continues and the scope has been widened to incorporate all change and savings activity recognising the cross cutting nature of many workstreams. Progress will be reported to every meeting of the IJB.
- We will update our Medium-Term Financial Plan on a regular basis reflecting the ongoing and legacy impact of Covid-19, the economic climate and any impact from the National Care Service and / or other policy decisions as these become clearer. This will allow us to continue to use scenario-based financial planning and modelling to assess and refine the impact of different levels of activity, funding, pressures, possible savings and associated impacts. This will also inform our planning for our 2024/25 budget.
- We will continue to monitor the impacts of Covid-19, Brexit, economic and inflationary factors along with operational issues through our financial and performance monitoring to allow us to take swift action where needed, respond flexibly to immediate situations and to inform longer term planning.
- We will continue to progress and report on our Strategic Improvement Plan until fully complete; work on this was not a priority during the ongoing pandemic response.
- We will complete the review of our Integration Scheme; work that had been undertaken pre pandemic has been refreshed during 2022/23 and an NHSGGC wide review is in place.
- We routinely report our performance to the IJB with further scrutiny from our Performance and Audit Committee and our Clinical and Care Governance Group. The service user and carer representation on the IJB and its governance structures is drawn from Your Voice which includes representatives from community care groups, representatives from our localities and representatives from equality organisations including disability and faith groups. We intend to continue the development our performance reporting during 2023/24, building on work done in 2022/23.

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- Workforce planning will continue to support identification of our current and future requirements. Recruitment and retention of staff is key to all service delivery and we have mitigated as far as possible by minimising the use of temporary posts and developing our workforce and organisational learning and development plans. Given the overwhelming response to the pandemic over a prolonged period our staff are tired both physically and mentally and the wellbeing of our workforce is paramount. We will progress the action plan agreed as part of our Workforce Plan 2022-25.
- We will progress with the redesign of the Learning Disability Inpatient bed model and progress the programme of health checks for people with a learning disability.
- Governance Code; we have robust governance arrangements supported by a Governance Code.
- The IJB continues to operate in a challenging environment and our financial, risk and performance reporting continue to be a key focus of each IJB agenda.

The future challenges detailed above and our associated response include the main areas of risk that the IJB is facing. The uncertainty of the longer term impact of Covid-19 on our population and the capacity for the HSCP and its partners to deliver services and implement our savings, Recovery and Renewal programme whilst maintaining financial sustainability remain significant risks.

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4 Performance summary

4.1 Introduction

In the previous chapters of this report we have focused on the key areas of work carried out by the HSCP over the course of 2022-23 including crucial activities as we recover from the Covid-19 pandemic. In this final chapter we draw on a number of different data sources to give a more detailed picture of the progress the partnership has been able to make against our established performance indicators. Quantitative performance for many of our performance indicators continue to reflect ongoing challenges being faced in the aftermath of the pandemic.

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 2022-25. We also provide performance data in relation to the National Integration Indicators and Ministerial Steering Group (MSG) Indicators. Finally, we provide a performance summary relating to recent inspections of our in-house services.

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).

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Strategic Priority 1 - Working together with children, young people and their families to improve mental and emotional wellbeing									
Indicator	**2022/23**	**Current Target**	**2021/22**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
Percentage of children and young people subject to child protection who have been offered advocacy. *(INCREASE)*	**61%**	100%	62%	63%	n/a	n/a	n/a	n/a	↓
Percentage of children with child protection plans assessed as having an increase in their scaled level of safety at three monthly review periods. (INCREASE)	**100%**	100%	84%	87.5%	n/a	n/a	n/a	n/a	↑
Percentage of children looked after away from home who experience 3 or more placement moves *(DECREASE)*	**0%**	11%	1.8%	1.2%	0.0%	1.4%	1.2%	7.1%	↑
Children and young people starting treatment for specialist Child and Adolescent Mental Health Services within 18 weeks of referral *(INCREASE)*	**86%**	90%	55%	61%	78%	74%	89%	90%	↑
Child & Adolescent Mental Health - longest wait in weeks at month end *(DECREASE)*	**24**	18	41	35	33	34	35	31	↑
Accommodated children will wait no longer than 6 months for a Looked After Review meeting to make a permanence recommendation *(INCREASE)*	**82%**	95%	94%	74%	94%	83%	100%	n/a	↓
Balance of Care for looked after children: % of children being looked after in the Community (LGBF) *(INCREASE)*	n/a	Data only	**92.7%**	91.1%	94.9%	98.0%	93.6%	91.5%	↑

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Strategic Priority 1 - Working together with children, young people and their families to improve mental and emotional wellbeing									
Indicator	**2022/23**	**Current Target**	**2021/22**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
% Child Protection Re-Registrations within 18 months (LGBF) *(DECREASE)*	n/a	Data only	**0**	0	15.8%	7.7%	0%	9%	
% Looked After Children with more than one placement within the last year (Aug-Jul). (LGBF) *(DECREASE)*	n/a	Data only	**20.8%**	20%	18.8%	24.5%	29.1%	19.6%	

Strategic Priority 2 - Working together with people to maintain their independence at home and in their local community									
Indicator	**2022/23**	**Current Target**	**2021/22**	**2020/21**	**2019/20**	**2018/19**	**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)*	**488**	600	458	551	575	514	491	364	
Percentage of people aged 65+ who live in housing rather than a care home or hospital *(INCREASE)*	**97%**	97%	97%	97%	97%	95.9%	96.6%	96.8%	
The number of adults (18+) receiving personal care at home or direct payments for personal care, as a percentage of the total number of adults needing care. *(INCREASE)* NI-18	n/a	63%	**65.2%**	58%	57%	64%	64%	63%	
People reporting 'living where you/as you want to live' needs met (%) *(INCREASE)*	**89%**	90%	89%	91%	88%	92%	84%	79%	

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Strategic Priority 2 - Working together with people to maintain their independence at home and in their local community									
Indicator	**2022/23**	**Current Target**	**2021/22**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
SDS (Options 1 and 2) spend as a % of total social work spend on adults 18+ (LGBF) *(INCREASE)*	n/a	Data Only	**8.86%**	8.69%	8.44%	8.15%	7.5%	6.6%	⇧
Percentage of people aged 65+ with intensive needs receiving care at home. (LGBF) *(INCREASE)*	n/a	62%	**64.4%**	62.2%	57.6%	57.5%	62.5%	61.1%	⇧
Percentage of those whose care need has reduced following re-ablement *(INCREASE)*	**48%**	60%	60%	31%	67	68	62	64	⇩

Strategic Priority 3 - Working together to support mental health and well-being									
Indicator	**2022/23**	**Current Target**	**2021/22**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
Mental health hospital admissions (age standardised rate per 1,000 population) *(DECREASE)*	n/a	2.3	n/a	**1.4**	1.6	1.5	1.5	1.5	⇧
Percentage of people waiting no longer than 18 weeks for access to psychological therapies *(INCREASE)*	**75%**	90%	76%	74%	65%	54%	80%	56%	▬
% of service users moving from drug treatment to recovery service *(INCREASE)*	**5%**	10%	9%	6%	16%	22%	12%	9%	⇩
Achieve agreed number of screenings using the setting-appropriate screening tool	**173**	419	0	5	33	93	331	468	⇧

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Strategic Priority 3 - Working together to support mental health and well-being									
Indicator	**2022/23**	**Current Target**	**2021/22**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
and appropriate alcohol brief intervention, in line with SIGN 74 guidelines. *(INCREASE)*									
Percentage of people with alcohol and/or drug problems accessing recovery-focused treatment within three weeks. *(INCREASE)*	**96%**	90%	95%	95%	89%	95%	87%	96%	

Strategic Priority 4 - Working together to meet people's healthcare needs by providing support in the right way, by the right person at the right time									
Indicator	**2022/23**	**Current Target**	**2021/22**	**2020/21**	**2019/20**	**2018/19**	**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)* (NHSGGC data)	**8**	0	7	2	2	4	4	4	
Acute Bed Days Lost to Delayed Discharge (Aged 18+ including Adults with Incapacity) *(DECREASE)* (MSG data)	**3,880**	1,893	4,546	2,342	1,788	2,284	1,860	2,704	
No. of A & E Attendances (adults) *(DECREASE)* (NHSGGC data)	**11,362**	Data only	11,654	9,854	12,748	12,943	12,587	12,503	
Number of Emergency Admissions: Adults *(DECREASE)* (NHSGGC data)	**6,185**	Data only	7,372	6,217	6,859	6,801	6,916	6,908	

Strategic Priority 4 - Working together to meet people's healthcare needs by providing support in the right way, by the right person at the right time									
Indicator	**2022/23**	**Current Target**	**2021/22**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
No. of A & E Attendances (adults) *(DECREASE)* (MSG data)	n/a	18,335	**16,877**	13,677	20,159	20,234	19,344	18,747	↓
Number of Emergency Admissions: Adults *(DECREASE)* MSG	n/a	7,130	**7,894**	7,281	7,538	7,264	7,432	8,032	↓
Emergency admission rate (per 100,000 population) for adults *(DECREASE)* NI-12	**9,036***	11,492	9,414	9,210	10,441	10,345	10,304	11,427	↑
Emergency bed day rate (per 100,000 population) for adults *(DECREASE)* NI-13	**106,814***	117,000	108,448	97,806	106,296	110,749	120,265	121,099	↑
Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges) *(DECREASE)* NI-14	**67***	100	77	98	78	79	79	83	↑
A & E Attendances from Care Homes (NHSGGC data) *(DECREASE)*	**297**	400	252	236	394	429	541	n/a	↓
Emergency Admissions from Care Homes (NHSGGC data) *(DECREASE)*	**148**	240	141	154	233	261	338	166	↓
% of last six months of life spent in Community setting *(INCREASE)* MSG	**n/a**	86%	89.5%	89.8%	88.3%	86.2%	85.0%	85.8%	–

* Full year data not available for 2022/23. Figure relates to 12 months Jan-Dec 2022. Data from PHS release, 11 May 2023

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Strategic Priority 5 - Working together with people who care for someone ensuring they are able to exercise choice and control in relation to their caring activities									
Indicator	**2022/23**	**Current Target**	**2021/22**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
People reporting 'quality of life for carers' needs fully met (%) *(INCREASE)*	**80%**	72%	92%	91%	92%	78%	72%	70%	⬇
Total combined % carers who feel supported to continue in their caring role *(INCREASE)* NI 8	**n/a**	Data only	28.4%	n/a	35.3%	n/a	37.5%	n/a	⬇

Strategic Priority 6 - Working together with our community planning partners on effective community justice pathways that support people to stop offending and rebuild lives									
Indicator	**2022/23**	**Current Target**	**2021/22**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
Community Payback Orders - Percentage of unpaid work placement completions within Court timescale. *(INCREASE)*	**83%**	80%	81%	75%	71%	84%	92%	96%	⬆
Criminal Justice Feedback Survey - Did your Order help you look at how to stop offending? *(INCREASE)*	**100%**	100%	100%	92%	100%	100%	100%	100%	➖
% Positive employability and volunteering outcomes for people with convictions. (INCREASE)	**67%**	60%	56.5%	66%	65%	55%	n/a	n/a	⬇

Strategic Priority 7 - Working together with individuals and communities to tackle health inequalities and improve life chances.									
Indicator	**2022/23**	**Current Target**	**2021/22**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
Breastfeeding at 6-8 weeks most deprived SIMD data zones *(INCREASE)*	n/a	25%	**17.9%**	7.5%	15.4%	22.9	27.3	17.2	
Premature mortality rate per 100,000 persons aged under 75. (European age-standardised mortality rate) *(DECREASE)* NI-11	n/a	Data Only	**333**	334	295	308	301	297	
Percentage of adults able to look after their health very well or quite well *(INCREASE)* NI-1	n/a	Data Only	**92%**	n/a	94%	n/a	94%	n/a	

Strategic Priority 8 - Working together with staff across the partnership to support resilience and well-being									
Indicator	**2022/23**	**Current Target**	**2021/22**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
% Staff who report 'I am given the time and resources to support my learning growth'. *(INCREASE)*	**74%**	90%	75%	n/a	77%	76%	70%	n/a	
% Staff who report "I feel involved in decisions in relation to my job". *(INCREASE)*	**71%**	Data Only	72%	n/a	n/a	69%	n/a	n/a	
% Staff who report "My manager cares about my health and well-being". *(INCREASE)*	**85%**	Data Only	88%	n/a	n/a	85%	n/a	n/a	

Strategic Priority 9 - Protecting people from harm									
Indicator	**2022/23**	**Current Target**	**2021/22**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
% Change in women's domestic abuse outcomes *(INCREASE)*	**90%**	70%	87%	84%	79%	64%	65%	66%	
People agreed to be at risk of harm and requiring a protection plan have one in place. *(INCREASE)*	**100%**	100%	100%	100%	100%	100%	n/a	n/a	

Organisational measures									
Indicator	**2022/23**	**Current Target**	**2021/22**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
Percentage of days lost to sickness absence for HSCP NHS staff *(DECREASE)*	**7.5%**	4.0%	6.9%	5.5%	7.3%	6.8%	8.5%	7.2%	
Sickness absence days per employee - HSCP (LA staff) *(DECREASE)*	**20.3**	17.5	14.7	13.6	19.1	16.4	13.0	13.6	

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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 (2021-22)

Information on nine 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 relate to 2021-22 and are summarised below.

The results show that we performed better than the Scottish average for seven of the nine indicators and performed close to the national rate for the remaining two. While performance declined for all of the indicators at the national level since the previous survey, we saw improving performance for five of the nine indicators.

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National indicator	2021/22	Scotland 2021/22	2019/20	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	**91.9%**	90.9%	94%	94%	96%	↓	↓
NI-2: Percentage of adults supported at home who agreed that they are supported to live as independently as possible	**80.4%**	78.8%	78%	74%	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	**73.8%**	70.6%	75%	64%	77%	↓	↓
NI-4: Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	**65.1%**	66.4%	62%	60%	69%	↓	↓
NI-5: Total % of adults receiving any care or support who rated it as excellent or good	**75.5%**	75.3%	70%	77%	82%	↑	↓
NI-6: Percentage of people with positive experience of the care provided by their GP practice	**69.7%**	66.5%	85%	84%	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	**83.6%**	78.1%	78%	76%	79%	↑	↓
NI-8: Total combined % carers who feel supported to continue in their caring role	**28.4%**	29.7%	35%	37%	45%	↑	↓
NI-9: Percentage of adults supported at home who agreed they felt safe	**90.5%**	79.7%	81%	82%	82%	↑	↓

Data from PHS release, 12 July 2022

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4.3.2 Operational performance indicators

National indicator	2022/23	Scotland 2022/23	2021/22	2020/21	2019/20	2018/19	2017/18	2016/17	Trend from previous year
NI-11: Premature mortality rate per 100,000 persons	**333***	466*	**338***	334*	259*	308*	301*	297*	↑
NI-12: Emergency admission rate (per 100,000 population) for adults	**9,036****	11,629***	9,414	9,210	10,439	10,345	10,497	11,427	↑
NI-13: Emergency bed day rate (per 100,000 population) for adults	**106,813****	112,637***	108,448	96,914	105,544	110,0628	119,011	121,099	↑
NI-14: Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges)	**67****	107***	77	98	78	79	79	83	↑
NI-15: Proportion of last 6 months of life spent at home or in a community setting	**88.3%****	89.8%***	89.5%	89.8%	88%	86%	85%	86%	↓
NI-16: Falls rate per 1,000 population aged 65+	**23.6****	22.6***	25.8	21.5	22.6	23.4	22.4	21.2	↑
NI-17: Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	n/a	75.8%***	**79.0%**	84%	84%	84%	88%	88%	↓
NI-18: % of adults with intensive care needs receiving care at home	n/a	64.9%*	**65.2%***	58%*	57%*	64%*	64%*	63%*	↑
NI-19: Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	**415**	919	342	189	156	170	117	228	↓
NI-20: Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	n/a	24.0% (2019/20)	n/a	n/a	**20.9%**	20.8%	22.4%	22.2%	↑

Data from PHS release, 11 May 2023. *Calendar years.
**Full year data not available for 2022/23. East Renfrewshire figure relates to 12 months Jan-Dec 2022.
*** Scotland fig is 2021/22.

The indicators below are currently under development by Public Health Scotland.

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

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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	**2022/23**	Target 22/23	**2021/22**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**2015/16**	**Trend from previous year**
Number of emergency admissions (adults)	**6,564**	7,130	6,767	6,517	7,538	7,264	7,432	8,032	7,922	
Number of emergency admissions (all ages)	**7,847**	8,331	7,860	7,281	8,645	8,246	8,513	9,199	9,123	
Number of unscheduled hospital bed days (acute specialties) (adults)	**64,364**	57,106	67,267	58,333	62,861	60,953	62,967	62,901	58,271	
Number of unscheduled hospital bed days (acute specialties) (all ages)	**66,726**	58,899	67,058	59,593	59,764	64,407	64,769	64,455	60,064	
A&E attendances (adults)	**17,355**	18,335	16,877	13,697	20,159	20,234	19,344	18,747	18,332	
A&E attendances (all ages)	**25,202**	25,299	24,270	17,843	27,567	27,850	27,011	25,888	25,300	
Acute Bed Days Lost to Delayed Discharge (Aged 18+ including Adults with Incapacity)	**4,652**	1,893	4,546	2,342	1,788	2,284	1,860	2,704	2,366	
% of last six months of life spent in Community setting (all ages)	n/a	86%	**89.5%***	89.8%	88.3%	86.2%	85.0%	85.8%	85.6%	
Balance of care: Percentage of population at home (supported and unsupported) (65+)	n/a	Data only	**96.7%**	96.6%	96.5%	95.9%	95.8%	95.7%	95.6%	
Balance of care: Percentage of population at home (supported and unsupported) (all ages)	n/a	Data only	**99.2%**	99.1%	99.2%	99.0%	99.0%	99.0%	99.0%	

Data from PHS release, 8 June 2023. (MSG Indicators)
*Provisional figure for 2021/22

4.5 Inspection performance

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 May 2023.

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	Inspection Report
Adoption Service	11/10/2019	5	Not assessed	5	Not assessed	Adoption Services - InspectionReport-305
Barrhead Centre	23/02/2018	6	Not assessed	Not assessed	6	Barrhead Centre - InspectionReport-296
Fostering Service	11/10/2019	5	Not assessed	5	Not assessed	Fostering Services - InspectionReport-306
Care at Home	25/06/2021	4	Not assessed	Not assessed	Not assessed	Care at Home - InspectionReport-309
HSCP Holiday Programme	26/07/2022	5	Not assessed	5	4	Holiday Programme - InspectionReport-312

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Thornliebank Resource Centre	07/04/2016	4	Not assessed	Not assessed	4	Thornliebank Rescource Centre - In
HSCP Adult Placement Centre	25/10/2019	5	Not assessed	5	5	Adult Placement InspectionReport-306

The Care Inspectorate launched the new evaluation framework in July 2018, which is based on the Health and Social Care Standards. Bonnyton House and Kirkton were inspected under the new quality inspection framework.

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 Bonnyton House - InspectionReport-312	01/07/2022	4 (Good)	4 (Good)	5 (Very Good)	5 (Very Good)	4 (Good)
Kirkton Kirkton - InspectionReport-304	23/7/2019	5 (Very Good)	Not assessed	Not assessed	Not assessed	5 (Very Good)

The quality framework for children and young people in need of care and protection, published in August 2019.

Service	Date of Last Inspection	Evaluation of the impact on children and young people			Inspection Report

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Joint Inspection for children at risk of harm	16 August 2022	6 (Excellent)			East Renfrewshire joint insp children anc

Evaluation of the impact on children and young people - quality indicator 2.1

For our inspections of services for children at risk of harm, we are evaluating quality indicator 2.1. This quality indicator, as it applies to children and young people at risk of harm considers the extent to which children and young people:

- feel valued, loved, fulfilled and secure
- feel listened to, understood and respected
- experience sincere human contact and enduring relationships
- get the best start in life.

Evaluation of quality indicator 2.1: Excellent

4.6 Use of Directions during 2022-23

Directions are the means by which the Integration Joint Board tells the Health Board and Local Authority what is to be delivered using the integrated budget and for the IJB to improve the quality and sustainability of care, as outlined in its strategic commissioning plan. Directions are a key aspect of governance and accountability between partners. Directions issued in 2022-23 are given below.

June 2022	LD Day Services Transport	ERC	Direction issued to East Renfrewshire Council to adopt the agreed policy; whereby the provision of transport is based on assessed need in line with set criteria.
March 2023	Budget 2023/24	ERC	Direction issued to East Renfrewshire Council to carry out each of the functions listed within the Integration Scheme in a manner consistent with: the existing policies of the Council and any relevant decisions of the Council in relation to the revenue

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			budget; and with the Integration Joint Board’s strategic plan.
March 2023	Budget 2023/24	NHS	Direction issued to NHSGGC to carry out each of the functions listed within the Integration Scheme in a manner consistent with: the existing policies of the Council and any relevant decisions of the Council in relation to the revenue budget; and with the Integration Joint Board’s strategic plan.

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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.

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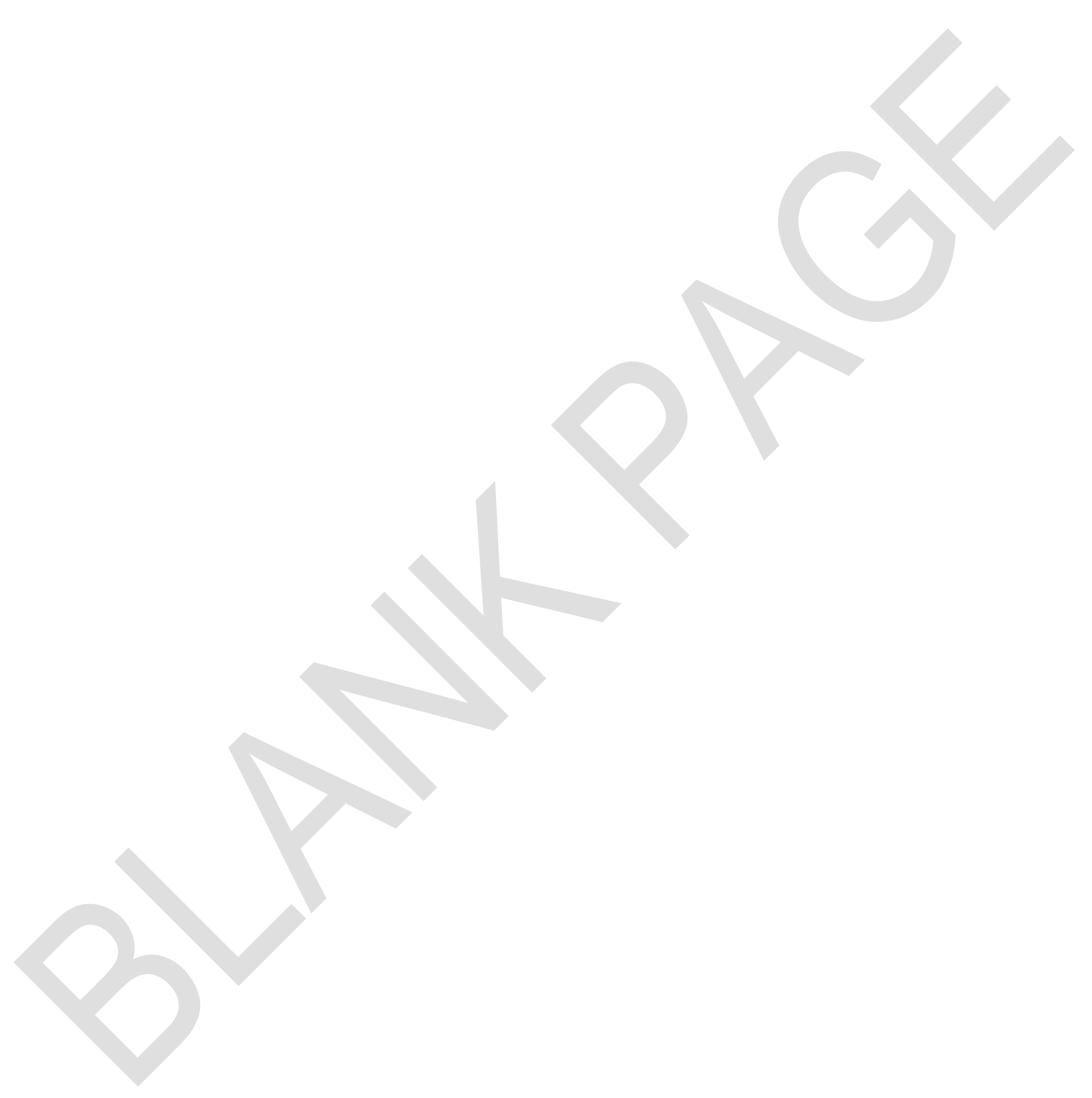
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