EAST RENFREWSHIRE
HEALTH AND SOCIAL CARE
PARTNERSHIP

East Renfrewshire Council

NHS Greater Glasgow and Clyde

Date: 14 November 2024
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TO: MEMBERS OF THE EAST RENFREWSHIRE INTEGRATION JOINT BOARD

Dear Colleague

EAST RENFREWSHIRE INTEGRATION JOINT BOARD (IJB)
WEDNESDAY 20 NOVEMBER 2024

Please find attached the undernoted items marked "to follow" on the agenda for the meeting of the Integration Joint Board on Wednesday 20 November 2024.

Yours faithfully

Councillor Katie Pragnell

Councillor Katie Pragnell
Chair, East Renfrewshire Integration Joint Board

Enc.

Undernote referred to:-

Item 8 DRAFT HSCP Strategic Plan 2025-28
Item 9 Clinical and Care Governance Annual Report

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barry.tudhope@eastrenfrewshire.gov.uk or **lesleyann.burns@eastrenfrewshire.gov.uk**

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EAST RENFREWSHIRE
HEALTH AND SOCIAL CARE
PARTNERSHIP

East Renfrewshire Council

NHS Greater Glasgow and Clyde

EAST RENFREWSHIRE INTEGRATION JOINT BOARD

Wednesday 25 September at 10.30 a.m.

SUPPLEMENTARY AGENDA

8. DRAFT HSCP Strategic Plan 2025-28 (copy attached, pages 3 – 48).

9. Clinical and Care Governance Annual Report (copy attached, pages 49 – 82).

AGENDA ITEM No. 8

EAST RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

East Renfrewshire Council | NHS Greater Glasgow and Clyde

Meeting of East Renfrewshire Health and Social Care Partnership **Held on**	Integration Joint Board 20 November 2024
Agenda Item	8
Title	Draft HSCP Strategic Plan 2025-28

Summary

The purpose of this report is update members on the progress of the review of the East Renfrewshire Strategic Plan and asks for comments on the draft of the Strategic Plan for 2025-28 prior to its going to wider consultation.

Presented by	Steven Reid: Policy, Planning and Performance Manager

Action Required

It is recommended that the Integration Joint Board:

- note the progress of the review, and
- comment on the draft Strategic Plan for 2025-28 prior to wider consultation.

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

EAST RENFREWSHIRE INTEGRATION JOINT BOARD

20 November 2024

Report by Chief Officer

DRAFT EAST RENFREWSHIRE HSCP STRATEGIC PLAN 2025-28

PURPOSE OF REPORT

1. The purpose of this report is update the IJB on the progress of the review of the East Renfrewshire Strategic Plan and asks for comments on the draft of the Strategic Plan for 2025-28 prior to its going to wider consultation.

RECOMMENDATION

2. It is recommended that the Integration Joint Board:
   - note the progress of the review, and
   - comment on the draft Strategic Plan for 2025-28 prior to wider consultation.

BACKGROUND

3. The Public Bodies (Joint Working) (Scotland) Act 2014 places a duty on integration authorities to create a strategic plan for the integrated functions that they control. The strategic plan should draw upon the 'commissioning' process. Commissioning is the term used for all the activities involved in assessing and forecasting needs. It links investment to agreed outcomes, considering options, planning the nature, range and quality of future services and working in partnership to put these in place.

4. Integration authorities are required to review their strategic plan at least every three years, and may carry out additional reviews from time to time. In carrying out a review of the strategic plan, integration authorities must consider:
   - the national health and wellbeing outcomes;
   - the integration delivery principles;
   - the views of the Strategic Planning Group.

   There should be a clear recording and measurement framework so that there is an ongoing process to assess whether aims are being achieved.

5. The current East Renfrewshire HSCP Strategic Plan was approved by the IJB on 16th March 2022 and covers the period 2022/23 to 2024/25. As such, a revision of the plan is required with a refreshed Strategic Plan to be established for 2025/28.

6. Our approach to the development of the plan was agreed in June 2024 with the East Renfrewshire Strategic Planning Group (SPG) who have responsibility for directing the development and implementation of the plan. An update on the development work was provided to the IJB at its meeting on 25th September 2024.

REPORT

7. The draft plan builds on our existing vision and priorities established in previous strategic planning. It will also recognise the changed circumstances for the HSCP since the last plan was developed, and intends to be open and realistic about the constraints the HSCP is working in.

8. The plan sets out key areas of focus for the HSCP in the years ahead and emphasises the broad partnership approach we are taking with third and independent sectors partners and our communities to meet the full range of needs in East Renfrewshire. It illustrates how the HSCP will contribute to the priorities and objectives set out in East Renfrewshire's community planning vision *A Place to Grow* and NHS Greater Glasgow and Clyde's clinical strategy *Moving Forward Together* (MFT).

9. This draft plan is the result of several months of development work as we have collaborated with colleagues, stakeholders, and local people. Our objective is that the plan reflects the shared priorities of local residents and sets out meaningful commitments for our wide partnership.

10. We were clear from the outset that we were not developing a strategic plan with a 'blank page' but building on core principles set out in our previous plans. The plan also links with a number of related plans and we have incorporated the learning from recent local planning and engagement activity that has informed those plans.

11. The development of our plan has followed the broad timeline set out below.

Jun-Jul 24	**Aug 24**	**Sept-Oct 24**	**Nov 24**	***Dec 24-Jan 25***	***Feb 25***	***Mar-Apr 25***	***Apr 25 onwards***
Initial planning – approach agreed; information and data gathering	Framework for plan agreed with SPG and management team	Engagement with staff, stakeholders, community groups, local people (workshops and survey)	Draft plan produced for consultation	*Public consultation inc. 'Big Lunch' public event*	*Post-consultation drafting*	*Approval and publication*	*Annual delivery plan agreed and implementation*

Stage one stakeholder engagement

12. We were clear as a partnership that we wanted to simplify our Strategic Plan to make it more meaningful and more focused around shared priorities. In discussion with stakeholders through our SPG, service-based planning officers and senior managers we agreed an initial framework for the plan. This helped give the development work more focus, and was the basis for discussion during our engagement activity. The framework streamlines our plan and significantly reduces our previous nine priorities to three strategic outcomes.

13. During October we held two in-person stakeholder workshops in each of our localities (Barrhead and Eastwood) and an online workshop hosted by the SPG. The three events were attended by 45 stakeholders from the statutory, third and community sectors. The workshops considered the following topics for our strategic plan:
    - Current and future challenges – what are the key challenges we need to respond to as a partnership? Which are the most pressing?
    - Our broad approach – how can our approach meet our challenges? What else would improve the way we work as a partnership?
    - Our strategic outcomes, priorities and intermediate outcomes - What changes/ outcomes do we hope to see by 2028? What areas/activities should we focus on?

14. To widen our engagement and capture the views of local people staff and stakeholders we conducted an online survey seeking views on the strategic outcomes in our framework. Respondents were asked to comment on our proposed outcomes and how these can best be delivered by the HSCP over the life of the plan. The survey was promoted online, through social media and was 'cascaded' by members of our local Participation and Engagement Network (PEN).

15. To date, we have received 50 responses to the survey, with two-thirds coming from local residents. There was strong support for the headline strategic priorities set out in our framework and recognition of the challenges facing the partnership including financial constraints. Survey respondents highlighted a range of areas for further action which have informed the content of this plan and will influence the action planning in our Annual Delivery Plan to support implementation.

Stage two planned engagement work

16. Having produced a draft plan, and subject to comments from the IJB, we will undertake further engagement work in order to finalise the plan. Following comments from the IJB and the NHSGGC Finance, Planning and Performance Committee we will undertake a full public / stakeholder consultation on the draft plan through the following methods:
    - Promotion of the draft with a short questionnaire to our prescribed consultees.
    - Promotion of the draft/questionnaire through HSCP website, social media, ERC Have Your Say page, staff bulletins.
    - Promotion and discussion of draft at Big Lunch event in December 2024.

17. Feedback from the consultation exercise will be fed into the subsequent draft of the Strategic Plan. The draft will be discussed at our Strategic Planning Group in February 2025 and the draft final Strategic Plan will be presented to the IJB for approval in March 2025.

Content

18. The draft strategic plan sets out:
    - our 'plan on a page';
    - the ambition, vision and strategic outcomes for the three-year period – including key areas of focus for delivery;
    - how we have developed the plan;
    - our current context and challenges;
    - information on related plans and policies;
    - explanation of how we measure success.

19. The three strategic outcomes established in the plan are:
    - People are enabled to live healthy and fulfilling lives;
    - Our communities are resilient and there are better opportunities for health and wellbeing;
    - People are safe and protected.

IMPLICATIONS OF THE PROPOSALS

Finance

20. There are no financial implications from the Strategic Plan review process. Engagement activity is undertaken within existing resources.

Staffing

21. No wider staffing implications. HSCP staff with planning responsibilities are involved in the revision of the Strategic Plan.

Legal

22. Timely revision of the Strategic Plan is a statutory requirement of the Integration Joint Board.

Equalities

23. Reflecting the Integration planning and delivery principles, the revision of the Strategic Plan will:
    - Take account of the particular needs of different service-users.
    - Take 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.

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

CONCLUSION

25. The updated Strategic Plan for 2025-28 will be the fourth iteration of our strategy since the establishment of the HSCP. The finalised plan will reflect the high-level aims and ambitions for the HSCP and will outline the approaches we will take as a wider partnership to meet the health and care needs of people in East Renfrewshire.

RECOMMENDATION

26. It is recommended that the Integration Joint Board:
    - note the progress of the review, and
    - comment on the draft Strategic Plan for 2025-28 prior to wider consultation.

REPORT AUTHOR AND PERSON TO CONTACT

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0141 451 0749

November 2024
Chief Officer, IJB: Julie Murray

BACKGROUND PAPERS

East Renfrewshire HSCP Strategic Plan 2022-25, IJB Paper, 16 March 2022
eastrenfrewshire.gov.uk/media/7440/IJB-item-06-16-March-2022/pdf/IJB_item_06_-_16_March_2022.pdf?m=1646923405760

East Renfrewshire Health and Social Care Partnership

Strategic Partnership Plan 2025-2028

WORKING DRAFT - FIRST

Contents

1. Introduction and our plan on a page

Welcome to the fourth Strategic Plan for East Renfrewshire Health and Social Care Partnership (HSCP). The plan sets out the shared ambitions and strategic priorities of our partnership; and how we will focus our activity to continue to deliver high quality health and social care to the people of East Renfrewshire. The plan covers the period 2025-28. It builds on the priorities set out in our previous HSCP strategic plans and links with a range of local HSCP thematic plans, East Renfrewshire Council (ERC) and NHS Greater Glasgow and Clyde (NHSGGC) plans and national plans.

Our strategic planning is based on strong evidence of local needs and our most recent review of this plan involved engagement activity drawing in voices from our partners in the community, third and independent sectors as well as people with lived experience and unpaid carers. We recognise that understanding local needs and planning the most effective responses is an ongoing process. As an inclusive partnership we will continue to engage widely as we review the delivery of our commitments in this plan, and work to bring in new and innovative approaches. This plan and supporting delivery plans will be reviewed annually, building on the experiences and new learning as we move forward.

East Renfrewshire HSCP provides care, support and protection for people of all ages, to enhance their wellbeing and improve outcomes. The health and social care sector is facing unprecedented challenges across Scotland the UK. We continue to see changing patterns of demand in the aftermath of the Covid-19 pandemic and significant financial constraints for the sector locally and nationally. As a small partnership we continue to respond to higher demands for support locally: supporting individuals with higher levels of emotional distress, complex needs and limited informal support networks. Our teams respond compassionately, creatively and with an unwavering commitment to improve outcomes for individuals and families.

This plan faces-up to the significant challenges that we are responding to as a partnership. It recognises that traditional approaches to providing support have to change, and that we need to think differently about how we support people and where they get support from. The plan recognises the opportunity to do things better with: higher levels of collaboration and learning across partners; stronger community-based responses and activities; and modern, innovative approaches to support healthy lifestyles and the self-management of individual needs.

Despite our challenges, the plan sets out our continuing commitment to our values and principles. We remain focused on our fundamental strategic priorities for health and social care such as supporting people to living independently and well at home, supporting better mental health and wellbeing, and ensuring access to high quality local health care services.

We want the plan to be a focal point for our wider partnership and for any individuals or organisations interested in or engaged with health and social care in East Renfrewshire. Although it covers a wide range of activity, we have aimed to streamline the plan with a more focused set of strategic outcomes. The outline of our Strategic Plan ‘on a page’ is set out below.

HSCP Strategic Plan 2025-28 on a page

Drivers and influencers	Challenges and pressures
• HSCP Vision and Values • National, GGC and local policy • Joint Strategic Needs Assessment • Partnership, stakeholder, service user and public views and priorities • Performance data, benchmarking and best practice	• Population and demographic change, particularly children and older people • Financial constraints / budgetary pressures • Increasing volume and complexity of presenting needs • Pressure on acute hospital in-patient services • Increasing pressure on our unpaid carers • Increasing mental health and wellbeing concerns • Ensuring choice and control • Achieving the appropriate balance of care • Addressing health inequalities • Ensuring public protection • Uncertainty on the development of the National Care Service (NCS) • Sustaining and supporting our workforce

Our approach

Focusing resources where most needed • Working in partnership with communities and 3rd and independent sector partners • Supporting self-management and digital approaches • Collaboration and shared learning on improvement/best practice • Person-centred/trauma-informed practice

Our strategic outcomes and areas of focus

People are enabled to live healthy and fulfilling lives	Our communities are resilient and there are better opportunities for health & wellbeing	People are safe and protected
• Supporting children, young people and their families to improve mental and emotional wellbeing • Supporting people to maintain their independence at home and in their local community • Supporting better mental health and wellbeing • Supporting people who care for someone, ensuring they are able to exercise choice and control • Supporting staff across the partnership to strengthen resilience and wellbeing	• Strengthening links with communities and 3rd sector supports • Supporting individuals and communities to tackle health inequalities and improve life chances • Supporting people's healthcare needs by providing support in the right way, by the right person at the right time • Supporting effective community justice pathways that support people to stop offending and rebuild lives	• Protecting people from harm • Addressing violence against women • Minimising self-harm and suicide • Health protection

Enablers for change

Service review and redesign • Our workforce • Local people and communities • Local Partners • Our Financial Plan • Data and intelligence • Digital technology • Equalities Outcome Plan • Commissioning Plan • Housing Contribution Statement

2. Our ambition, vision and strategic outcomes

2.1 Our ambition

It is the ambition of East Renfrewshire HSCP to meet the challenges we face and embrace new opportunities with a renewed commitment to innovation and high quality services and supports, designed and delivered in partnership with local people and partners.

We want to ensure that health and care supports available in East Renfrewshire meet the needs, values and personal ambitions of the people who live here. We want supports to be truly person-centred, focused on human rights and empowering people to thrive at whatever stage they are at in life.

We want to see strong collaboration and shared learning across the partnership, and over the life of this plan we will work to further strengthen collaborative practices, building on examples such as our Talking Points Partnership, Community Hub and local delivery of the Communities Mental Health and Wellbeing Fund.

Due to our current financial circumstances we are having to focus our finite resources where they are most needed. This means prioritising social care resources to ensure that we support the people with the most significant needs (currently those assessed as having 'critical' or 'substantial' needs) and that we meet our legal duties in managing risk and harm. This means that people with lower level needs may not receive social care supports in the same way in East Renfrewshire.

To ensure this is done fairly we will work closely with individuals and families, taking a strengths and assets-based approach. We will continue to invest in voluntary and community resources that help people to live well and independently. We will encourage and sign post people with lower level needs to these services/supports so that they still get the help they need to live well. We will also advise people on how to make best use of their own personal assets and resources and show people the ways that technology can help meet health and social care needs.

We will ensure that a range of supports are in place to meet health and care needs early, preventing deterioration and helping people avoid crisis situations. As a broad and inclusive partnership our ambition is to maximise the supports and opportunities that are available for local people in the community, supporting prevention and working to tackle health inequalities across our communities. We recognise the wider determinants of health and wellbeing including education, employment and income, and the importance of good quality, affordable and appropriate housing. Through collaborative and ethical commissioning we will work with communities,

third sector organisations and our independent sector providers, championing the most innovative and effective ideas and approaches.

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. Over the life of this plan we will continue to develop our responses to new risks and vulnerabilities as these emerge.

Our health and care system depends more than ever on those that provide care and support, both paid and unpaid. Our ambition in East Renfrewshire is to increase recognition of the role that unpaid carers play, and ensure that the supports needed by carers are in place. As a partnership our workforce are our greatest asset. We want to ensure that those providing invaluable health and care services are happy and motivated; and feel respected and fulfilled in their role for years to come.

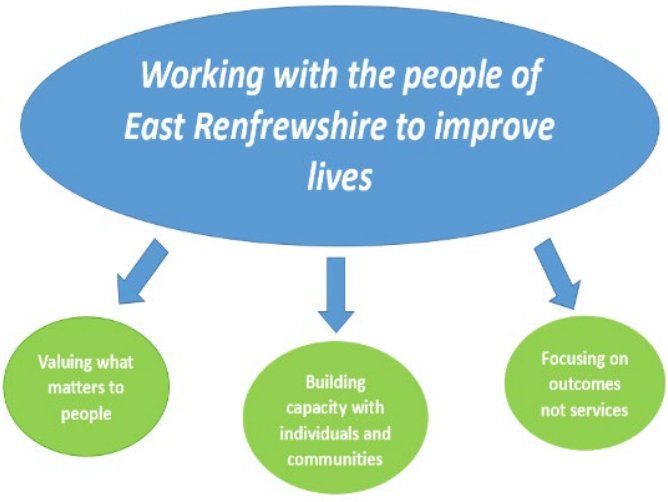
2.2 Our partnership

Under the direction of East Renfrewshire's Integration Joint Board (IJB), our HSCP builds on a secure footing of a nearly 20 year commitment to health and social care partnership in East Renfrewshire. Our experiences over the years, not least during and since the Covid-19 pandemic have reinforced the benefits of working together as a broad and inclusive partnership. Moving forward we will further strengthen our supportive relationships with independent and third sector partners. Our partnership must extend beyond traditional health and care services to a long-term meaningful partnership with local people and carers, volunteers and community organisations.

2.3 Our vision

Our vision statement, *"Working 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 and includes our three main priorities which guide everything we do as a partnership:

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



We want to support people to live good lives, supporting them to be independent, to be safe and healthy and to achieve the goals and outcomes that are important and unique to them.

2.4 Our strategic outcomes

For this iteration of our strategic plan we have worked to make the plan more focused and easier to understand. The plan covers a wide range of activities and approaches being promoted by the partnership; recognising the interconnectedness of different elements of our work, and the importance of taking a 'whole system' approach to the development and delivery of health and social care supports. However, we have chosen to streamline the plan, reducing our previous nine strategic priorities to three headline strategic outcomes.

Our strategic outcomes articulate our overarching priorities for the three year period and are ambitious for the health and wellbeing of local people. Despite the challenges that the partnership faces, we believe that all local people can live their lives in good physical and mental health and achieve their full potential.

People are enabled to live healthy and fulfilling lives	Our communities are resilient and there are better opportunities for health and wellbeing	People are safe and protected

These priorities compliment the three pillars set out in the new East Renfrewshire Community Planning Partnership vision for 2040, *A Place to Grow*. Delivering on our HSCP strategic outcomes will contribute to the pillars in the community plan:

- Our children and young people flourish
- Our communities and places thrive
- We all live well.

More information on East Renfrewshire – *A Place to Grow* can be found *here*.

This strategic plan also contributes to the delivery of the principles and priorities of the NHSGGC Moving Forward Together programme, as well as the NHSGGC Clinical Vision and NHSGGC thematic plans. Central to our approach is the 'tiered' model of healthcare which promotes self-management and the person at the centre. The model sees different levels of appropriate advice, treatment and support tailored to what we need. The model is responsive to different levels of demand and resource.

What our strategic outcomes mean, how we will work towards them over the life of this plan, and how they align to the themes in other relevant plans, are set out in the following sections. We will develop a more detailed outcomes framework and annual delivery plans to support the implementation of our strategy, and these will inform our performance monitoring framework.

PEOPLE ARE ENABLED TO LIVE HEALTHY AND FULFILLING LIVES

Why this outcome is important

This outcome is fundamental to the role of the HSCP and the wider partnership that we continue to build in East Renfrewshire. The partnership is committed to delivering **high quality health and social care** services that meet the identified needs of our people and communities. We also recognise that health and wellbeing is a **shared responsibility** for individuals and families, communities and those providing help and support.

We work to ensure that East Renfrewshire is a place where everyone, regardless of whether they require HSCP services, is empowered to live **heathy lives** and have the opportunities to make **positive lifestyle choices**. We want to enable people to take responsibility for their health and wellbeing and be able to manage wellbeing for themselves and their families.

As a partnership, we want to help people to live good lives, supporting them to be independent, to be safe and healthy and to achieve the goals and outcomes important and unique to them. We will ensure that people living in East Renfrewshire can access the support they need to meet identified needs at **all stages of life**. This means supporting the needs of **children and their families**, supporting **independence** for **older people** and people with **disabilities** and **long-term conditions**, and supporting people with their **mental health** needs. It also means supporting our **unpaid carers** and ensuring the **wellbeing of staff** working in health and social care.

As stated, our vision is to value what matters to people, build capacity with individuals and communities and focus on outcomes. Where people are accessing HSCP-provided supports our principles ensure we will:

- Promote, support and preserve maximum independence and resilience where practical and practicable;
- Promote equitable access to social care resources;
- Adhere to the principals of early and minimum intervention;
- Target resource to those vulnerable individuals most at risk of harm or in need of protection.

We recognise that everyone is unique. Each person has their own goals and needs and we aim to work with each individual and their families to have good conversations to help work out a fair share of support. In order achieve the principles above and to fairly

use finite resources we take a **strengths and assets-based approach**. We will help residents to work out what strengths, assets and resources they have, what is available within the community and support network.

We will continue to invest in **voluntary and community resources** that help people to live well and independently. We will encourage and signpost people with lower level needs to these services/supports so that they still get the help they need to live well. We will also advise people on how to make best use of their own personal assets and resources and show people the ways that technology can help meet health and social care needs.

Our approach to the provision of local health and social care supports reflects the principles set out in the NHSGGC Quality Strategy, *Quality Everyone Everywhere*, which aims to ensure people experience **high-quality** individualised, person-centred care and sets the following objectives:

- People experience person-centred, high-quality care in every place and every interaction;

- The voices of our population, patients and staff are embedded in the decisions we make.

We will make best use of **digital technology** and approaches such as home health monitoring systems to support independence and self-management of conditions. We will work locally to promote the many opportunities recognised in the NHSGGC Digital Health and Care Strategy including improving the way we work, supported by data/ information, tools and technology; and promoting electronic health technologies and online solutions to deliver better care. Through our Talking Points Collaborative we will continue to promote the benefits of digital technologies to support independent living through referrals for community alarms, promoting dementia friendly technologies and referrals to the Tech-enabled Care team within the HSCP. Ensuring person-centred care, digital solutions will be appropriate and tailored to the needs of individuals. We would also like to see greater awareness of digital solutions for better health and wellbeing among our communities for everyday life and lower levels of need.

Our engagement work tells us that some people experience a 'revolving door' of services, do not feel they have adequate options following an intervention, or have to explain their circumstances afresh for each service they encounter. Over the life of this plan we want to further strengthen our partnership working with greater **interconnectedness** between partner organisations and staff. We want build our local networks, with greater knowledge of the types of support available from other partners allowing more effective signposting and identification of support 'gaps'. Better communication between partners is the foundation for more collaborative approaches and shared learning.

We are committed to the rights of individuals to exercise **choice and control** in relation to their care and support and we will work to ensure the principles and opportunities of Self-directed Support (SDS) are embraced. In addition to the funding options that SDS offers, we need to continue to work with local people, communities and partner organisations to provide genuine choices and good information to help people live fulfilling lives and achieve their personal outcomes. We will continue to promote and develop our visible points of access including initiatives such as Talking Points and the East Renfrewshire SDS Forum.

As a partnership, we support our population across all life stages and recognise the value of a **'life course' approach**. Rather than focusing only on a single condition at a single life stage, a life course approach considers the critical stages, transitions and settings where large differences can be made in promoting or restoring health and wellbeing. In line with our principle of early and minimum intervention we aim to identify opportunities to minimise risk factors and promote positive factors at key stages of life, from infancy and childhood, adolescence, working age, and into older age. We continue to support the mental and emotional wellbeing of children and young people and support transitions for vulnerable people. For older people and people with long-term conditions we promote Future Care Planning and early establishment of Power of Attorney; and work to ensure appropriate community-based resources, residential care and housing that meets specific needs. In developing this plan, our engagement highlighted the importance of

recognising the needs of our working-age population, including people with physical or mental health needs who may be most impacted by changes to the way services are being delivered.

How we will deliver this priority

Supporting children, young people and their families to improve mental and emotional wellbeing

Our multi-agency approach to supporting the needs of children and young people in East Renfrewshire is set out in "At Our Heart – The Next Steps" our *Children and Young People's Services Plan 2023-2026*. At Our Heart is a holistic plan and our overarching strategic plan only seeks to reemphasise our commitment to improving the mental and emotional wellbeing of our children and young people. This continues to be one of the highest priorities for the HSCP as we go forward. Priority outcomes and key activities taken forward by the HSCP are outlined below.	
Priority outcomes	Key activities
We will protect our most vulnerable children, young people and families	• The Signs of Safety approach to keeping children safe will be rolled out across the local children's services partnership. • Local partners will collaborate with young people to design and deliver diversionary programmes and opportunities that promote inclusion, responsibility, and improve wellbeing. • Recovery and mental health services for 16-26 year olds will be evaluated to determine options for the best model of delivery for this age group in transition to adulthood.
We will ensure children and young people with complex needs are supported to overcome barriers to inclusion at home, school, and communities	• Improve access to inclusive opportunities information to ensure children and their families are aware of what services, programmes, and activities are available to them locally. • Arrangements for young people with complex needs to achieve and sustain a positive transition into young adulthood will be strengthened to ensure the experience is improved and the outcome in line with young people and families expectations. • Support the local implementation of the NHSGGC Specialist Children's Services Neurodevelopmental Service Specification.

We will deliver on our Corporate Parenting responsibilities to our looked after and care experienced children and young people by fully implementing The Promise	• Create settled, secure, nurturing and permanent places to live within a family setting for all care experienced children and young people in line with expectations from The Promise Good Childhood. • Corporate Parents will provide welcoming, inclusive, supportive opportunities for children and young people and encourage them to express their views. • Support young people to remain in a positive care placement until they are ready to move on and/or good quality accommodation with options to support their needs. • Unaccompanied asylum seeking children and young people will be supported by all Corporate Parents to integrate into local communities and access the care and support they need.
We will respond to the mental and emotional wellbeing, and physical health needs of children and young people	• Improve access to and awareness of the range of mental health supports available, to increase uptake and improve wellbeing. • Promote the Healthier Minds Resource website for children, families and partner agencies to increase knowledge and skills, and enhance support strategies. • Create learning opportunities and activities that provide accurate information to support young people to make safer and informed lifestyle choices.

<u>Supporting people to maintain their independence at home and in their local community</u>

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. 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.	
Priority outcomes	Key activities
People are better able to find good information and access a range of activities and supports	• Promote the range of local opportunities and supports available through visible points of access including the Community Hub, Talking Points and SDS Forum. • Promote better collaboration and knowledge between staff and organisations through local networks. • Support various link worker approaches, e.g though GP practices, supporting dementia, Improving the Cancel Journey (ICJ).
Individuals and families are better able to self-manage health and wellbeing, and long-term conditions	• Expand and promote the uptake of digital solutions for health management and better health and wellbeing – through development of options and wider awareness. • Promote better 'future proofing' such as Future Care Planning, early establishment of Power of Attorney. • People with dementia and their families are better supported through the delivery of the East Renfrewshire Dementia Action Plan. • There is a sustained focus on promoting positive health behaviours.
The people we work with have choice and control over their lives and the support they receive	• Ensure that the principles and opportunities of Self-directed Support continue to be promoted • As a partnership, establish greater choice and innovation by developing the range of local opportunities and types of support • Work with housing providers to ensure housing needs are met and consider future housing opportunities

Supporting better mental health and wellbeing

We are focused on promoting 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 and living experience to develop our approach to ensure people get the right service, in the right place at the right time. We continue to enhance our approach to minimising drug and alcohol related harms and deaths and improving overall wellbeing amongst people with harmful drug or alcohol use and their families, through our implementation of the East Renfrewshire Alcohol and Drugs Plan 2024-27.

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. This includes a focus on suicide prevention through the implementation of the East Renfrewshire Suicide Prevention Strategy 2024-27.

We will continue to work in partnership with people who use services, carers and staff to influence the Greater Glasgow and Clyde Adult Mental Health Strategy 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

Priority outcomes	Key activities
People are supported to self-manage their mental health and can access a range of supports on their journey to recovery from mental ill health and alcohol and drugs harms	• Support people to self-manage the impact that mental ill health has on their life. • Enhance access to primary care mental health services • Ensure people with complex mental health conditions are fully involved in the design and delivery of their own care plans. • Developing the provision of peer support within services and growing the recovery community, including the design and implementation of a recovery hub.
Wellbeing is enhanced through a strong partnership approach to prevention and early intervention	• Work with our communities to promote positive mental health and wellbeing.

	• Support and promote mental health and wellbeing initiatives delivered through third sector and community-led activity.
Staff and volunteers have the skills, knowledge and resilience to support individuals and communities	• Maximise opportunities for skills development in relation to mental health, recovery and suicide awareness and prevention across services and the wider partnership. • Ensure effective and efficient frontline staffing and service design across mental health and recovery to ensure fast, appropriate access to treatment.

Supporting people who care for someone, ensuring they are able to exercise choice and control

The contribution of unpaid carers to the provision of care cannot be overstated and the daily efforts of families and loved ones to those needing support is fully recognised by the partnership. In the aftermath of the Covid-19 pandemic, unpaid carers have been under increasing pressure as a result of indirect health consequences and the impact of pressures on health and social care resources. The *East Renfrewshire Carers Strategy 2024-26* 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 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. Further detail on our activity is contained in the East Renfrewshire Carers Strategy.	
Priority outcomes	Key activities
Carers are identified at the earliest opportunity and are offered support in their own right.	• Identify carers at an earlier stage in their caring role. • Increase awareness of carers, their rights and the impact of caring.
Carers can easily access the advice, information and support they need at the time they need it.	• Ensure people caring for someone living in East Renfrewshire know where to go to find up to date advice, information and the right support.

Improve the process and uptake of Adult Carer Support Plans	• Support carers to identify and achieve the outcomes that matter to them (through the promotion of adult carers support plans).
Carers get a break from and are able to maintain their own health and wellbeing	• Increase awareness of the different options available to carers for short breaks and promote opportunities to increase these options.
We will work with partners to mitigate any negative impact caring has on carers' finances.	• Work with partners to ensure supports are available to carers to minimise the impact of financial hardship as a result of caring and rising living costs.
Unpaid carers are recognised and valued as equal partners in care and involved in decision making relating to their caring role.	• Involve carers as equal and valued partners in planning support and in the planning of services that affect them or the person they care for.
Staff who are carers are supported in the workplace	• Deliver Carers Strategy actions including peer support sessions, awareness raising, promotion of flexible work and carer leave policies.

Supporting staff across the partnership to strengthen resilience and wellbeing

Our health and care system depends on those that provide care and support, both paid and unpaid. As a partnership our workforce are our greatest asset. We want to ensure that those providing invaluable health and care services are happy and motivated; and feel respected and fulfilled in their role for years to come. Working together with staff and our partners we will continue to develop and embed positive practices and interventions to promote staff wellbeing over the life of the plan. We will work to ensure that this priority is delivered across the wider partnership with advice, support and activities made available as widely as possible.	
Priority outcomes	Key activities
Staff have access to resources and information that can improve their wellbeing	• Ensure that all staff have access to universal information with regard to health and wellbeing across the partnership's services.
Staff feel connected to their team or service and we embed a health and wellbeing culture across the partnership	• Develop leadership competencies across management in order to focus on resilience across the partnership. • Ensure regular wellbeing conversations with staff and teams.

Opportunities are promoted for staff to take part in physical activity, rest and relaxation	• Promote relaxation and physical activity opportunities across the partnership

OUR COMMUNITIES ARE RESILIENT AND THERE ARE BETTER OPPORTUNITIES FOR HEALTH AND WELLBEING

Why this outcome is important

As well as our commitment to delivering high quality health and social care services for people with assessed needs we want our local communities to be resilient and be places that promote good health and wellbeing. This means promoting good **public health** through **healthy lifestyle choices**, and ensuring people can access the health and care interventions they need at the **right time** and in the **right place**. We will encourage local people to live healthy lives, providing advice, support and signposting to opportunities in our communities. When a concern arises, be it physical illness, mental health, or another concern that impacts your wellbeing, we will provide support to you as soon as possible to prevent it from growing into a more complex issue.

This strategic plan is transparent about the challenges facing the health and social care sector. As resources have become increasingly stretched, the HSCP has had to change its approach to how people access social care, introducing a new Supporting People Framework. Under the framework the HSCP is currently targeting resources towards people assessed as having 'critical' or 'substantial' needs. Regardless of whether the resource position changes in the years ahead, it is clear that the way many people in East Renfrewshire access help is having to change. As described under our previous outcome, we are taking a strengths-based approach, working with individuals and families to identify what assets are available to them in their own networks and in their local communities. A key challenge for our partnership is ensuring that the necessary **community–based help and support** is available and accessible. We recognise that the third/voluntary sector is not immune to the resource challenges we are facing and local organisations are facing their own issues in relation to funding, increased demand pressures and shortages of volunteers.

It is a shared responsibility to ensure a resilient community sector and we will work with our partners to strengthen the resources available in our communities to improve health and wellbeing. The HSCP will take an active role in the Community Planning Partnership in East Renfrewshire, supporting the delivery of the ambitious new community planning vision for 2040, *A Place to Grow*. The vision has three 'pillars' including supporting a "future where we all live well". This pillar sets out the following long-term ambition and outcomes for residents and communities in East Renfrewshire:

Our **ambition** is that everyone can live well at all stages of life and communities will be taking the lead in driving change for good health and wellbeing.	
Our communities will: • Be stronger, connected and leading the way in solutions to support each other to live well • See health inequalities reduced • Be actively involved in volunteering and community leadership • Have varied and diverse groups and third sector organisations that are respected and valued partners	**Our residents will:** • Be supported to age-well and live healthy, active lives • Have routes out of poverty • Be empowered to make healthy choices and have access to high quality sports and physical activity facilities • Have access to creative and vibrant cultural experiences and opportunities to celebrate diverse heritages • Have opportunities and support to participate in lifelong learning

We will continue to strengthen links between the HSCP and community and third sector support, recognising the role of community capacity building approaches, working to identify gaps in support and aiming to ensure that people can access different types of help for different needs across our local groups and support providers.

The partnership is committed to address the **health inequalities** that we see across our communities. We will continue to work together with community planning partners to improve health and wellbeing outcomes for our most disadvantaged localities. 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.

Under this outcome we will ensure that our local health care, including **primary care** is of the highest quality and meets the needs of all residents. As well as promoting self-care and supporting people with long-term conditions we will ensure that local provision supports the rest of the health and social care system, minimising unnecessary use of hospital and acute services. We will continue to work with our NHSGGC partners to ensure a 'whole system' of health and social care enabled by the delivery of key primary care and community health and social care services.

We will continue to support communities through a range of **community justice** services working with our multi-agency partners to ensure there are strong pathways to recovery and rehabilitation following a criminal conviction. We will support a range of innovative approaches to meet the needs of our communities and reduce the risk of further offending.

How we will deliver this outcome

Strengthening links with communities and 3rd sector supports

The partnership is committed to developing the volume and range of help and support for health and wellbeing available in our communities. While new models or support are urgently required, we recognise the pressures our voluntary/third sector is under. It is a shared responsibility to support the sector, identify gaps and areas where further development is required. We also need to develop our approach to being a 'listening' partnership that can respond to the changing needs of our communities.	
Priority outcomes	Key activities
Gaps in community resources for health and wellbeing are identified and addressed	• Partners work together to map and understand local support and identify gaps. • Community-based groups are support to strengthen their response to address identified gaps in support. • Work in partnership to build the capacity of community organisations, groups and individuals to deliver their own solutions.
Residents are clear on the role of the HSCP, statutory providers and the support available from third/community sector organisations	• The partnership communicates its holistic, 'tiered' approach to help people find support that is appropriate to different levels of need.
We are a genuinely 'listening' partnership with ongoing, transparent engagement.	• Continue to develop the scope and activities of our Participation and Engagement Network (PEN), involving more views from people with lived experience. • Review options for more consistent engagement activity.

Supporting individuals and communities to tackle health inequalities and improve life chances

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. We will work to ensure that the health improvement activities we support are accessible, well communicated, and flexible; driven by the needs of local people. The HSCP will continue to support community planning activity that aims to tackle the root causes of health inequalities as reflected in the new community planning vision, *A Place to Grow*. This includes activity to address child poverty, promote health literacy and strengthen community resilience. We will continue to promote digital inclusion with a particular focus on supporting people to live well independently; and play a proactive role in managing their health and wellbeing.	
Priority outcomes	Key activities
Health inequalities will be reduced by working with communities and through co-produced targeted interventions	• Deliver tailored health improvement programmes and activities in communities with greater health inequalities. • Continue to support local activity to tackle Child Poverty and mitigate its effects. • Work to ensure people in our most disadvantaged community are able to access digital opportunities that support independence and wellbeing.
Activity to address health inequalities is informed by data, intelligence and the experiences of our communities	• We use Health and Wellbeing Survey data to direct our targeted work in local neighbourhoods to address health inequalities. • Community involvement in service development is sustained (through approaches like Recovery Hub). • The needs of individuals and groups are identified early – before crisis.
People understand their own responsibility for health and wellbeing.	• There is a sustained focus on encouraging positive health behaviours (reflecting the national public heath priorities). • Promote information that raises awareness of self-management and self-care.

Supporting people's healthcare needs by providing support in the right way, by the right person at the right time

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. Over the life of this plan we will support the local delivery of the priority outcomes set out in the *NHSGGC Primary Care Strategy 2024-29*:

- We are more informed and empowered when using primary care;
- Our primary care services better contribute to improving population health;
- Our experience as patients in primary care is enhanced;
- Our primary care workforces is expanded, more integrated and coordinated with community and secondary care;
- Our primary care infrastructure – physical and digital - is improved;
- Primary care better addresses health inequalities.

We continue to support the development of our multi-disciplinary teams across the HSCP including, for example, our multi-disciplinary Front Door model, leadership arrangements, and frailty hubs. We will continue to build our collaborative working to support our care home community in maintaining residents in the community, and avoiding hospital admissions.

We have seen increasing use of digital communication as people interact with healthcare providers. We will take an evidence-based and inclusive approach to supporting the anticipated change in the way our communities access healthcare. This means ensuring wider access to digital communication technologies, keeping pace with new approaches and opportunities and making sure a suite of options are available for those requiring alternatives.

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. We will support the delivery of NHSGGC board-wide initiatives to help those experiencing frailty including the frailty pathway, Home First and other approaches supporting older people to stay well at home. We will deliver the priorities set out in the NHSGGC *Unscheduled Care Design and Delivery Plan* for 2024-2027 which remains committed to the three key themes established in the joint commissioning plan for Unscheduled Care:

- **Prevention and early intervention** with the aim of better support people receive the care and treatment they need at or close to home and to avoid hospital admission where possible.
- **Improving the primary and secondary care interface** by providing GPs with better access to clinical advice and designing integrated patient pathways for specific conditions.

• **Improving hospital discharge** and better supporting people to transfer from acute care to appropriate support in the community.	
Priority outcomes	Key activities
Early intervention and prevention of admission to hospital to better support people in the community	• Continue to develop our community pathways to reduce patient conveyance to ED and manage within the community; when appropriate • Develop pathways for individuals diagnosed and living with long-term conditions to improve self-management and maintain them within the community • Focused support across care homes to maintain resident health to support them to be maintained within the home environment and avoid acute attendance • Optimise the use of community beds for proactive assessment/reablement and rehabilitation • Further develop and deliver a person-centred approach to Future Care Planning
Improved hospital discharge and better support for people to transfer from acute care to community supports	• Collaborative working include MDT weekly huddle with hospitals to support discharge planning for all East Ren inpatients • Hospital to Home Social Work inreach across all sites for complex cases to support early discharge • Daily reporting, monitoring and review of delays • Bonnyton 6 bedded unit available for interim care although Home First with community rehabilitation/ reablement input.

<u>Supporting effective community justice pathways that support people to stop offending and rebuild lives</u>

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 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 continue to strengthen our links with community services and programmes to provide greater access and support for people to stop offending. 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.	
Priority outcomes	Key activities
Optimise the use of diversion and intervention at the earliest opportunity	• Use appropriate risk assessment tools to identify need and reduce the risk of further offending. • Deliver accredited programmes aimed at reducing reoffending
Ensure that robust and high quality community interventions and public protection arrangements are available	• Deliver multi-agency public protection arrangements with police, health and prisons which assess and manage sex offenders, serious and violent offenders • Enhance skills and knowledge in trauma informed practice across justice services • Increase effective use of structured deferred sentence, bail supervision electronic monitoring
Ensure that services are accessible and available to address the needs of individuals accused or convicted of an offence	• Deliver a whole systems approach to diverting both young people and women from custody • Ensure people subject to statutory and voluntary supervision including licence have early access to community mental health, alcohol and drug recovery services • Working with local partners to ensure a range of beneficial unpaid work placements are taken up • Actively participate in the East Renfrewshire Employability Partnership to develop pathway and employability support

PEOPLE ARE SAFE AND PROTECTED

Why this outcome is important

Everyone has the right to live in safety and be protected from neglect, abuse and harm. We will continue to keep vulnerable people in our communities safe, preventing harm and supporting people at risk of 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.

In our work to protect adults at risk from harm we will continue to respond to the changing needs. The vision of the **East Renfrewshire Adult Protection Committee** is to create a culture of continuous learning and improvement which engages all partners to support adults at risk of harm to live their lives the way they want. We are committed to learning from the experiences of individuals, communities and partners. We will reflect and learn from our experiences, sharing best practice and improving our services to ensure our services meet the needs of adults at risk of harm and their carers in East Renfrewshire. We are focused 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. Over the life of this plan we will continue to strengthen the consistency and robustness of our processes and continue to develop awareness of Adult Support and Protection with our partners, providers and the public.

Through the delivery of our **East Renfrewshire Child Protection Committee Improvement Plan 2023-2026** we are supporting a range of multi-agency activity to minimise harm to our children and young people. We are focused on ensuring that children, young people and their families are actively part of safety planning and these plans are accurately recorded and shared with them. Our multi-agency approach sees partners working together to ensure oversight and timeous responses to child protection concerns.

Domestic abuse continues to be the predominant reason for referral to our children's services and features as one of the most common concerns within child protection interagency referral discussions. Through our multi-agency approach we work collaboratively to deliver a significant range of actions to ensure an effective and sustainable approach to preventing, reducing and

responding effectively to domestic abuse and all forms of violence against women and girls. This includes the implementation of **Routine Sensitive Enquiry**, **Multi Agency Risk Assessment Conference (MARAC)** and **Safe and Together** practice to ensure a perpetrator pattern based, child centred, survivor strengths approach to working with domestic abuse. We will continue to strengthen the capacity of our services and action across the whole system to address the long-term effects of trauma and abuse experienced by women, children and young people. We will continue to support a MARAC in East Renfrewshire for high-risk domestic abuse victims and we will continue to work together with **East Renfrewshire Women's Aid Service** to provide direct support for women and children who have experienced domestic abuse.

We are committed to working in partnership to minimise **self-harm and suicide**. East Renfrewshire *Suicide Prevention Strategy and Action Plan 2024 - 2027* has been developed following the publication of the national strategy and action plan "Creating Hope Together"; a joint strategy between Scottish Government and COSLA. The delivery of this strategy and action plan is integral to our role as a Health and Social Care Partnership (HSCP), supporting local individuals and communities, and through implementation of the plan we are committed to creating a suicide safe East Renfrewshire, free of stigma through awareness raising, education and community based partnership working.

In the aftermath of the Covid-19 pandemic we are more conscious than ever of our role in **health protection** for the wider population of East Renfrewshire. This means ensuring the safety of all residents through: the delivery and promotion of vaccinations against infectious disease; information and education to support positive attitudes and behaviour for health safety; and, recognition of changing requirements as the needs of our population changes.

How we will deliver this outcome

Priority outcomes	Key activities
Individuals and their carers are active participants in shaping their support and the way in which Adult Support and Protection activity is undertaken in East Renfrewshire.	• We will ensure that the views of adults at risk, their families and carers are heard and help shape the way we deliver services. • We will ensure that adults are offered independent advocacy at the earliest opportunity, in the way that is most appropriate for them. • We will make best use of all our opportunities for the prevention and identification of harm

	• We will continue to strengthen the way in which we work together and share responsibility with our partners, providers and the third sector in order to provide consistency and continuity to adults at risk of harm • We will continue to develop awareness of Adult Support and Protection with our partners, providers and the public. • We will work with HSCP staff, partner agencies, providers and adults at risk to identify and address stumbling blocks (barriers) that impact on how we move forward in a collaborative fashion. • We will ensure that adult's strengths, assets and trauma contribute to our understanding of risk and their circumstances. • We will continue to learn and improve each time we carry out a Large Scale Investigation. • We will take steps to ensure the full involvement of all key partners in relevant aspects of adult support and protection practice going forward. • We will include partners as we continue to check the quality of ASP activity, ensuring our risk assessments are robust and supported by appropriate evidence including chronologies.
Ensure that children are kept safe in their families and communities.	• Deliver the commitments in the East Renfrewshire Child Protection Committee Improvement Plan 2023-2026
Create a Suicide Safe East Renfrewshire, free of stigma through awareness raising, education and community based partnership working.	• Deliver the commitments in the East Renfrewshire Suicide Prevention Strategy and Action Plan 2024 – 2027, focusing on the priority areas: Establish Local Suicide Prevention Network; Education / Training; Communications; Community Development / Lived Experience; Data Collection / Analysis
The health of East Renfrewshire's population is protected from major incidents and other threats	• Deliver health protection measures including successful uptake of locally-delivered vaccination programmes.

3. Developing our plan

3.1 Introduction

This plan is the result of months of development work as we have collaborated with colleagues, stakeholders, and local people. Our objective is that the plan reflects the shared priorities of local residents and sets out meaningful commitments for our wide partnership.

We were clear from the outset that we were not developing a strategic plan with a 'blank page' but building on core principles set out in our previous plans. The plan also links with a number of related plans and we have incorporated the learning from recent local planning and engagement activity that has informed those plans.

Our approach to the development of the plan was agreed in June 2024 with the East Renfrewshire Strategic Planning Group (SPG) who have responsibility for directing the development and implementation of the Strategic Plan.

The development of our plan has followed the broad timeline set out below.

Jun-Jul 24	**Aug 24**	**Sept-Oct 24**	**Nov 24**	***Dec 24-Jan 25***	***Feb 25***	***Mar-Apr 25***	***Apr 25 onwards***
Initial planning – approach agreed; information and data gathering	Framework for plan agreed with SPG and management team	Engagement with staff, stakeholders, community groups, local people (workshops and survey)	Draft plan produced for consultation	*Public consultation inc. 'Big Lunch' public event*	*Post-consultation drafting*	*Approval and publication*	*Annual delivery plan agreed and implementation*

3.2 Stage one stakeholder engagement

We were clear as a partnership that we wanted to simplify our Strategic Plan to make it more meaningful and more focused around shared priorities. In discussion with stakeholders through our SPG, service-based planning officers and senior managers we agreed an initial framework for the plan. This helped give the development work more focus, and was the basis for discussion during our engagement activity.

During October we held two in-person stakeholder **workshops** in each of our localities (Barrhead and Eastwood) and an online workshop hosted by the SPG. The three events were attended by 45 stakeholders from the statutory, third and community sectors. The workshops considered the following topics for our strategic plan:

- Current and future **challenges** – what are the key challenges we need to respond to as a partnership? Which are the most pressing?
- Our broad **approach** – how can our approach meet our challenges? What else would improve the way we work as a partnership?

- Our strategic **outcomes**, priorities and intermediate outcomes - What changes/outcomes do we hope to see by 2028? What areas/activities should we focus on?

To widen our engagement and capture the views of local people staff and stakeholders we conducted an online **survey** seeking views on the strategic outcomes in our framework. Respondents were asked to comment on our proposed outcomes and how these can best be delivered by the HSCP over the life of the plan. The survey was promoted online, through social media and was 'cascaded' by members of our local Participation and Engagement Network.

By mid-November we had received 50 responses to the survey, with two-thirds coming from local residents. There was strong support for the headline strategic priorities set out in our framework and recognition of the challenges facing the partnership including financial constraints. Survey respondents highlighted a range of areas for further action which have informed the content of this plan and will influence the action planning in our Annual Delivery Plan to support implementation.

3.3 Stage two planned engagement work

The contents of our emerging plan will be part of discussions at the East Renfrewshire 'Big Lunch' community event in December. Following comments from our IJB and the NHSGGC Finance, Planning and Performance Committee we will undertake a full public / stakeholder consultation on the draft plan through the following methods:

- Promotion of the draft with a short questionnaire to our prescribed consultees.
- Promotion of the draft/questionnaire through HSCP website, social media, ERC Have Your Say page, staff bulletins.
- Promotion and discussion of draft at Big Lunch event in December 2024.

Feedback from the consultation exercise will be fed into the subsequent draft of the Strategic Plan. The draft will be discussed at our Strategic Planning Group in February 2025 and the draft final Strategic Plan will be presented to the IJB for approval in March 2025.

Through our SPG we will develop a more detailed outcomes framework to support the plan and outcome-focused action planning will be presented in our Annual Delivery Plan.

4. Our context and challenges

4.1 Introduction

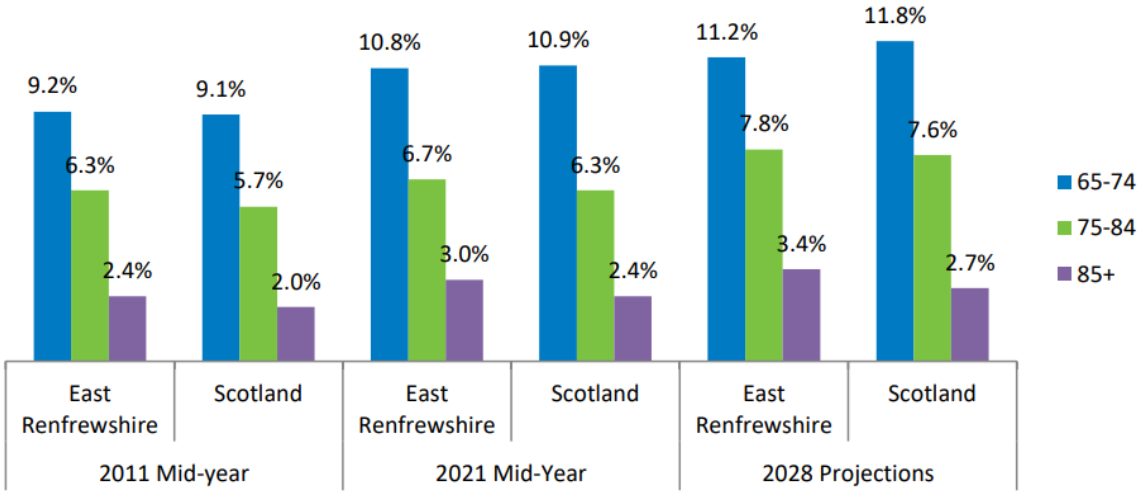
This section summarises our current context in relation to East Renfrewshire's demographic and health profile and recognised future challenges.

4.2 Population and demographics

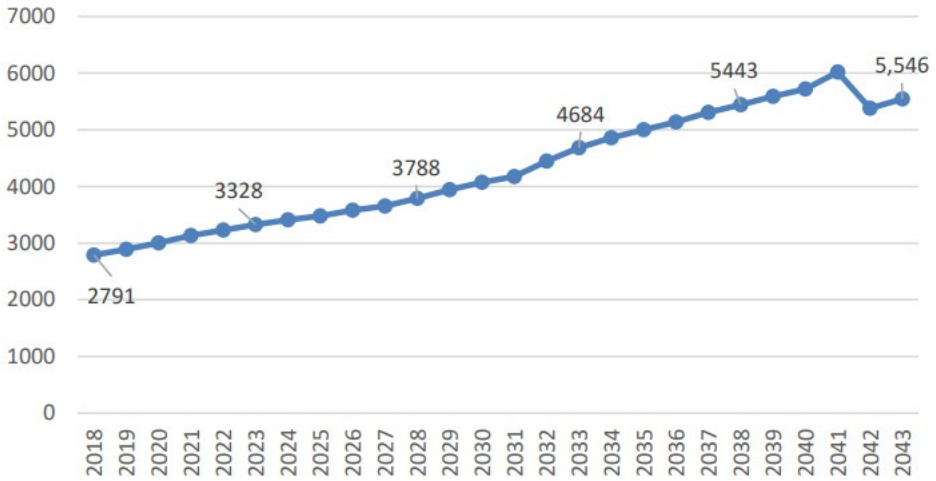
Like the rest of Scotland, East Renfrewshire faces significant changes in its population in the coming years. We expect our population to increase, to have more elderly residents, to see a decline in death rates and to have an increase in the number of households, as more people live alone. East Renfrewshire is already one of the most ethnically and culturally diverse communities in the country and we expect this trend to continue.

These changes impact the decisions we make on the provision of health and social care in East Renfrewshire. Our population is changing with a corresponding increase in the health and care needs of our residents. The projections highlight that there will be an increase in the young and old population, who make greater use of universal health services. Forecasts suggest that the population of East Renfrewshire is set to increase by 6.4% between 2018 and 2028. The percentage of the 75 and over age group is projected to increase by 26.8% over the same period. People over the age of 80 are the greatest users of hospital and community health services and social care.

% population over 65 (2011, 2018 and 2028 projections)



Number of East Renfrewshire residents aged 85+, projected to 2043



4.3 Inequalities

Overall, East Renfrewshire is one of the least deprived local authority areas in Scotland. Many residents enjoy a good quality of life and health in the area is relatively good. However, this mask the notable discrepancies that we see across the area with some neighbourhoods experiencing significant disadvantage and poorer health and wellbeing outcomes.

More than half of East Renfrewshire's population (55%), and 67% of the Eastwood population live in Scottish Index of Multiple Deprivation (SIMD) datazones that are among the 20% least deprived in Scotland. 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 datazones.

The difference in deprivation between areas is a major determinant of health inequality. People living in the most deprived neighbourhoods are more exposed to environmental conditions which negatively affect health. Access to green space, pollution effects, housing quality, community participation, and social isolation are all measures of social inequality which have an impact on health. These factors underpin both physical and mental health.

The NHS Greater Glasgow and Clyde 2022/23 Adult Health and Wellbeing Survey shows that those in the most deprived areas had poorer indicators for smoking, exposure to smoke, use of e-cigarettes, binge drinking, consuming fruit/vegetables and meeting the target for physical activity. Those in the most deprived areas were less likely to feel safe using local public transport or walking alone in their area. Those in the most deprived areas and those with a limiting condition or illness were more likely to say they had no qualifications.

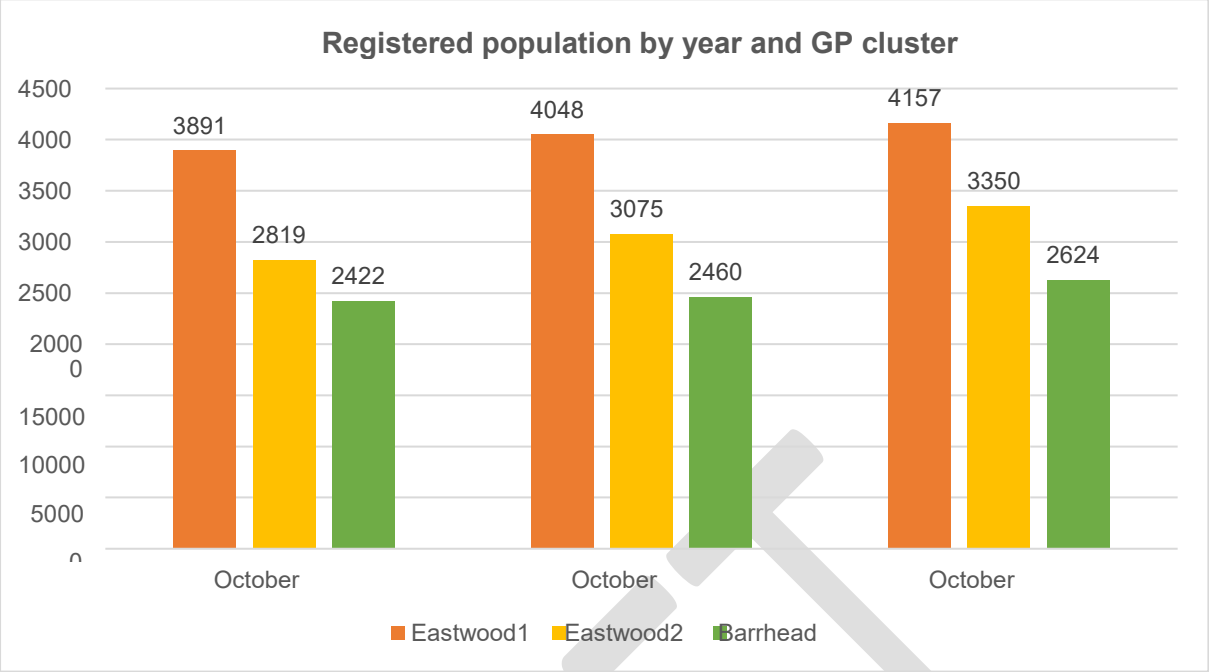
Although East Renfrewshire has one of the lowest levels of child poverty in Scotland at 14.4% the ongoing and cumulative impacts of the Covid-19 pandemic and the cost-of-living crisis has seen families facing more financial pressures than ever before. We recognise the impact of poverty on the health and wellbeing of children and young people and that the damaging effects can have a long-term impact into adulthood.
In line with our socio-demographic profile we see differing health outcomes for the populations in our two localities of Barrhead and Eastwood. While life expectancy at birth is above the Scottish average for East Renfrewshire as a whole, it remains below average in the Barrhead locality. Both males and females born in the most deprived neighbourhoods have a lower life expectancy than those born in the least deprived. Early mortality rates and the prevalence of long-term conditions including cancers are also higher for Barrhead, exceeding the Scottish average. And we are seeing a significantly higher rate for deaths among people aged between 15 and 44 years in the Barrhead locality at three times the rate for Eastwood. We also see higher rates of prescriptions and hospital use for mental health-related issues in our more disadvantaged neighbourhoods.

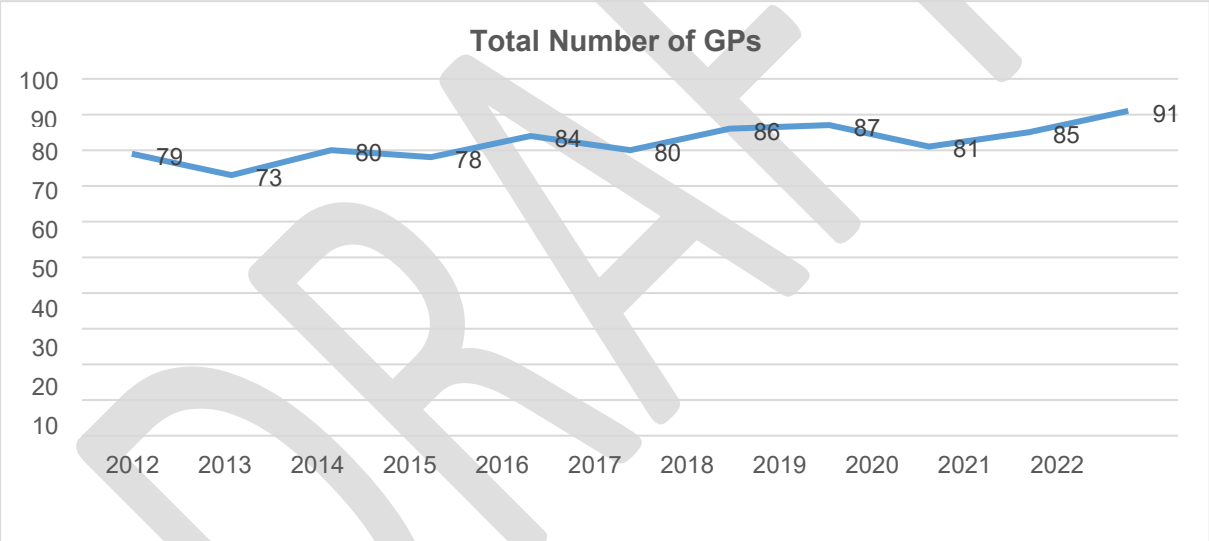
Indicators	Data Type	Time Period	Barrhead Locality	Eastwood Locality	East Renfrewshire HSCP	Scotland
General Health						
Male average life expectancy in years	mean	2017 - 2021*	75.1	81.5	79.4	76.5
Female average life expectancy in years	mean	2017 - 2021*	81.1	84.8	83.7	80.7
Deaths aged 15-44 per 100,000	rate	2019 - 2021	154.1	51.5	77.2	117.1
Population with long-term condition	%	2022/23	22.9	19.8	21.3	21.7
Cancer registrations per 100,000	rate	2019 - 2021	640.1	589.4	602.5	630.3
Anxiety, depression & psychosis prescriptions	%	2021/22	21.1	15.8	17.2	20.1
Hospital Care (Mental Health)						
Psychiatric patient hospitalisations per 100,000	rate	2019/20 - 2021/22	214.5	124.7	147.4	230.7
Unscheduled bed days per 100,000	rate	2022/23	11,742	10,163	10,566	18,735

4.4 Primary care provision

As we would expect, population growth in East Renfrewshire is impacting on the demand for local primary care services. Trends in the GP Practice populations show a steady increase each year from 2015 for the majority of practices in East Renfrewshire and for each of our three GP clusters of Eastwood 1, Eastwood 2 and Barrhead. There is significant pressure on GPs due to the level of new patient registrations.

The chart below shows the change in the registered population for each GP cluster. All areas have seen an increase with the largest being within the Eastwood 2 cluster which has increased by 5314 (18.84%) since 2015. Since 2019 EW1 has increased by 2.7%, Barrhead by 6.7% and EW2 by 8.9%. Increases in the population and new housebuilding in the area is having an impact upon the existing GP infrastructure, especially within the Eastwood2 cluster.





4.5 Housing

Housing issues such as affordability, suitability, size, condition and quality can all influence the health and wellbeing of people. As East Renfrewshire's population changes the need for specialist homes for older people and people with long-term conditions is increasing. Assisted living and care homes can help to support health outcomes, such as reducing the risk of falls and fractures, which in turn reduces the demand for community-based care services including Care at Home.

Ensuring our communities have access to good quality housing and housing-related services is key to enabling people to live as independently as possible and also makes a significant contribution to reducing health inequalities locally. The *Housing Contribution Statement (HCS)* operates as the "bridge" between strategic housing planning and that of health and social care and is being in line with the new East Renfrewshire Local Housing Strategy 2024-29.

4.6 Transport and accessibility

During the engagement exercise for this strategic plan, many people raised issues around transport and the difficulty of accessing community-based supports and healthcare without adequate local transport. This is an issue that the HSCP will continue to address with our community planning partners.

4.7 Our financial context

To be added following announcement of financial settlement (January 2025).

This section will set out the financial context for the three-year period including key challenges and plans for transformational change; and will set out our planned budgeting framework.

5. Related plans and policies

6.1 Introduction

This section outlines the main plans and policies that inform and are linked to the East Renfrewshire Strategic Plan 2025-25.

6.2 National and Local Statutory Plans

The Independent Review of Adult Social Care and the National Care Service

The Independent Review of Adult Social Care in Scotland was published in 2021 and was supported by an Advisory Panel comprising Scottish and International experts. The core remit of the review was to "recommend improvements to adult social care in Scotland".

The report describes social care as a "springboard, not a safety net". HSCP strives to focus on that springboard, lifting people up and supporting empowered, independent people and communities "Everyone in Scotland will get the social care support they need to live their lives as they choose and to be active citizens. We will all work together to promote and ensure human rights, wellbeing, independent living, and equity."

Recommendations from the review informed the development of the National Care Service (NCS) Scotland Bill which was submitted to Scottish Parliament in June 2022 The Scottish Government's emerging plan on the creation of a NCS continues to develop, engagement work continues and at this time the extent of change is undetermined, however it is likely to have significant implications for HSCPs. This Strategic Plan has been developed based on what is currently known to us at this time. Any significant changes in the national landscape, will be considered locally in terms of its potential impact on our ability to deliver this plan.

Moving Forward Together (NHS Greater Glasgow and Clyde)

The way that health and social care services in NHS Greater Glasgow and Clyde are provided is changing. NHS GGCs Moving Forward Together (MFT) Transformation in Practice strategy provides a clear plan for change and compliments direction of this Strategic Partnership Plan. Delivery of the Programme will see improvements in care and outcomes for everyone, MFT describes a tiered model of services where people receive care as near to their home as possible, travelling to specialist centres only when expertise in specific areas is required and promotes greater use of digital technology and maximising the utilisation of all resources, with a drive to ensure all practitioners are working to the top of their professional abilities. It recommends supported self-care and improved links between primary and secondary care.

This new system of care will be organised in the most effective way to provide safe, effective, person-centred, and sustainable care to meet the current and future needs of our population.

More information can be found on these pages *Moving Forward together - NHSGGC*

Mental Health Strategy 2023-2028 (NHS Greater Glasgow and Clyde)

The NHS GGC Mental Health strategy refresh is part of the Moving Forward Together (MFT) programme. Strategies for Mental Health Services in GGC are aligned to the Scottish Government's Mental Health and Wellbeing Strategy *Scotland's Mental Health and Wellbeing: Strategy* (www.gov.scot) and the NHSGGC 'Healthy Minds' report *Healthy Minds Resource - NHSGGC.*

The new NHS GGC strategy expands on its scope to take account of the range of services relevant to the wider complex of mental health services and the continuing impact of COVID-19 as services go about restoring and refreshing the focus on Strategy changes, initially for the next five years. The Strategy refresh approach to implementation will include:

- Promoting prevention options to improve wellbeing.
- A commitment to more established points of access and clear referral pathways.

- No wrong door approaches, with referrals to secondary specialist mental health services, not being sent back to Primary Care Services, but instead discussed and progressed between secondary specialists' services.
- Greater co-production with people with lived and living experience, and families and carers.
- A focus on inequalities including people with protected characteristics and those affected negatively by the socio-economic determinants of health and wellbeing.
- Improved faster access for those in mental health crisis.
- Self-management resources for people with long term mental health issues.

Greater Glasgow and Clyde: Alcohol Recovery Pathway

In response to the increase in alcohol related harm and to ensure safe, effective delivery of practice, the Alcohol Recovery Pathway was developed to standardise quality alcohol care and treatment in Alcohol and Drugs Recovery Service (ADRS) across Greater Glasgow and Clyde (GGC).

The guideline is aimed at all staff involved in the care and treatment of individuals who use alcohol on its own or combined with other substances. The guidance recommends ten principles for the provision of care and treatment of adults with harmful, hazardous, and dependent alcohol use across GGC ADRS. These are:

1. "No wrong door" access to services
2. Equality of treatment.
3. People have timely access.
4. Services are psychologically and trauma informed.
5. Access to mental health assessment and treatment at point of delivery.
6. Chronic disease management approach.
7. Informed choice of alcohol interventions.
8. Support to remain in treatment.
9. Clear pathways into other health, care, and recovery services
10. People have the option to have components of their treatment shared with primary care.

National Carers Strategy

The Scottish Government published its National Carers Strategy in December 2022. It underlines the value that carers across Scotland bring to the health and social care sector and highlights the importance to support them in there caring role. The strategy details the challenges that carers face, including the ongoing impact of Covid-19, the cost-of-living crisis, and the personal health and wellbeing impacts they can experience. The key themes of the strategy intend to put the individual carer at the centre and focus on five distinct aspects of unpaid carer support are:

- Living with Covid-19
- Recognising, valuing, and involving carers
- Health and Social Care Support
- Social and Financial Inclusion
- Young Carers

National Drugs Mission

In 2021, the Scottish Government announced its national mission to reduce drug related harms and deaths. Its key approaches involved, faster access to support services, improved front line drug services, holistic support throughout the recovery journey, and greater capacity for residential rehabilitation. The Mission allocated £50m per year that is distributed across Alcohol and Drug Partnership areas. The mission will seek to reduce deaths and harms through key approaches, including:

- Emergency life-saving interventions (naloxone, safe consumption, targeting those at risk)
- Implementation of Medication-Assisted Treatment (MAT) Standards
- Aligning the wider policy landscape on poverty, deprivation, trauma, and adverse childhood events to support drug prevention.
- Supporting the wider complex needs of people with addictions, including mental health, homelessness and contact with the justice system.
- Improved support to affected children and families.

More information on the national drugs mission can be found here: https://www.gov.scot/policies/alcohol-and-drugs/national-mission/

6.3 East Renfrewshire Policies and Plans

Summaries to be added

- East Renfrewshire Community Plan – A Place to Grow
- At Our Heart - East Renfrewshire's Children and Young People's Services Plan 2023-2026
- Supporting People Framework
- Medium-term Financial Plan
- East Renfrewshire Carers Strategy
- East Renfrewshire Alcohol and Drugs Plan 2024-27
- East Renfrewshire Suicide Prevention Plan
- HSCP Participation and Engagement Strategy
- HSCP Strategic Commissioning Plan

6. How we measure success

Our performance reporting is fully aligned to the strategic priorities set out in this plan. In addition to regular performance reporting to our Performance and Audit Committee and Integration Joint Board, we publish Annual Performance Reports giving a retrospective look at the previous year's performance. These reports set out progress made to deliver our strategic priorities over the previous 12 months.

We review our performance data against agreed local and national performance indicators, including:

- National Core Suite of Integration Indicators
- Ministerial Strategic Group (MSG), and
- Statutory Performance Indicators.

In addition to data, our performance reports draw on personal experiences, views and examples of service developments and approached to describe the improvement process and how improved outcomes are being achieved.

AGENDA ITEM No. 9

EAST RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

East Renfrewshire Council

NHS Greater Glasgow and Clyde

Meeting of East Renfrewshire Health and Social Care Partnership **Held on**	Integration Joint Board 20 November 2024
Agenda Item	9
Title	Clinical and Care Governance Annual Report 2023-24

Summary

To present the Clinical and Care Governance Annual Report 2023-24 for East Renfrewshire which sets out the main aspects of safe, effective and person-centred care.

Presented by	Dr Claire Fisher, Clinical Director

Action Required

The Integration Joint Board is asked to note and comment on the report.

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

EAST RENFREWSHIRE INTEGRATION JOINT BOARD

20 November 2024

Report by Clinical Director

CLINICAL AND CARE GOVERNANCE ANNUAL REPORT 2023-24

PURPOSE OF REPORT

1. To present to the Integration Joint Board the East Renfrewshire Clinical and Care Governance Annual Report 2023-24.

RECOMMENDATION

2. The Integration Joint Board is asked to note and comment on the report.

BACKGROUND

3. The Annual Report sets out the main aspects of safe, effective and person-centred care, to provide assurance to NHS Greater Glasgow and Clyde. These are, historically, the main pillars of clinical and care Governance and how assurance is structured for reports and updates to NHS Greater Glasgow and Clyde.

REPORT

4. East Renfrewshire Health and Social Care Partnership continues to face challenges in delivering safe, effective and person-centred care. The Annual Report for Clinical and Care Governance 2023 -2024 highlights the governance structure in place and how it contributes to the mitigation of areas of risk. The report also highlights good practice that has taken place. The level of inspection activity has been considerable and the main aspects of this have been summarised in this report. Some examples of good practice have been the Bloods and Go work, Pressure Ulcer Prevention and the support for Adults with Attention Deficit Hyperactivity Disorder. There has been good practice within the HSCP on the learning from complaints and also the positive feedback on services received via Care Opinion.

IMPLICATIONS OF THE PROPOSALS

5. None

DIRECTIONS

6. None

CONCLUSIONS

7. The structure and processes for Clinical and Care Governance continues to be supported by East Renfrewshire Health and Social Care Partnership. The wider challenges will continue, and these are not unique to East Renfrewshire Health and Social Care Partnership. The work of the staff has been exemplary in facing these challenges and the level of assurance reflected in this annual report is thanks to them.

RECOMMENDATIONS

8. The Integration Joint Board is asked to note and comment on the report.

REPORT AUTHOR AND PERSON TO CONTACT

Dr Claire Fisher, Clinical Director
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November 2024

Chief Officer, IJB: Julie Murray

BACKGROUND PAPERS

Clinical and Care Governance Annual Report 2023 -2024

13. Another vital change is the introduction of a Community Co-ordinator role which will allow the opportunity to develop a place based approach to care, provide greater efficiency with flex resource to cover absence, offer a better career path development opportunity for frontline staff, enhance field based supervision, practice support and competence assurance and allow greater interaction and communication with frontline teams to support wellbeing.

14. An initial focus of the project activity was to work with frontline homecare colleagues who were not on the standard 4 days on/4 days off work pattern. Consultation exercises, supported by HR and Trade Union colleagues, took place to successfully support the remaining frontline care staff on legacy work patterns to transition to the preferred work pattern, which facilitated efficiencies of resource utilisation.

15. Following agreement to progress some key priority appointments in summer 2024, work has moved at pace to recruit to these roles, in accordance with organisational change policy.

16. Care is being taken to ensure that the structural redesign implementation is correctly sequenced and that principles of consistency and fairness are upheld.

17. The operational team alongside HR and Trade Union colleagues have collaborated well and have successfully completed group and individual consultation sessions.

18. Following these, four managerial positions and six Scheduling and Monitoring team roles have been successfully filled.

19. Another group of roles is currently being appointed to involving both internal and external recruitment and this work is due to complete this month. This involves new roles with supervisory responsibility for frontline Homecare teams, Telecare Response staff and the Scheduling and Monitoring function, as well as a new role in Brokerage.

20. Next steps for the project are to progress the remaining roles required within the revised in house team structure and continue collaborative working with the external provider market to achieve best value hourly rates and optimum commissioning model arrangements.

21. Activity on both work streams is underway and will continue during the remainder of 2024 and the first quarter of 2025, with an estimated project completion date of end of March 2025. This will ensure that the service can move into the new financial year on a robust footing.

22. Central to the new practice model is a key focus for the in house service to deliver a strengthened re-ablement approach, compassionate end of life care and effective care to support prevention of hospital admission.

23. There is also an ongoing need to facilitate timely acute discharges as a key strategic priority for the partnership.

24. The in house service will continue to deliver a proportion of mainstream care and from a risk management perspective, it is vital that the service is appropriately scaled and has sufficient resilience.

CONSULTATION AND PARTNERSHIP WORKING

25. The Chief Officer, Chief Finance Officer, Head of Service and HR Business Partner have been fully consulted on the structure changes, associated costs and impact. The appropriate Organisational Change Policy is being followed in relation to the staffing changes. Our Trade Union colleagues have been engaged throughout the process and are supportive of the changes.

IMPLICATIONS OF THE PROPOSALS

Finance

26. The current full year effect of the modelled cost of the service is c£16.3 million and the funding in scope is £16.4 million. This level of funding is after the full target savings for 2024/25 has been removed:
    - £1.7m Supporting People Framework
    - £0.3m commissioned costs
    - £0.15m structure savings

27. The modelled costs will continue to be refined as the programme progresses however this demonstrates that delivery of the required savings on a recurring basis should be fully achieved in 2025/26. The shortfall in 2024/25 is included in the revenue monitoring reporting.

28. The modelling does not allow for any impact from the recently announced UK budget, this will be assessed in due course for the HSCP.

Workforce

29. The progression of the redesign has resulted in the deletion of job roles that were no longer fit for purpose and the creation of new roles to support operational care at home provision. Affected staff (nine) have been consulted and have now successfully secured other permanent posts within the new structure.

DIRECTIONS

30. No direction is required.

CONCLUSIONS

31. In summary, the project has made good progress in determining a modernised, strengthened and scalable practice model and in advancing appointments to priority posts within the revised structure, which will support the service to remain equipped to meet the demands upon it.

32. There is a keenness and drive to swiftly progress the remaining elements of the revised structure and external market arrangements to ensure resilience within the service, manage the cost pressures and alleviate uncertainty for the affected staff members.

RECOMMENDATIONS

33. The Integration Joint Board is asked to note the positive progress made.

REPORT AUTHOR

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7 November 2024

Chief Officer, IJB: Julie Murray

BACKGROUND PAPERS

None

EAST RENFREWSHIRE
HEALTH AND SOCIAL CARE
PARTNERSHIP

East Renfrewshire Council

NHS Greater Glasgow and Clyde

East Renfrewshire Health and Social Care Partnership

Clinical and Care Governance Annual Report 2023 -2024

Contents

1. Executive Summary

The arrangements for Clinical and Care Governance within East Renfrewshire HSCP have been well established.

The Clinical and Care Governance Committee was disestablished as a formal reporting committee to the Integration Joint Board in 2019. The HSCP has a Clinical and Care Governance Group that meets quarterly, chaired by the Clinical Director. There is an Adult Services Clinical and Care Governance Group, chaired by the Head of Adult Services: Learning Disability and Recovery. Children Services report by exception through the Chief Social Work Officer to the HSCP Clinical and Care Governance Group.

The Annual Report 2023-2024 for Clinical and Care Governance for East Renfrewshire HSCP sets out the main aspects of safe, effective and person-centred care, to provide assurance to NHS Greater Glasgow and Clyde.

These are, historically, the main pillars of clinical and care Governance and how assurance is structured for reports and updates to NHS Greater Glasgow and Clyde.

The importance of learning from complaints and feedback is a theme for clinical and care governance. This report will provide examples of the learning that has occurred from the promotion of Care Opinion and applying learning from Significant Adverse Events, Significant Case Reviews, Inspection Reports and Complaints.

East Renfrewshire HSCP continues to face several challenges, risks and uncertainties in the coming years, and this is set out in the current Medium-Term Financial Plan (MTFP) for 2024/25 to 2028/29 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 Supporting People Framework launched on the 1 April 2023 and introduces a universal approach to risk. We have introduced this framework, which is based upon research and evidence from practice to inform our decision making to allow us to support individuals in the best way we can making our decision clearer and fairer.

The supporting people framework will minimise the need for formal support, by identifying the individual’s own strengths, assets, natural networks, technological supports and community resources.

The savings targets identified through the Supporting People Framework has proven to be a significant challenge for the HSCP, and the status of this and progress towards savings targets is set out in regular updates to the Integration Joint Board.

2. Introduction

East Renfrewshire Health and Social Care Partnership are required by NHS Greater Glasgow and Clyde to provide an annual report covering the main aspects of clinical and care governance with the focus on safe, effective and person-centred care.

This report is intended to provide an overview of how East Renfrewshire HSCP has considered the risks through the clinical and care governance structure and the main challenges identified.

There was work undertaken on the impacts of the Health and Care (Staffing) (Scotland) Act 2019 during 2023-2024 but the full impacts of this work for clinical and care governance are out with the scope of this report.

The report covers the reporting period 1st April 2023 to 31st March 2024.

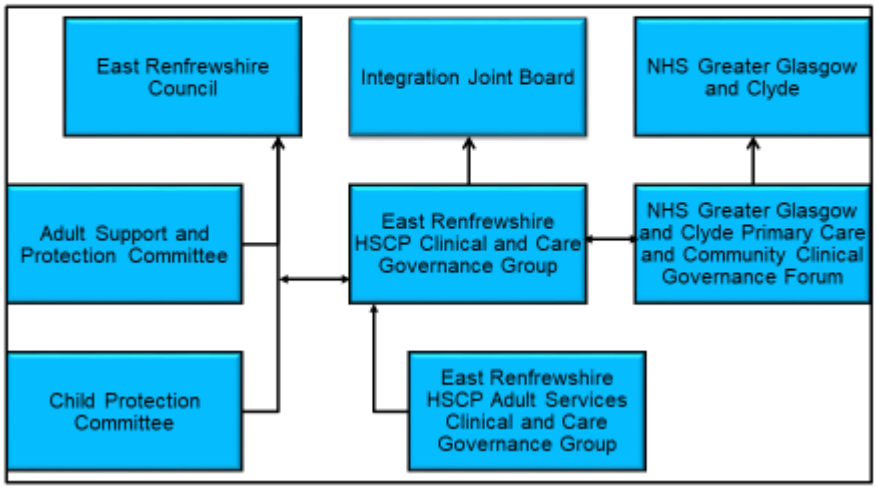
3. Clinical and Care Governance Structure East Renfrewshire HSCP

The HSCP has a Clinical and Care Governance Group, chaired by the Clinical Director and membership that reflects the Directorate Management Team, Your Voice and Third Sector partners.

The structure is depicted in Figure 1 and incorporates the current structure. The principal groups that have reporting relationships and influence have been depicted.

Key Message: The clinical and care governance structure reflects the HSCP scope for clinical and care governance.

Figure 1
East Renfrewshire HSCP Clinical and Care Governance Structure 2024



The HSCP Clinical and Care Governance Group met on 21st June 2023; 20th September 2023; 7th December 2023 and 13th March 2024. The group is chaired by the Clinical Director.

The Adult Services Clinical and Care Governance Group met on 9th May 2023; 15th August 2023; 17th October 2024 and 7th March 2024. The group is chaired by the Head of Adult Services: Learning Disability and Recovery.

The NHS Greater Glasgow and Clyde Primary Care and Community Clinical Governance Forum meet six times a year and there is an exception report prepared for every meeting from the HSCP, and the Clinical Director and Chief Nurse attend this meeting.

The Adult Protection and Child Protection Committees will also have governance reporting as required depending on investigations conducted and concluded and sharing any learning. Main areas of risk will be reported by the Head of Service to the HSCP Clinical and Care Governance Group.

4. SAFE

4.1 Significant Adverse Events

The updated NHS Greater Glasgow and Clyde Policy on the Management of Significant Adverse Events was live from November 2023. The aim to provide high quality care, which is person centred, effective and safe. For most patients requiring healthcare this aim is satisfied but on occasion care does not proceed as planned. From the full range of clinical events reported in NHS Greater Glasgow and Clyde there is a smaller set of instances where there is a risk of significant harm to patients.

East Renfrewshire HSCP have a responsibility to ensure these events are appropriately reviewed to minimise the risk of recurrence by applying lessons learned. This opportunity for learning exists at times without a significant adverse outcome for the patient, e.g., a near miss or a lower impact event which exposes potential clinical system weaknesses that could lead to further significant harm. Such events have been traditionally referred to as Significant Adverse Events (SAE). East Renfrewshire HSCP update progress to the NHS Greater Glasgow and Clyde Primary Community and Clinical Care Governance Forum that meets six times a year.

4.2 Open Significant Adverse Events

East Renfrewshire HSCP had four open Significant Adverse Event incidents that occurred during the 2023 -2024 reporting period.

Table 1 shows the breakdown of the four by specialty, date of incident, category and the governance group tracking progress to completion.

Table 1: Open SAE breakdown by service, date of incident, category and progress for incidents that occurred 2023 - 2024 for East Renfrewshire HSCP.

Service	Date of Incident	Category	Progress
Children and Families	15/12/2023	Cardiac arrest	Review is ongoing and is expected to conclude by end 2024.
Children and Families	5/11/2022	Sudden illness	This SAE has now concluded and is in Quality Assurance. There have been 9 actions identified which will be progressed 2024 -2025.
Learning Disabilities	9/10/2023	Medication/ Monitoring	This SAE will be expected to conclude by end 2024.

Older Adults Community Mental Health	27/7/2023	Overdose Prescribed Medication	This SAE will be expected to conclude by end 2024.

Key Message: There is governance routes established for all incidents that are identified as satisfying the criteria for investigation via the Significant Adverse Event Review process. Progress is reported to the Primary Care and Community Clinical Governance Forum.

4.3 Significant Adverse Event Review Thematic Analysis of Actions

This section will focus on what learning has been identified from completed Significant Adverse Events.

Table 2 provides the actions identified actions from completed reviews.

There were three completed reviews for 2023 – 2024. Table 2 shows that there were actions from all three.

Table 2: Three completed Significant Adverse Event Reviews 2023 - 2024 for East Renfrewshire HSCP where actions were identified

Specialty	Category	Summary	Number Actions Identified	Actions Overdue
Specialist Learning Disability Inpatients	Self-Harm	Near miss attempted suicide.	6	0
Community Mental Health Team	Suicide	Completed Suicide	1	0
Addictions Service	Suicide	Completed Suicide	1	0

There are eight actions identified. The completed reviews identify recommendations for remedial measures to prevent recurrence as much as possible and to share the learning. Progress is tracked through the Datix system. There are no overdue actions at the time of compiling this report.

Table 3 summarises the three completed review actions that have been completed, by theme.

Table 3 Completed Significant Adverse Event Reviews in 2023 – 2024 by Action Theme for East Renfrewshire HSCP

Action Theme	Addictions Team	Community Mental Health Team	SLDS In-Patients	Total for Action Theme and Percentage of Total
Policy/Guidance/Protocol; includes development, review and implementation	0	0	2	**2**
Service/Strategic/Managerial; includes service provision and redesign, meeting targets, and culture and leadership	1	0	0	**1**
Communication; includes within teams and interface between teams	0	0	2	**2**
Training; includes sourcing external training, development of training packages, and delivering training	0	0	2	**2**
Workforce management; includes staffing levels, skill mix, workforce planning, and performance management	0	1	0	**1**
Total	**1**	**1**	**6**	**8**

The above table shows that the categories are spread throughout the criteria used and there is no clear trend to identify.

For the purposes of this report, two illustrative examples have been chosen to explain in more detail the type of work undertaken.

Case Study 1: Specialist Learning Disability Service In-Patients

This action was identified as a high priority local action. The work involved a plan to be in place to give time to staff for training and development. This emphasised the importance of management of ligatures, staff leadership and management and providing training specific to individual patients.

This work has been undertaken by the service to ensure that this happens.

Case Study 2: Community Mental Health Services

This action was identified as a medium priority local action. The work involved a need to develop systems to allow for rapid identification from EMIS of a patient's named nurse. The systems need to ensure that when on leave, the specific tasks needed to be completed are delegated. This led to all named nurses updating progress.

Case Study 3: Specialist Learning Disability In-Patients

This action was identified as a medium priority local action. This action was to ensure that Personality Disorder training to be a core element in the Continuing Professional Development

calendar. This was to include bespoke patient centred personality disordered training for high-risk cases.

Key Message: There has been substantial work in identifying and applying the learning from the completed Significant Adverse Event Reviews.

4.4 Datix Incident Overview

East Renfrewshire HSCP has challenges with compliance with regards to processing Datix incidents timeously. Compliance is monitored weekly by the Directorate Management Team.

There is a wider context for East Renfrewshire HSCP that should provide context for the reasons for this. Of all the services that regularly use the Datix system, Specialist Learning Disability Services will generate the highest amount of Datix incidents, followed by Care at Home and the Care Home Team.

The Care at Home and Care Home Team have worked to address the issues with overdue Datix out with the scope of this report.

Table 5 provides a breakdown of overdue Datix incidents by category and specialty 31st March 2024.

Table 5: Overdue Datix Incidents by Category 31st March 2024

	In the holding area, awaiting review	Being reviewed or Recoded and reassigned	Awaiting final approval	Total
Addiction Services	0	0	3	3
Administration Services	1	13	1	15
Adult Autism Team	0	1	0	1
Care at home	1	3	102	106
Care Home Team	41	22	12	75
Children & Families Integrated Teams (East Renfrewshire)	1	5	0	6
Community Learning Disabilities Team	1	6	0	7
Community Mental Health Team	0	1	0	1
Community Nursing	1	0	0	1
Community Paediatrics (SCPT)	0	1	0	1
Community Pharmacy	0	2	0	2
District Nursing	0	6	0	6
GP Practices	0	2	0	2
Health Visiting	1	2	0	3
Learning Disabilities	0	10	0	10
Older Adults Community Mental Health	0	2	0	2
Prescribing Team	0	3	0	3
Psychiatry	0	1	0	1
Rehabilitation Service	0	1	0	1
Telehealth Service	0	2	0	2
Treatment Room Nursing	0	1	0	1
Total	47	84	118	249

Key Message: East Renfrewshire HSCP has challenges with compliance in the progression of overdue incidents. The Directorate Management Team receive weekly updates to highlight the main services with overdue incidents. This situation will vary depending on issues within services.

4.5 Inspection Activity 2023 - 2024

4.5.1 Care at Home

The Care Inspectorate undertook an unannounced inspection of our care at home service during 15th - 30th January 2024. At the time of the inspection, the service was providing homecare to 499 people with approximately 3000 people being supported by telecare.

Whilst the report is predominately around care at home, for the first time, Telecare service has also been included as part of the inspection process.

In preparation for the inspection the Care Inspectorate reviewed previous inspection findings, registration and complaints information, information submitted by the service and intelligence gathered throughout the inspection year.

During the inspection, Inspectors visited 40 people using the service along with some of their friends and family as well observing practice and daily life, reviewing documents, and speaking to staff and management.

Highlights from the report include:

- People valued the caring and friendly nature of staff, support to remain independent at home, and the ongoing social contact from regular visits. One person told us "I don't know what we'd do without the carers. Nothing is too much for them and they've become like an extension of the family".
- Compliments about the service from people and their family members reflected our own positive observations of staff interactions with people. We observed staff treating people with kindness, warmth, and humour. We were impressed by staff's ability to complete care tasks efficiently whilst establishing rapport and positive communication with people. A person explained, "I look forward to my visits. The social contact is just as important as the care for me".
- People were supported to achieve positive outcomes at times. A person spoke passionately about how home care had empowered them to live independently in the community. Staff had supported another person to complete daily physiotherapy exercises that improved their mobility, allowing them to be as active as possible
- Telecare was well-resourced and organised, received many compliments from people using the service, and provided vital reassurance and interventions for people when needed.
- The management team had introduced meaningful changes in recent months, and needed time to fully embed these initiatives and evidence sustained improvements in practice and outcomes for people.
- Leaders had introduced a range of new policies and procedures for the service to follow. This included areas such as communication, managing complaints, and responding to a variety of challenges.
- Staff with supervisory duties told us they felt better supported with clearer direction, which promoted consistency
- Leaders have improved the support and management of frontline staff to promote staff retention, morale, and consistency
- The induction programme for new workers was thorough with a blend of face-to-face training, shadowing opportunities, and input from professionals such as district nurses and pharmacy professionals. This comprehensive induction helped prepare staff well to understand their role and meet people's needs.
- The wellbeing of staff was a priority for the service, and there was investment in community resources for staff to use in recognition of their hard work. Workers accessed various health and wellbeing services across the council area. One staff member told us 'This is something I would have struggled to arrange by myself so accessing through work is a big boost'. These creative initiatives helped enhance staff morale as well as promoting staff recruitment and retention.

The service was awarded 3s (adequate) across all the 4 inspection themes evaluated under the quality inspection framework. These include: -

- How well do we support people's wellbeing?
- How good is our leadership?

- How good is our staff team?
- How well is our care and support planned?

We also received a grade of 4 (good) for one area: People experience compassion, dignity and respect. This falls within the main inspection theme of 'How well do we support people's wellbeing'.

No requirements have been placed on the service by the Care Inspectorate, however there were 4 areas for improvement identified.

The areas for improvement via an action plan:

- To promote people's health and wellbeing, the provider should continue to improve the consistency of staff and timings of visits. This will ensure people who experience the service are supported by people they know and have confidence in.
- Promote people's wellbeing, the provider must improve the quality of personal care planning. This should include, but is not limited to, ensuring plans are person-centred, fully reflective of people's holistic needs and wishes, reviewed within agreed timescales, and regularly audited to promote accuracy
- To support people's wellbeing, the provider should ensure that staff have ongoing access to training and development relevant to their role.
- The management should continue to look at ways to improve the consistency of staff and timings of visits to ensure people who experience the service are supported by people they know and have confidence in. This has been in place since the inspection in 2021

This is a significant improvement from our 2019 which awarded the service 1s (unsatisfactory) and 2s (weak) and made 9 recommendations. These requirements were assessed as met in 2021 when we had an unannounced inspection which focused on our care during the Covid-19 pandemic, where we were awarded 4s (Good) in the two areas evaluated: -

- How well do we support people's wellbeing?
- How good is our care and support during the COVID-19 pandemic?

Whilst we will continue to work to improve grades, the report is fair and reflective of where the service is at, particularly in light of the current challenges across the sector at both a local and national level. The inspection has given the HSCP confidence that the redesign is focused in the right areas, and that we are working towards delivering a better service for our residents and staff.

4.5.2 East Renfrewshire Alcohol and Drug Recovery Service Medication Assisted Treatment Standards

East Renfrewshire Alcohol and Drug Recovery Service (ADRS) continue to implement and embed the Medication Assisted Treatment (MAT) Standards. The Standards adopt a rights-based approach, ensuring individuals have choice in their treatment and are empowered to access the right support for where they are in their recovery journey.

The Adult Services Clinical and Care Governance Group will have sight of progress of the action plan and any issues with regards to compliance.

4.5.3 Mental Welfare Commission Visit 2023- 2024

The Mental Welfare Commission visited Claythorn House on 22nd June 2023. The full report is available below. This is a hosted service for East Renfrewshire HSCP as part of Specialist Learning Disability In-Patents.

https://www.mwcscot.org.uk/sites/default/files/2023-09/GartnavelRoyalHospital-ClaythornHouse_20230622a.pdf

Claythorn House is a mixed-sex 12-bedded acute assessment and treatment unit for individuals with intellectual disability and mental ill health, based on the Gartnavel Royal Hospital site. The Mental Welfare Commission last visited this service on 19 October 2021 and made recommendations about care plan reviews and the replacement of a bath. On this visit, they followed up on the previous recommendations as well as look at the care and treatment being provided in the unit.

Summary of recommendations:

Recommendation 1:

Managers should review care plan documentation to ensure that patients' care plans reflect good practice guidance.

Recommendation 2:

Managers should ensure that care plans provide a clear rationale regarding any limits or restrictions placed on patients as part of risk assessment and management strategies.

Recommendation 3:

Managers should ensure that the intended work to soundproof and better manage noise levels in the ward continues to be prioritised.

Recommendation 4:

Managers should urgently review the broken control panel, which allows the nursing team to manage electrical and water supply to individual rooms to ensure patient-centred care.

The service has worked on the recommendations, and they have been completed as requested by the Mental Welfare Commission.

4.5.4. Joint Inspection of Adult Support and Protection

The joint inspection of Adult Support and Protection in East Renfrewshire took place between January and June 2023, by the Care Inspectorate in collaboration with Healthcare Improvement Scotland and His Majesty's Inspectorate of Constabulary in Scotland.

The inspection methodology included the scrutiny of our performance using a range of key approaches:

- position statement and supporting evidence submitted by the HSCP
- HSCP and partner staff survey
- 2 focus groups; one for frontline practitioners and one for strategic leaders
- Scrutiny of records of adults at risk of harm over a two year period; January 2021 to January 2023

The Care Inspectorate acknowledged the unprecedented and ongoing challenge of service recovery because of the Covid-19 pandemic throughout this time and noted their appreciation for the partnership's co-operation and onsite support during the joint inspection.

The final inspection report was published on 27 June 2023 and described services overall as strong and effective which have led to positive outcomes for people because of timely, person-centred, and efficient adult support and protection interventions.

Inspectors praised the overall quality and effectiveness of core adult support and protection processes and noting that key processes were very effective and demonstrated major strengths. The inspection also commended our strategic leadership noting strong, integrated and cohesive leadership which supported positive experiences and outcomes for adults at risk of harm. The inspection recommended that the strategic leadership of the Adult Protection Committee could be further strengthened by more involvement of people with lived experience of adult support and protection.

The inspection noted a summary of strengths as detailed below:

- 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 noted four key areas for improvement as detailed below:

- The partnership should improve the quality of chronologies to ensure they are comprehensive, and inclusive of relevant life events and analysis.
- The involvement of adults at risk of harm and their unpaid carers at a strategic level should be a priority for the partnership.
- Strategic leaders should establish multi-agency quality assurance and self-evaluation of adult support and protection practice including a multi-agency approach to audit of records.
- Strategic leaders should build on the existing foundations to ensure the full involvement of all key partners in relevant aspects of adult support and protection practice going forward.

The inspection commended continuous improvement approach and the strong integrated partnership approach locally noting health colleagues as a strong partner and an integral part of ASP locally. The inspection specifically noted our Care Home Liaison Nurses, our Pharmacy Team and our dedicated ASP business support team as models of good practice.

4.5.5 Establishment D Medicines Management Improvements

As a result of the Adult Support and Protection referrals received by the Medication Support Service, Pharmacy staff became involved in supporting improvements within this care home in relation to medicines processes. Medication errors and process issues had been identified: medicines storage issues, prescription ordering issues.

East Renfrewshire HSCP Nursing Homes Pharmacist had recently started providing Pharmacotherapy Service in the GP practice providing medical care for the patients of this nursing home and was undertaking Polypharmacy medication reviews.

Care Home patients had previously been excluded from roll out of serial prescribing. Following a successful pilot, this can now be implemented in care homes. Serial prescriptions are issued for a 6-month period during which the Pharmacy dispense monthly from this prescription.

Following the initial assessment, it was determined that serial prescribing would be a beneficial change to the current arrangements which could be beneficial to the care home, Pharmacy and GP practice. By providing a 6 monthly prescription, there are fewer prescriptions each month for GP practice to process; 6 monthly reviews provide more regular opportunities to review ongoing medicines requirements and thus reduce waste; and reduce nursing home staff time required to order prescriptions each month.

The HSCP Pharmacy team provided information to all parties on serial prescribing. Once implementation was agreed, a series of meetings took place with Care Home managers and nursing staff, Community Pharmacy staff and HSCP Pharmacy staff. These meetings ensured implementation was seamless and any issues or concerns were addressed prior to commencement. Implementation was rolled out on a unit by unit basis. Prior to each unit changing over to serial prescriptions, the HSCP Care Homes Pharmacist undertook Polypharmacy reviews for all residents to ensure all medication was up to date, safe and appropriate. A powerpoint presentation was created on serial prescribing processes that was shared with all care home staff and will be used as training material within the care home. A webinar was also developed and shared on good practice advice for medicines waste management.

A standardised communication form was co-created to facilitate communication between the nursing home, community Pharmacy and GP practice. This form ensures an audit trail regarding any messages about medication changes.

Serial prescribing has now been introduced to 2 out of 3 units with the 3rd unit scheduled for October 2023.

The Care Inspectorate widely acknowledged at Large Scale Investigation meetings that the HSCP Pharmacy Team were invaluable in giving recommendations and advice to support the improvements achieved.

Joint working between the HSCP Pharmacy team, Community Pharmacy, GP practice and nursing home team has ensured that implementation of serial prescribing has been effective and has provided early benefits in workload reduction and improved prescription management processes in one care home.

Learning gained during this process will be applied to further serial prescribing implementation within East Renfrewshire Care Homes. The tools and materials developed to support the implementation in this care home will be available to support wider roll out.

The current situation from the Care Inspectorate is located on the link below.

https://www.careinspectorate.com/index.php/care-services?detail=CS2018372062

Key message: Inspection activity has been extensive, and assurance and learning has been progressed within 2023 -2024.

EFFECTIVE

Service Updates

5.1 Community Pharmacy

The HSCP Clinical and Care Governance Group has been actively supported in its work from the lead Community Pharmacist for Independents and Multiples.

The work of the Scottish Community Pharmacy Network featured, which represents 1256 independently owned or large chain pharmacy. Each pharmacy is an independent contractor to the NHS, and this is administered by each health board.

The Acute Medication Service is a key component of their work. Pharmacists and their teams provide pharmaceutical care and advice on the medicines prescribed.

There are two main developments – the Digital Prescribing and Dispensing Pathways and AMS Digital Payments.

Future developments for redesign

- Focus on and incentivise the detection and resolution of pharmaceutical care issues.
- Medication reviews
- Condition monitoring
- Prescribing for long term conditions

There is ongoing support through smoking cessation and Emergency Hormonal and Bridging Contraception.

5.2 Frailty

The Lead Allied Health Professional provided an update to the Clinical and Care Governance Group during 2023 -2024 on the work of the Frailty Programme.

Frailty is a progressive, long-term condition related to ageing. There is a loss of physical and/or cognitive resilience resulting in vulnerability to changes in health and slower recovery from illness, injury and other stressors.

NHS Greater Glasgow and Clyde have a Frailty Programme, and the Design and Delivery Plan was approved for 2021 – 2024.

There is a focus on 3 key themes:

- Early intervention and prevention of admission to hospital to better support people in the community
- Improving hospital discharge and better supporting of people to transfer from acute care to community support

- Improving the primary / secondary care interface jointly with acute to better manage patient care in the most appropriate setting.

East Renfrewshire HSCP have, through this programme delivered:

- Initiate / completed Comprehensive Geriatric Assessment in patient's own home
- Advanced clinical assessment
- Assess patient function in their own environment
- Facilitated Multi-Disciplinary Team input
- Aids and equipment provision
- Identify polypharmacy / medication side effects and refer to pharmacist for review
- Refer to community services such as Homecare, Social Work, Telecare, Visual impairment, Speech and Language Therapy, District Nursing
- Improve understanding of frailty and how to slow progress
- discussions with patients and families

Some examples of good practice:

Home First Response Service

This was launched with phased implementation from November 2022. Full staffing complement across all HSCPs was achieved in October 2023.

This delivers an augmented multi-disciplinary approach composed of Frailty Practitioners, AHPs, Pharmacy and Frailty Support Workers embedded within two acute sites (QEUH and RAH). They work alongside the acute team to identify, assess and turn around patients at the earliest opportunity, up to 72 hours if possible. Advanced Practitioners in Frailty are aligned to Community Rehabilitation Teams in East Renfrewshire.

Care Homes Falls Pathway via Flow Navigation Centre (FNC)

This was rolled out across all 13 Nursing and Residential Homes in East Renfrewshire.

It has a NHS Greater Glasgow and Clyde Standard Operating Procedure, and provides virtual early assessment of resident whose primary problem is an injury sustained by a fall in a nursing home.

Early video assessment, formation of an action plan and treatment plan, to help to avoid an unscheduled and potentially lengthy attendance to the emergency department (ED).

Further development “Call Before You Convey” model is enhancing senior decision-making support for Care Homes in East Renfrewshire.

5.3 Medicines and Healthcare products Regulatory Agency (MHRA) alert August 2023

An alert from the Medicines and Healthcare products Regulatory Agency was issued on 30 August 2023 regarding Medical Beds, trolleys, bed rails, bed grab handles and lateral turning devices: Risk of death from entrapment or falls.

This MHRA alert has implications for all HSCPs.

The alert impacts nursing, occupational therapy, physiotherapy and staff that routinely prescribe the equipment across the whole organisation.

The reason for this alert was from 1 January 2018 to 31 December 2022 there were 18 reports of deaths related to bed rails and associated equipment, and 54 reports of serious injuries across the whole of the United Kingdom.

The MHRA report highlighted that the incidents were caused from the following:

- Inadequate risk assessment and / or failure to update a risk assessment following a change of any kind.
- Maintenance / Servicing issues
- Prescription of equipment for children and /or people of small stature
- Inappropriate use or incompatibility with other equipment

For East Renfrewshire, there has been an estimate (February 2024) that Service User numbers who use bed grab rails are 3250 and for those who use Bed Safety Rails is 509, giving a total of 3759.

These numbers are subject to regular revision through the data cleansing work underway to update records.

NHS Greater Glasgow and Clyde have convened a short life working group to oversee this work. Professor Angela Wallace is Executive Lead supported by District Nurse Team Lead and Occupational Therapy Professional Lead for Partnerships. Links have been made to care homes through the Care Home Collaborative.

The work to contact service users and update the risk assessments is a considerable task. Given this, the MHRA have recommended that HSCPs need to take a proportionate approach to risk and follow a universal, targeted and specialist approach when undertaking reviews.

Key Message: This work has been identified as a risk, and the Adult Services Clinical and Care Governance Group will be receiving updates on progress and reporting to the HSCP Clinical and Care Governance Group by exception.

5.4 Community Treatment and Care (CTAC)

Bloods and Go

Following implementation of CTAC services in 2021 as part of East Renfrewshire Primary Care Improvement Programme it was acknowledged that there was still an unmet requirement for adult phlebotomy services on behalf GP Practices.

The Scottish Government announced that for 2022-23 that we should continue to deliver the priority services set out in the Memorandum of Understanding with a particular focus on three priority areas, one of which was CTAC, using existing regulations.

Therefore, in February 2023 following a deep dive of CTAC services in March and October 2022 a further Week of Care audit was carried out to determine the demand of CTAC activity remaining in practice.

Bloods and Go in action

We proposed to the East Renfrewshire HSCP Primary Care Improvement Plan (PCIP) Oversight group that funding be used for an enhanced phlebotomy service to complement

existing CTAC services called ‘Bloods and Go’. A service which currently operated in NHS Lanarkshire.

There has been a growing recognition of the importance of ensuring these PCIP services are designed in ways that meet the needs of individuals and communities by helping people access the ‘right person at the right place at the right time’.

‘Bloods and Go’ would allow any patient who has been seen by an East Renfrewshire GP or GP Practice Health Professional and who requires bloods to be obtained, to attend any of the two health centres within East Renfrewshire for this ‘on the day’ procedure.

Following a visit to NHS Lanarkshire we were able to identify the model, and processes required to enable us to deliver a similar service in East Renfrewshire. East Renfrewshire HSCP were able to identify space in both health centres and PCIP had them converted and kitted out to the clinical spaces required for ‘Bloods and Go’ service.

The ‘Bloods and Go’ phlebotomy service is a function of the CTAC service and phlebotomy is one of the core tasks within CTAC. Phlebotomy was routinely delivered by CTAC Community Health Care Assistants hosted within GP practices since 2018, and therefore ‘Bloods and Go’ would be an extension of this service.

Currently the GP / Health Professional request blood tests on GP Order Comms which are picked up and samples taken by CTAC Community Health Care Assistants based in GP Practice clinics. These are then processed at labs and the GP or health professional requesting these then receives the results. The ‘Bloods and Go’ service would function in the same way, but the samples would be collected in one of the health centres rather than the GP Practice clinic. The service would be a drop-in clinic model, no booking / appointing systems are required as the new phlebotomy service allows patients to attend for ‘on the day’ bloods and go. ‘Bloods and Go’ is a phlebotomy only service, no other clinical interventions are carried out.

The ‘Bloods and Go’ service is delivered within Eastwood and Barrhead Health and Care Centres, in repurposed, dedicated consultation spaces.

The workforce of the ‘Bloods and Go’ service is Band 3 Heath Care Support Workers and Band 2 receptionists with oversight from Band 5 Treatment Room Nurse. All Treatment Room staff work on a rotational basis across all CTAC services. Two consultation bays are hosted at Eastwood Health and Care Centre, and one hosted in Barrhead Health and Care Centre. The service offers a phlebotomy service to individuals aged 16 years and over from all 15 GP Practices Monday to Friday from 8.30am to 4.30pm. The ‘Bloods and Go’ service was tested in both health and care centres with a few GP Practices over the first two weeks of June 2024 before being rolled out to all 15 GP Practices. To date we have seen over 1,200 patients access the ‘Bloods and Go’ service across both health and care centres. The feedback has been very encouraging from patients, staff and GPs.

Governance of PCIP services come from East Renfrewshire HSCP Clinical Director and Primary Care Transformation Manager. The CTAC service is managed and led by the PCIP Team Leader for CTAC / VTP and the Senior Nurse for Adult Community Nursing Services.

Existing governance and reporting structures are through our local PCIP Oversight Group and the NHS Greater Glasgow and Clyde Board wide CTAC Service Development Group who continue to review and develop the CTAC programme.

5.5 Community and District Nursing

Palliative End of Life Care (PEOLC)

East Renfrewshire HSCP is part of the NHS Greater Glasgow and Clyde PEOLC Strategic Leads Meeting and Quality Improvement Group.

Excellence in Care indicators for PEOLC have been set nationally, these are specific to people who have received District Nursing care in the last month of their life and who had an identified PEOLC need. The national target is 60%.

NHS GGC aims are:

- *85 % of patients with a PEOLC need will have a preferred place of death by March 2025*
- *85 % of patients with frailty score of 9 will have a future care plan completed by December 2024*
- *95% of all patients on District Nursing Caseload will have a current frailty score*

Work is underway on assessing compliance for this work on developing the HSCP Strategy; developing local Community nursing palliative care group as per work plan and to understand local data and triangulate and develop locally our objectives to meet national excellence indicators.

Pressure Ulcer Prevention

The District Nursing Service regularly review caseload with acquired pressure ulcers. In January 2024, the service completed a review.

There were no avoidable pressure ulcers at that point, which had reduced from one avoidable in December 2023 for East Renfrewshire.

East Renfrewshire HSCP is implementing improvement work underway across NHS Greater Glasgow and Clyde. This has led to increased reporting. There have been improvements such as ensuring every patient's clinical information is updated including those on 3 monthly injections. The team also ensure that the Vaccination & Injectable team are carrying these assessments out when visiting.

Table 6 shows that for Caseload Acquired Pressure Ulcers from 1st February 2023 to 31st November 2024 shows that there were 186 days between avoidable Pressure Ulcers, which compares favourably with comparable data from other HSCPs.

A Green Day is when there are no new to caseload pressure ulcers that were categorised as avoidable.

Table 6 Pressure Ulcer Caseload Acquired Green Days Feb 23 to Jan 24

Caseload Acquired Green Days

Report Period: 01/02/2023 to 31/01/2024

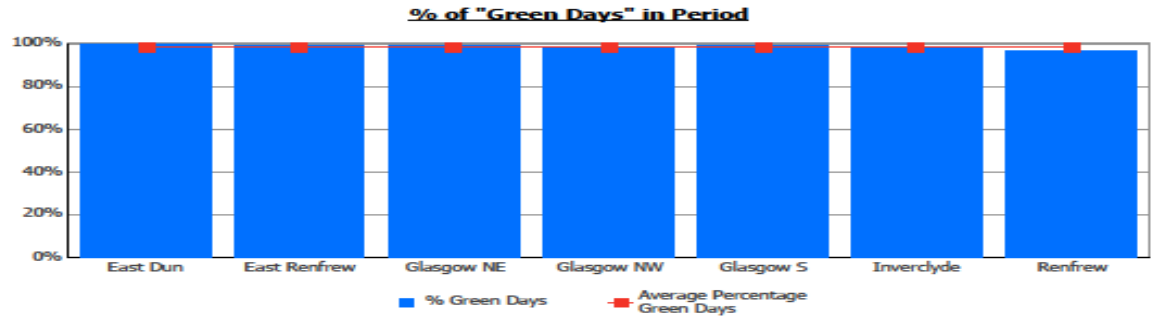
Activity relates to Pressure Ulcer Wounds that are indicated as: New within caseload and Avoidable. (Excludes Grade 1)

Most Consecutive "GREEN DAYS" in the period (where no such Pressure Ulcers were identified)

Area	Start Date	End Date	Days Between Avoidable PU
East Renfrew	02/06/2023	05/12/2023	186
Glasgow NE	08/06/2023	29/08/2023	82
Glasgow NW	11/08/2023	07/12/2023	118
Glasgow S	23/05/2023	06/12/2023	197
Inverclyde	24/04/2023	10/07/2023	77
Renfrew	12/09/2023	01/01/2024	111
All Areas	12/09/2023	05/12/2023	84

Percentage GREEN DAYS in Period.

Area	Days that were NOT a Green Day	Percentage Green Days
East Dun	1	100%
East Renfrew	3	99%
Glasgow NE	4	99%
Glasgow NW	8	98%
Glasgow S	4	99%
Inverclyde	9	98%
Renfrew	12	97%
All Areas	38	90%



DEFINITION
A "GREEN DAY" is classed as any day where there was no "New in Caseload" Pressure Ulcer that was "Avoidable" identified.

File: Safety Cross Caseload Acquired Green Days
Source: CNIS
Page: 1 of 1
Information Services(Partnerships)
19/02/2024 12:35:35

Key message: District Nursing are demonstrating good compliance within the parameters set by NHS Greater Glasgow and Clyde.

5.6 Sparks – support for adults with attention deficit hyperactivity disorder (ADHD)

Our Occupational Therapists within the Mental Health, Recovery and Alcohol Drugs and Recovery Services are once again leading the way with their innovative approach.
The team has launched 'Sparks', a new 7-week course for adults (over 18's) with ADHD to help them identify and understand their own strengths and develop strategies that will help improve everyday function and their quality of life.

This course is the only one of its kind being offered in Greater Glasgow and Clyde at present, developed by East Renfrewshire and Greater Glasgow and Clyde Occupational Therapists.

Living with ADHD as an adult can be extremely challenging and by introducing this groupwork we are able to reach and support more residents and help them improve their

daily life. We are very much focused on outcomes for our residents and are grateful the HSCP has been supportive of our ideas for different ways of working.

Occupational Therapists Anna Gray and Paul Duffy

People with a diagnosis of ADHD in East Renfrewshire who have been assessed by the team and are suitable for the group will be offered a place on the course running across both health centres (Eastwood and Barrhead).

6. PERSON CENTRED CARE

6.1 Complaints 2023 – 2024

A total of 141 complaints were received by the Health and Social Care Partnership during 2023/2024. This is a 29% reduction on the 199 received in the prior year.

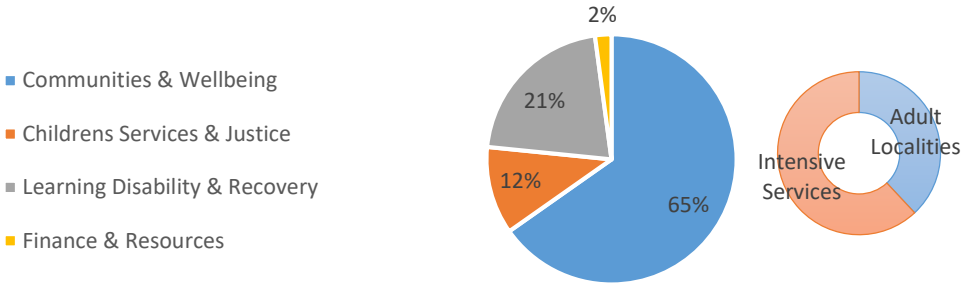
116 (82%) were handled at the first stage as frontline complaints, and 25 at stage 2. Table 7 below provides a breakdown per quarter.

Table 7: 2023 -2024 Complaints per quarter

	Q1	Q2	Q3	Q4
Stage 1	29	29	27	31
Stage 2	6	8	6	5
Upheld/Partially upheld	19	21	21	23
Resolved	1	1	1	4
Not upheld	15	15	11	9

Chart 1 below shows the split of all complaints received by Head of Service Area.

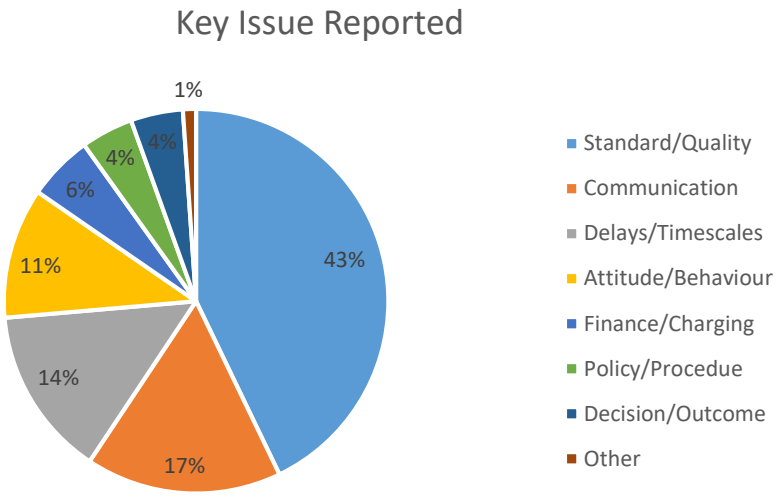
Chart 1:Total complaints received by Head of Service Area



The service with most complaints was Intensive services, however this only accounted for 40% of the total Health and Social Care Partnership complaints. In general, we expect to see a higher proportion of complaints within intensive services given the number of individuals supported by care at home, telecare and Bonnyton House. This is an improvement on the year prior where 69% of all complaints were in care at home.

Adult localities had 25% and mental health services 15%, both of which provide a number of different services to a high number of individuals.

From the 141 complaints received, 91 (65%) were either upheld, partially upheld or resolved. These complaints were categorised into the following themes: -



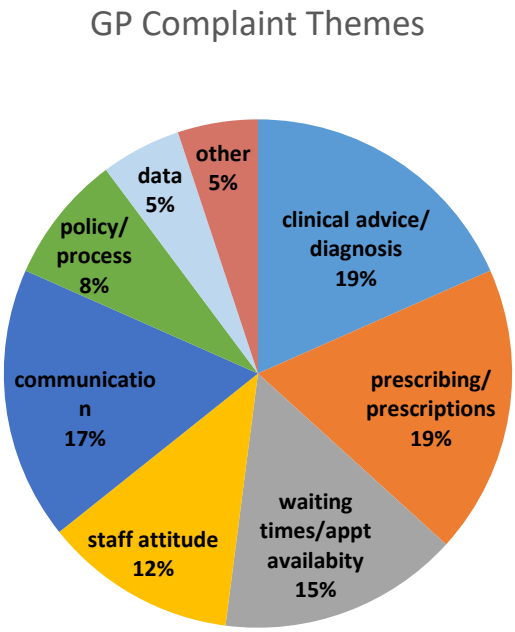
Whist the policy decision to implement eligibility criteria (Supporting People Framework) was made during 2023-24, we have not seen a large number of complaints. This is possibly as the outcome of reviews and subsequent changes to care packages didn't start until later in the year and a few early enquiries were through MSPs and Elected Members.

The following actions were identified where areas of learning were highlighted within complaints: -

- Further training on new care at home scheduling system
- Review of care at home procedures in relation to 'as required' medication
- Review of key safe policy

- Implementation of regular reporting between Telecare and corporate finance re notification of death to ensure any outstanding debts are addressed to executor
- Focus at District Nursing Team meeting on information governance and safe handling practices
- Improved processes between Telecare and Corporate Finance to improve management of overdue invoices.
- Inclusion of direct debit forms with new telecare installations to allow support customers to more easily set up preferred payment options
- Improved process between Primary Care and Community Mental Health teams whereby PCMHT present cases (which do not meet PCMHT criteria) to CMHT allocation meeting to allow assessments to be continued by CMHT without patients having to repeat their story from beginning.

During 2023-24, GPs received 153 complaints. The main themes are shown below



Of the 153 complaints, 102 were handled at stage 1 and 51 at stage 2 with 94 (61%) found to be upheld or partially upheld. Only one GP did not submit a return for one quarter, which is an improvement on prior years.

In terms of optometry complaints, half or more practices failed to submit returns, with a total response rate for the year of only 40%. From those who did submit returns, only 3 complaints were received. It is assumed that no complaints were received for the practices who did not submit returns, however we continue to encourage the completion of the survey even when it is a nil return.

Key message: We will continue to develop and improve reporting to ensure we are capturing learning from complaints and implementing this across our services.

6.2 Care Opinion

Care Opinion is an independent, not-for-profit website, where people can provide anonymous feedback on health and social care services about their experience of care.
It is intended to complement existing processes for dealing with feedback and complaints (www.careopinion.org.uk).

East Renfrewshire HSCP have fully committed to the active promotion of Care Opinion.

There is a Care Opinion Implementation Group that is chaired by the Chief Nurse that oversee the work in supporting staff promotion as well as awareness of the people of who use health and social care services.

For the purposes of this report, an overview of the stories that have been received to date and the impact that providing the feedback has had. Staff welcome the feedback, and the positive feedback is good for staff morale. Feedback that would appear critical gives the opportunity for individuals and teams to reflect and think about any changes that can be put in place as a result.

Table 8 shows the number of stories for 2023 -2024 for East Renfrewshire HSCP by month. There were 54 stories in total.

Table 8: When Stories were told East Renfrewshire HSCP by month 2023 -2024

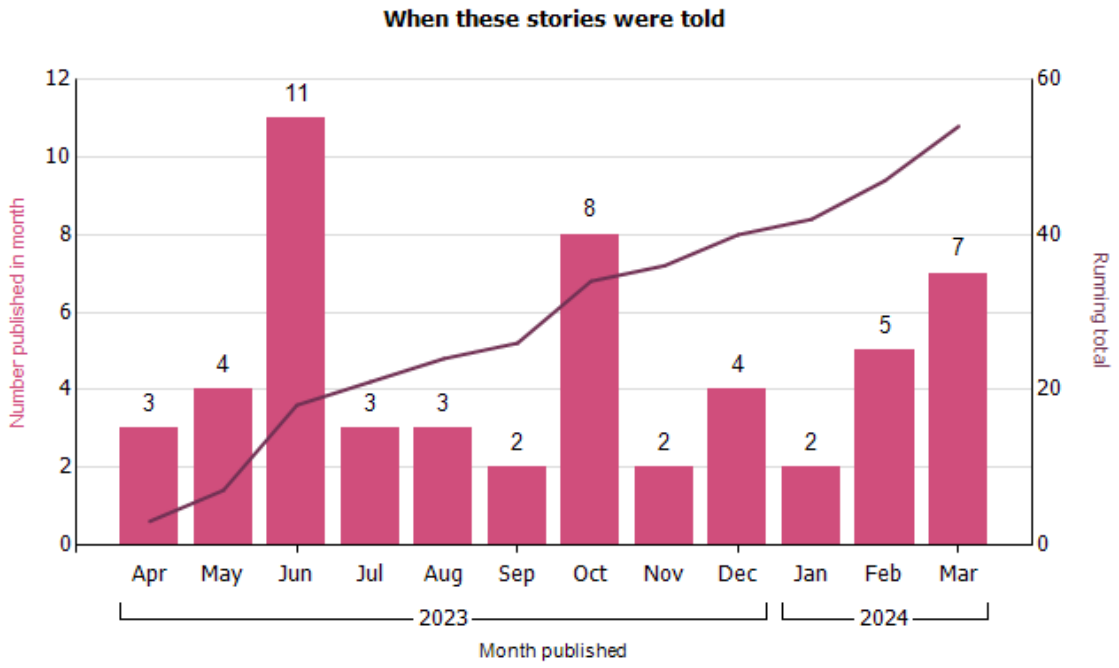


Table 9 shows that the promotion of Care Opinion using Freepost Envelopes has been successful with 20% of total feedback received this way. This has been due to staff distributing the information to assist those who would struggle accessing the website.

Table 9: How Stories were submitted East Renfrewshire HSCP 2023 - 2024

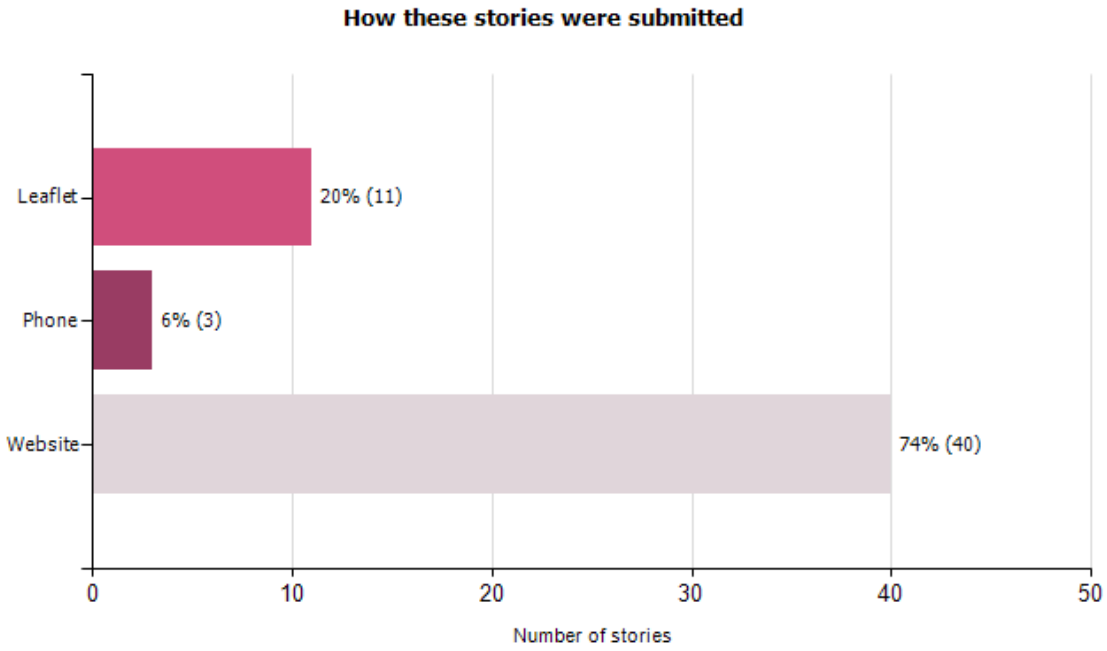
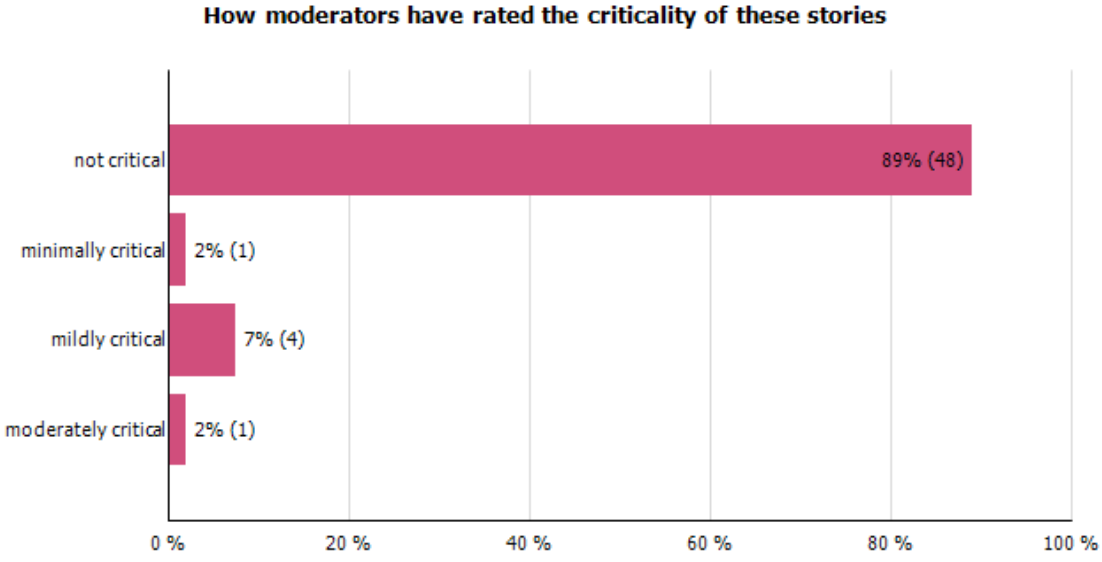


Table 10 shows that 89% of stories were not critical. This provides assurance to the HSCP and a boost for staff that people are appreciative of the service they have received, and that constructive feedback can lead to reflection and change.

Criticality is how Care Opinion define stories from non-critical to severely critical.

Table 10: Care Opinion ratings of Criticality 2023 - 2024



One of the advantages of the use of Care Opinion is that it promotes feedback as a whole health and social care system.

Residents within East Renfrewshire also use Care Opinion to provide feedback on services they receive from the wider NHS.

Table 11 shows that for 2023 – 2024 there were 197 stories received for NHS Greater Glasgow and Clyde services from residents of East Renfrewshire. 81% of the feedback was noncritical. This demonstrates that residents of East Renfrewshire use Care Opinion to give feedback on their experiences of health care, as well as increasingly on the services provided by the HCSP for health and social care.

Table 11: Stories from East Renfrewshire residents 2023 -2024 by month for NHS Greater Glasgow and Clyde

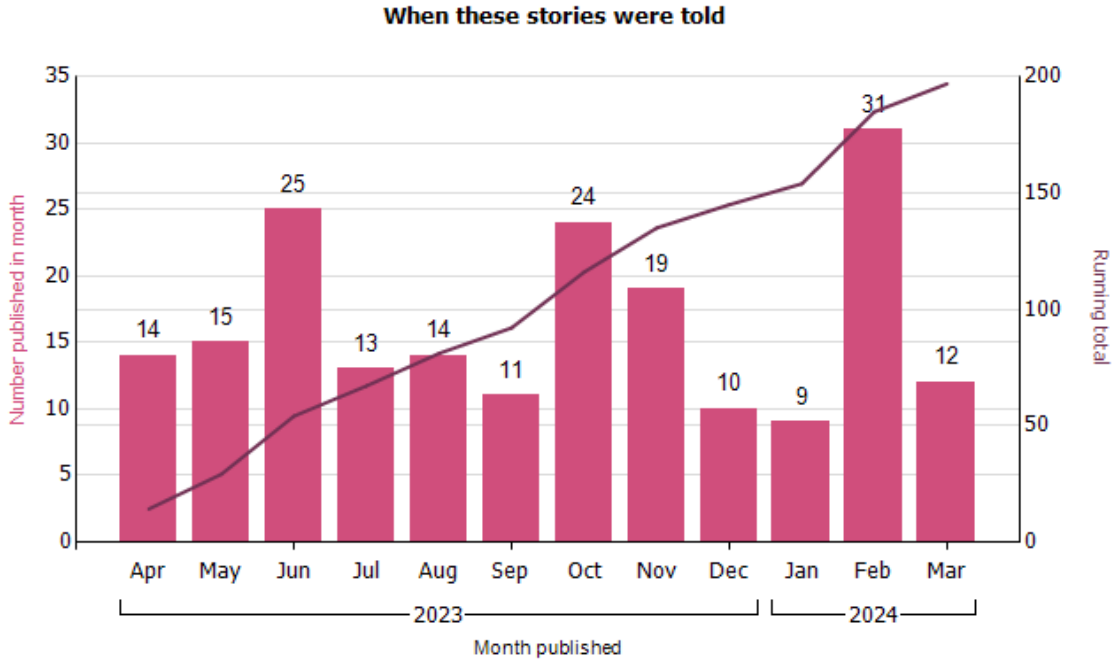


Figure 5 shows the feedback for East Renfrewshire HSCP for the 54 stories on what was good about your care from East Renfrewshire HSCP.

The main highlights are the professional, great staff, amazing nurses and friendly staff.

Figure 5: What was good about your care from East Renfrewshire HSCP?

Figure 6 shows how did the experience of care make you feel.

Figure 6: How did experience of care from East Renfrewshire HSCP make you feel?

The main highlights are people feel supported, Informed and grateful.

The following is a selection of the stories that the HSCP has received this year.

My husband had terminal cancer and was given an end-of-life diagnosis in September 2023 he subsequently died in February 2024.

Initially Joan, Gillian and Donna supported every couple of weeks by calling in and checking we were both managing ok and that all the correct medicine was in place.

But in January 2024 my husband deteriorated quickly and required daily nursing from the team. They organised the equipment he needed to get him home from hospital quickly. They called every morning to administer his medication together with all other aspects of care, they were a tremendous support to me liaising with doctors and the hospice to get the best care for my husband.

They surpassed all my expectations and are absolutely fabulous coming out regularly when I required help outside of the morning visit. They would call chemists when we needed drugs urgently, nothing was too much trouble and they genuinely cared so much. They are a wonderful caring team honestly the best medical professionals I have met during my husband's 9 year battle. I will always be grateful and will never forget those amazing nurses. Thank you

https://www.careopinion.org.uk/1175158

From start to finish, my experience was excellent. All staff could not be better. Equipment supplied proved to be beneficial.

https://www.careopinion.org.uk/1124872

I have been working with St. Andrew's House for years on and off, returning about a year ago and got a new worker. She has been great and really helped. I like most of the staff and this time round I have made some real changes. I'm happier now.

https://www.careopinion.org.uk/1133671

Key message: The promotion of Care Opinion will continue with the focus on increasing both the number of stories and the number of services actively promoting the use of Care Opinion.

7. Conclusion

East Renfrewshire HSCP continues to maintain its clinical and care governance structures to assure NHS Greater Glasgow and Clyde that there is compliance regarding the priorities of ensuring safe, effective and person-centred care, in the context of significant financial challenges.

This was a very challenging year for the HSCP as we worked to balance meeting the demand for services within the allocated budget. We needed to deliver £7.1 million savings as part of our plans to balance our budget and we were not able to do this and ended the year with a shortfall of £2.5 million against this target.

The main operational challenges that led to the increased cost pressures were meeting demand for Care at Home, the cost of special observations within the Learning Disabilities In-Patients service which we host on behalf of all six HSCPs within Greater Glasgow and Clyde and the costs of prescribing through our GP practices. The main area we fell short on delivering planned savings was from our Supporting People Framework. This framework is based on eligibility criteria and was put in place early in the financial year to support reviews of the level of care we provide as we knew we would have to stop providing lower levels of need. We underestimated the impact and timeframe for the culture and practice changes required to implement such significant change alongside managing the expectations of the individuals and families we support.

As the year progressed it became clear that our approach was not delivering the level of cost reductions and savings needed and a formal financial recovery process was invoked at the November 2023 meeting of the Integration Joint Board.

Despite these challenges we will continue to work collaboratively with stakeholders, building upon our excellent working relationships to implement our strategic vison for the future delivery of health and social care for East Renfrewshire.