AGENDA ITEM No. 8

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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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

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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

- 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

Challenges and pressures

- 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

- 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

Our communities are resilient and there are better opportunities for health & 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

People are safe and protected

- 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

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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,

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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:

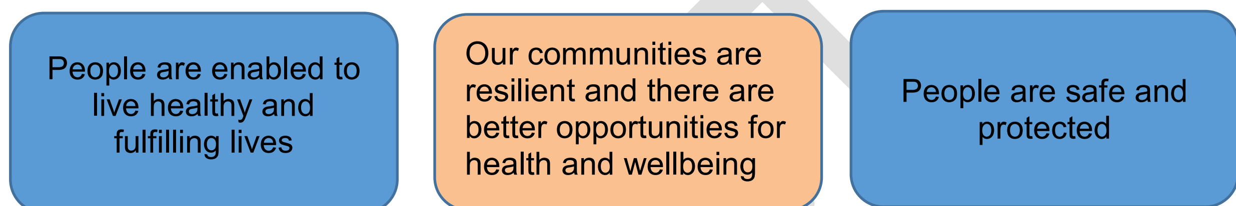
- Valuing what matters to people
- Building capacity with individuals and communities
- Focusing on outcomes and not services

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.



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.

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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

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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

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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

<table>
<tr><td colspan="2">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.</td></tr>
<tr><th>Priority outcomes</th><th>Key activities</th></tr>
<tr><td>We will protect our most vulnerable children, young people and families</td><td>• 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.</td></tr>
<tr><td>We will ensure children and young people with complex needs are supported to overcome barriers to inclusion at home, school, and communities</td><td>• 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.</td></tr>
</table>

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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.

Supporting people to maintain their independence at home and in their local community

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.

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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

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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.

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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.

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

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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:

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<table>
<tr><td colspan="2">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.</td></tr>
<tr><td>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</td><td>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</td></tr>
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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.

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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.

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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

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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

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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

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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

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	• 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.

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3. Developing our plan

3.1 Introduction

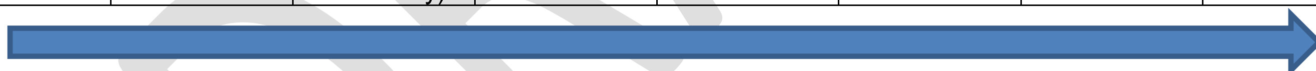
This plan is the result of months of development work as we have collaborated with colleagues, stakeholders, and local people. Our objective is that the plan reflects the shared priorities of local residents and sets out meaningful commitments for our wide partnership.

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.

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4. Our context and challenges

4.1 Introduction

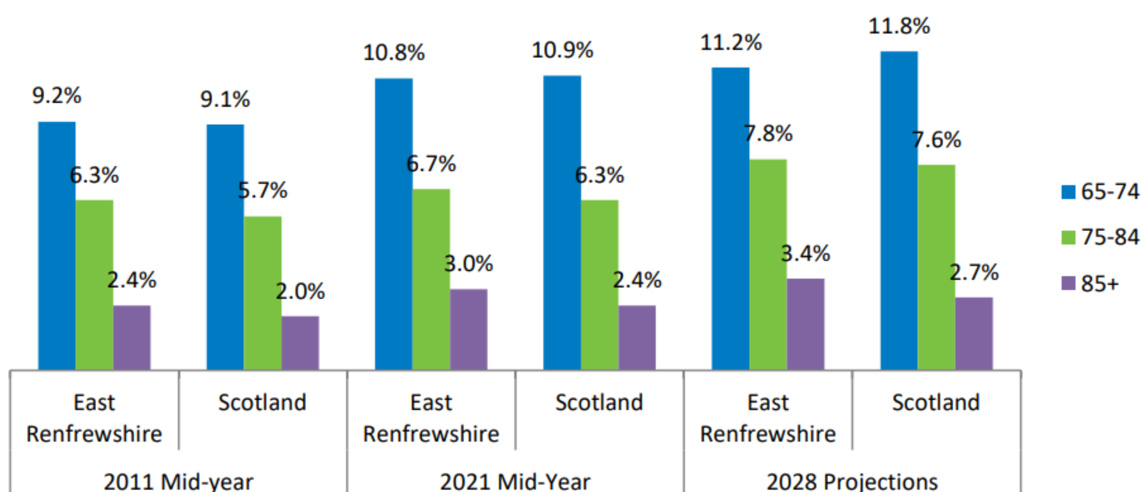
This section summarises our current context in relation to East Renfrewshire's demographic and health profile and recognised future challenges.

4.2 Population and demographics

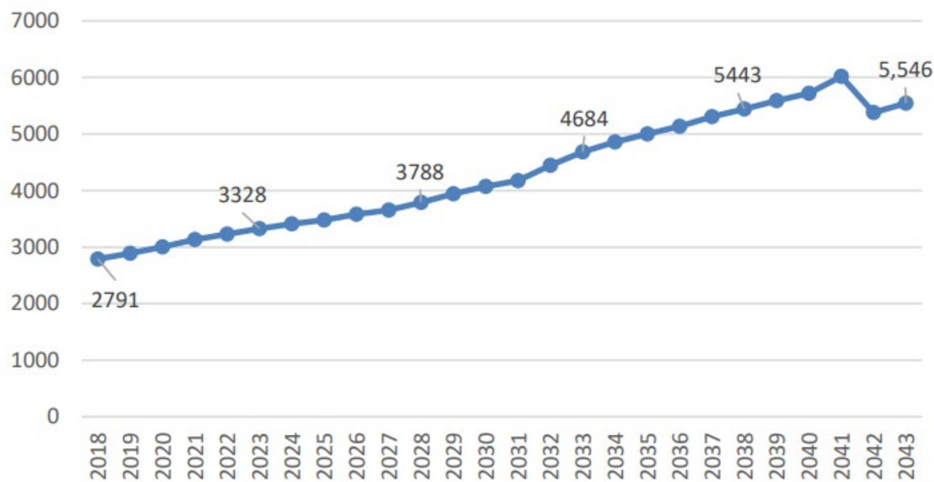
Like the rest of Scotland, East Renfrewshire faces significant changes in its population in the coming years. We expect our population to increase, to have more elderly residents, to see a decline in death rates and to have an increase in the number of households, as more people live alone. East Renfrewshire 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.

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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.

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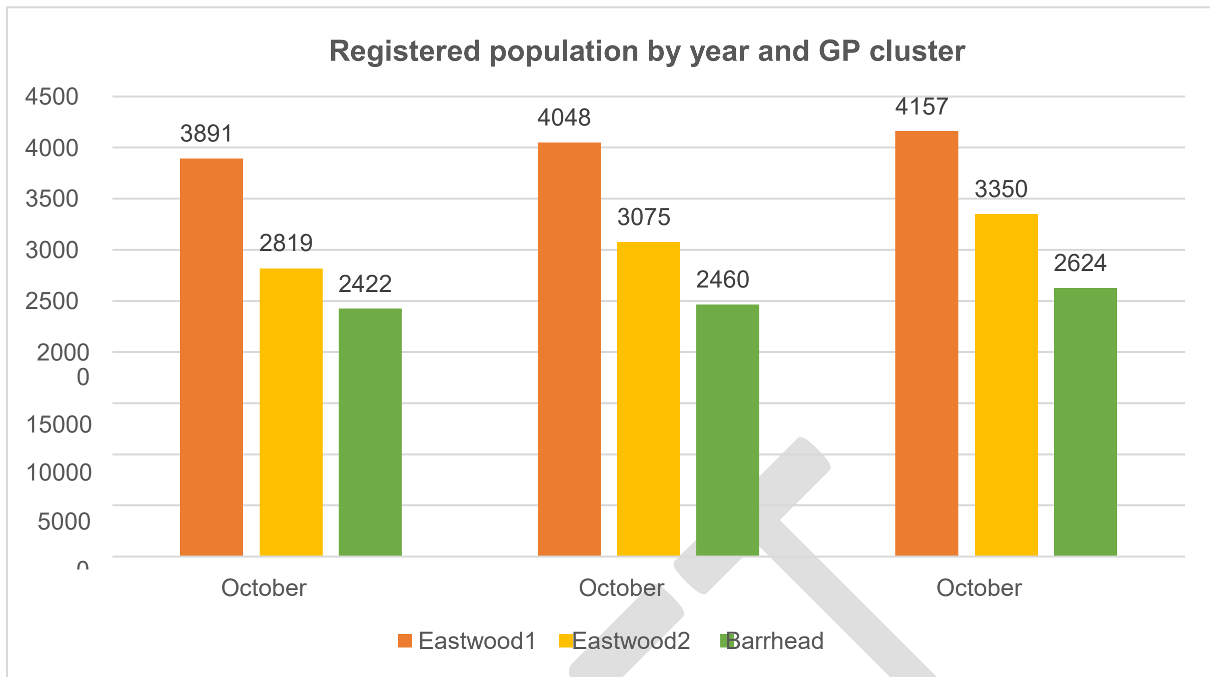

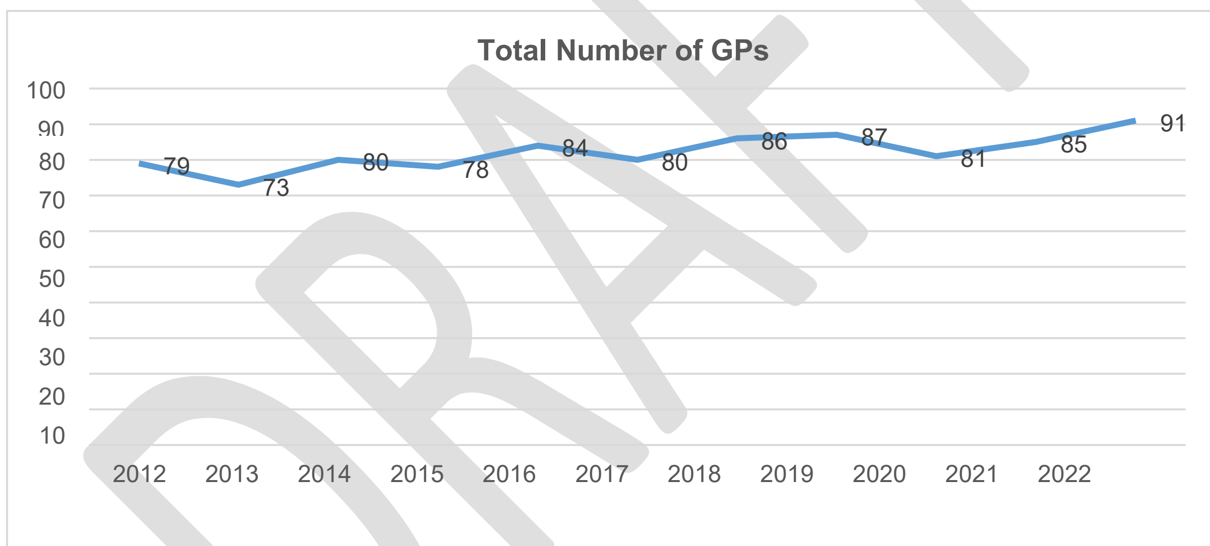

4.5 Housing

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.

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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

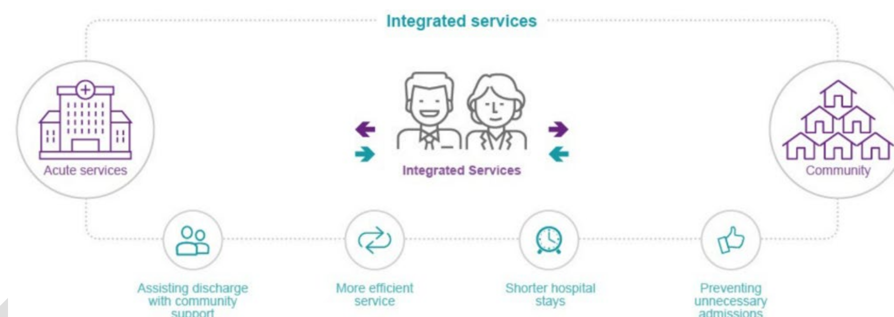
The Independent Review of Adult Social Care and the National Care Service

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.

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- 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.

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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

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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.

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