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

- ☒ No Directions Required
- ☐ Directions to East Renfrewshire Council (ERC)
- ☐ Directions to NHS Greater Glasgow and Clyde (NHSGGC)
- ☐ Directions to both ERC and NHSGGC

Implications

- ☐ Finance
- ☐ Policy
- ☐ Workforce
- ☐ Equalities
- ☐ Risk
- ☐ Legal
- ☐ Infrastructure
- ☐ 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

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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.

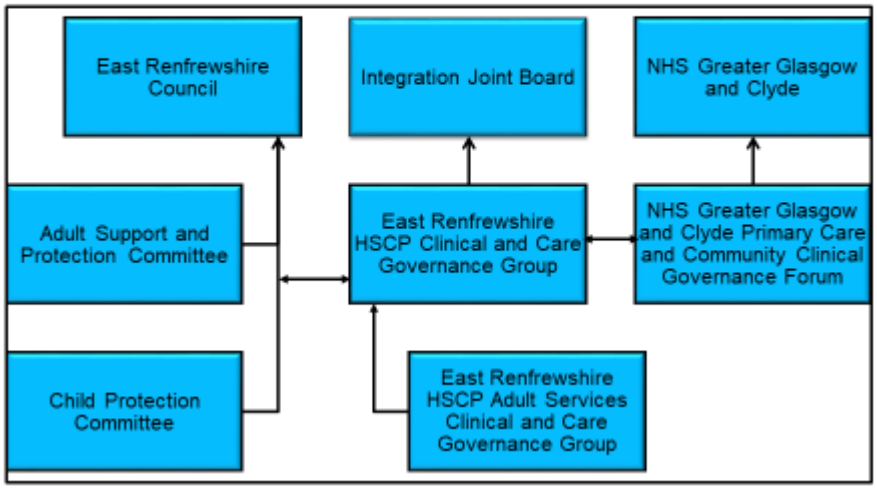
3. Clinical and Care Governance Structure East Renfrewshire HSCP

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

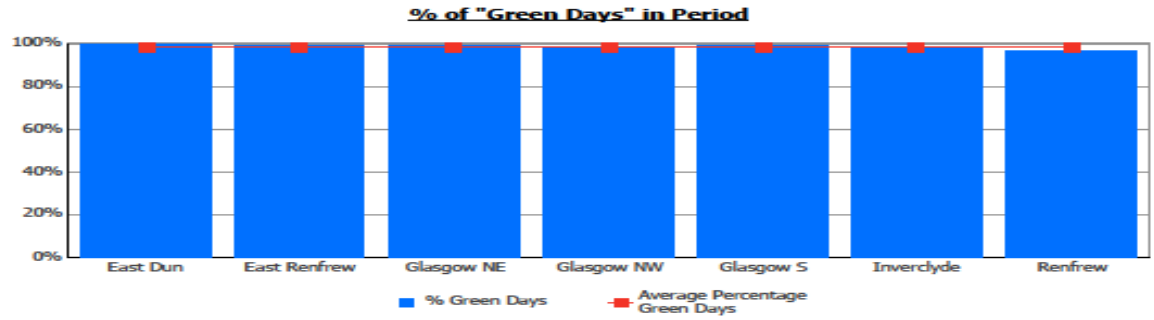
Activity relates to Pressure Ulcer Wounds that are indicated as: New within caseload and Avoidable. (Excludes Grade 1)

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

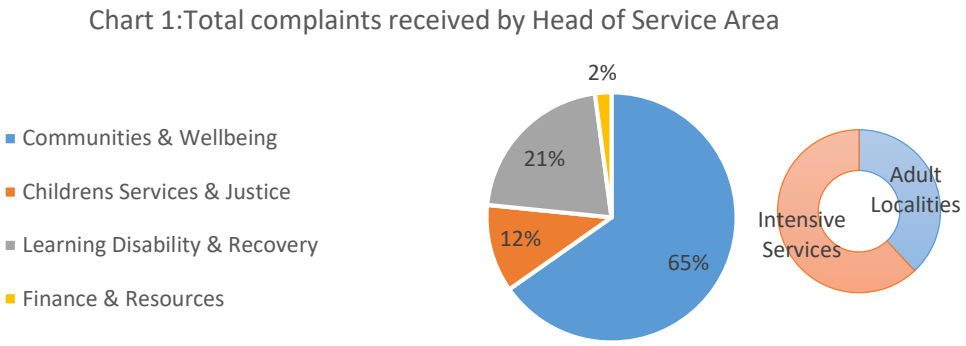
A total of 141 complaints were received by the Health and Social Care Partnership during 2023/2024. This is a 29% reduction on the 199 received in the prior year.

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

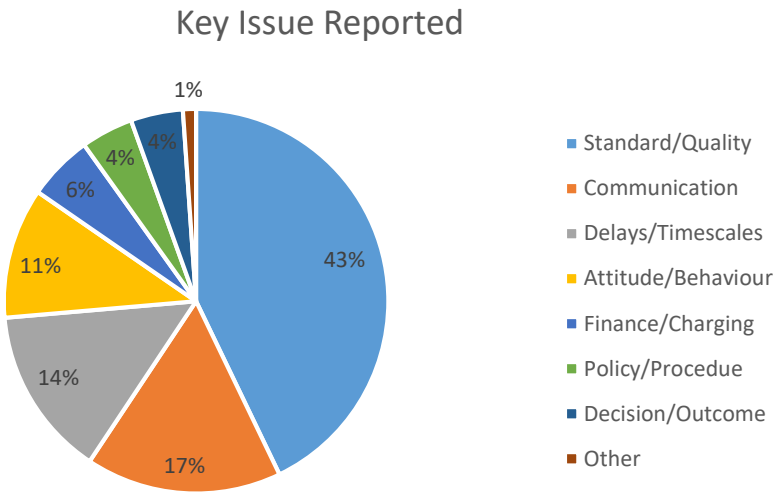
Chart 1 below shows the split of all complaints received by Head of Service Area.



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: -



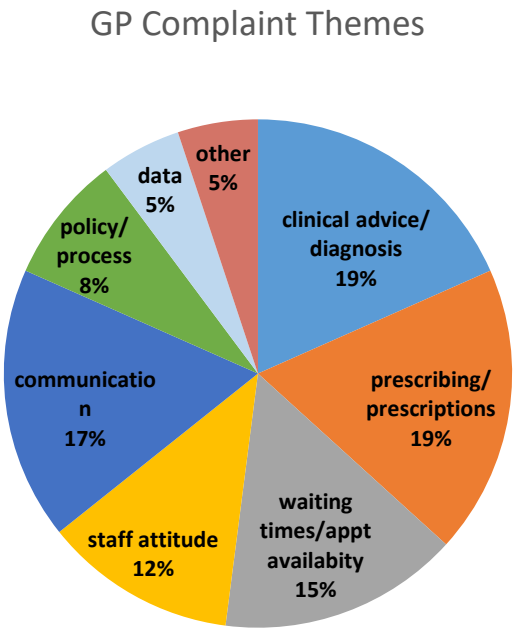
Whist the policy decision to implement eligibility criteria (Supporting People Framework) was made during 2023-24, we have not seen a large number of complaints. This is possibly as the outcome of reviews and subsequent changes to care packages didn't start until later in the year and a few early enquiries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

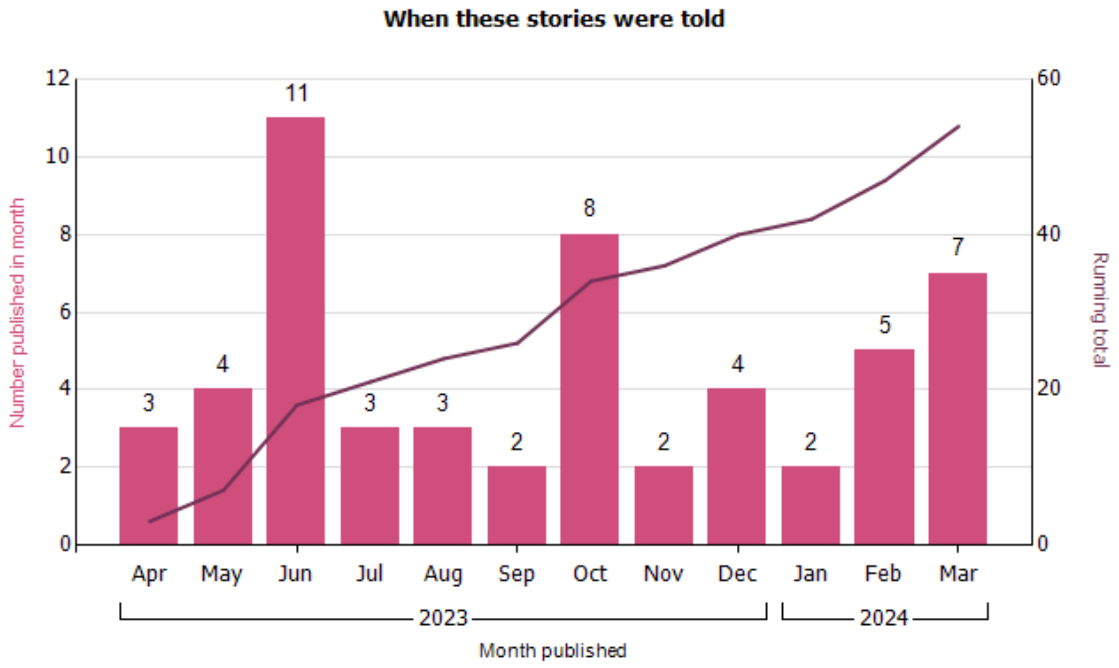


Table 9 shows that the promotion of Care Opinion using Freepost Envelopes has been successful with 20% of total feedback received this way. This has been due to staff distributing the information to assist those who would struggle accessing the website.

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

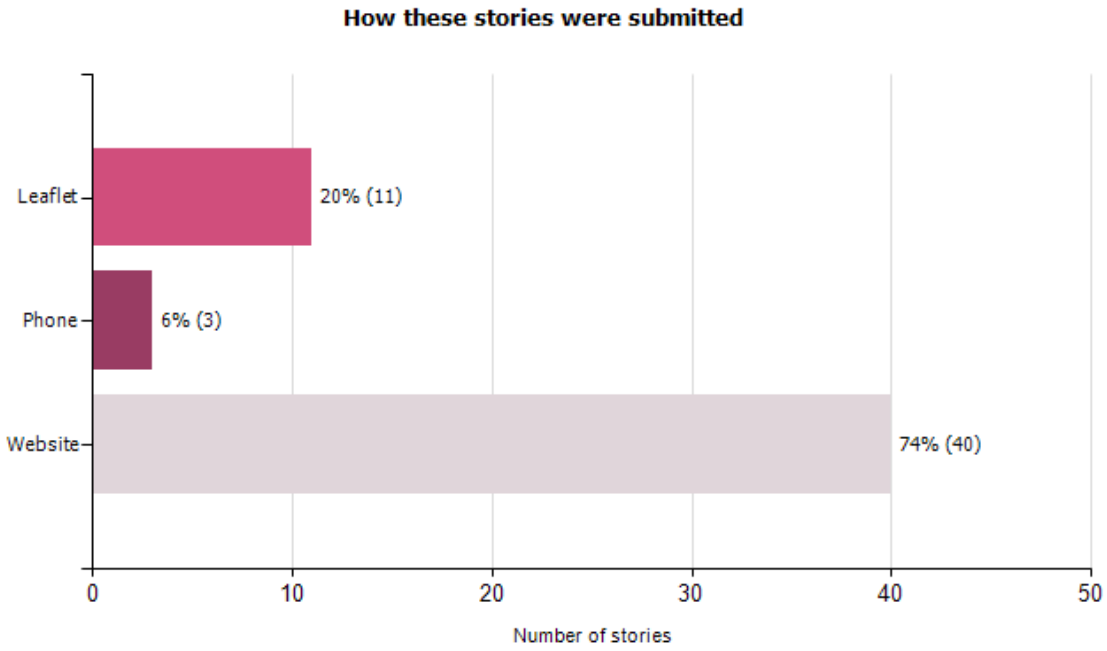
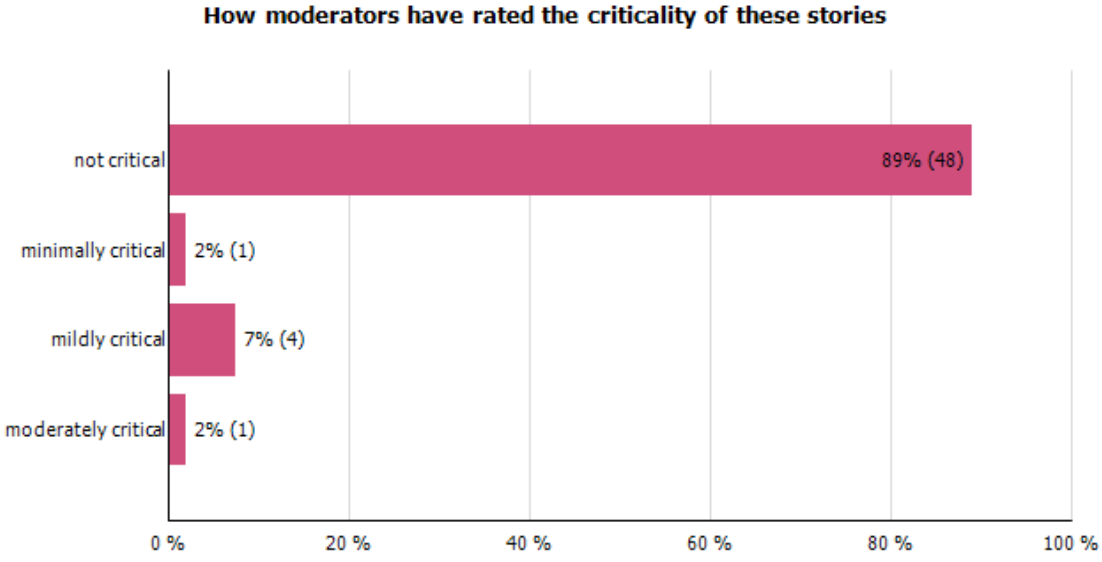


Table 10 shows that 89% of stories were not critical. This provides assurance to the HSCP and a boost for staff that people are appreciative of the service they have received, and that constructive feedback can lead to reflection and change.

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

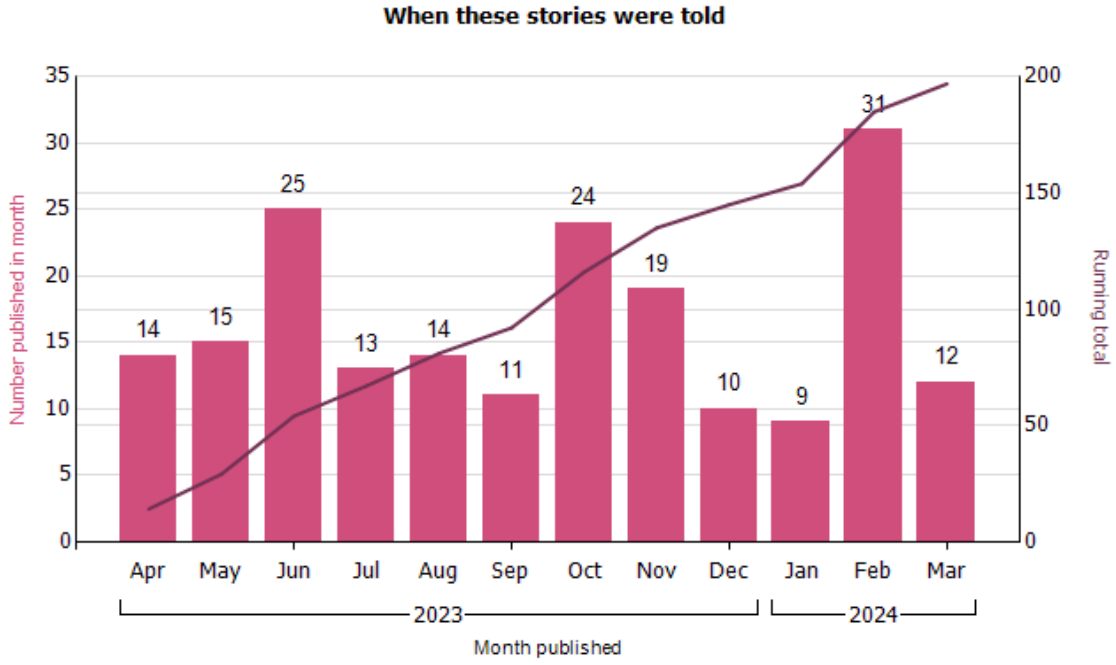


Figure 5 shows the feedback for East Renfrewshire HSCP for the 54 stories on what was good about your care from East Renfrewshire HSCP.

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.