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**	Performance and Audit Committee 25 June 2025
Agenda Item	9
Title	Annual Performance Report 2024/25

Summary

This report provides members of the Performance and Audit Committee with the Annual Performance Report for the Health and Social Care Partnership for 2024-25. This is our ninth Annual Performance Report and outlines performance in relation to the delivery of our Strategic Plan 2022-25. The Annual Performance Report is a high level, public facing report.
It summarises the performance of the HSCP against agreed local and national performance indicators and outlines the ways we have delivered services and supports during the year.

Presented by	Steven Reid Policy, Planning and Performance Manager

Action Required

The Performance and Audit Committee is asked to note and comment on the contents of the Annual Performance Report 2024-25.

EAST RENFREWSHIRE PERFORMANCE AND AUDIT COMMITTEE

25 JUNE 2025

Report by Chief Officer

ANNUAL PERFORMANCE REPORT 2024/25

PURPOSE OF REPORT

1. This report provides members of the Performance and Audit Committee with the Annual Performance Report for the Health and Social Care Partnership for 2024-25.

RECOMMENDATIONS

2. The Performance and Audit Committee is asked to note and comment on the contents of the Annual Performance Report 2024-25.

BACKGROUND

3. The Public Bodies (Joint Working) (Scotland) Act 2014 requires Integration Joint Boards to publish an Annual Performance Report, setting out an assessment of performance in planning and carrying out those functions for which they are responsible. The 2014 Act requires publication of the report within 4 months of the end of the financial year being reported on, therefore by 31 July each year.

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

5. The required content of the performance reports is set out in The Public Bodies (Joint Working) (Content of Performance Reports) (Scotland) Regulations 2014. In addition Scottish Government has issued guidance for the preparation of performance reports:
    - Performance against national health and wellbeing outcomes.
    - Performance in relation to integration planning and delivery principles.
    - Performance in relation to strategic planning and any review of strategic plan during year.
    - Financial planning, performance and best value.
    - Performance in respect of locality arrangements.
    - Inspections of services.

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

REPORT

7. The Annual Performance Report sets out how we delivered on our vision and commitments over 2024-25 recognising the continuing challenges facing the health and social care sector in terms of changing patterns of demand and continuing financial constraints. This is our ninth Annual Performance Report. We review our performance against agreed local and national performance indicators and against the commitments set out in our Strategic Plan for 2022-25. The report is principally structured around the priorities set out in our strategic plan, linked to the National Health and Wellbeing Outcomes as well as those for Criminal Justice and Children and Families.

8. The main elements of the report set out: the current strategic approach of the HSCP (in line with the HSCP Strategic Plan 2022-25); how we have been working to deliver our strategic priorities and meet the challenges of the pandemic over the past 12 months; our financial performance; and detailed performance information illustrating data trends against key performance indicators.

9. The report meets the requirements of the national statutory guidance and is a static 'backward looking' review of activities and performance during the previous financial year.

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

11. The national outcome measures are based on survey feedback available every two years from a national survey of people taken from a random sample based on GP practice populations. The respondents have not necessarily used HSCP services. The most recent data comes from the 2023/24 survey. The HSCP also collects local data relating to people who have used our services and supports. This is included in the report as it is collected throughout the year and can be tracked over a longer time period.

12. The national organisational measures are taken from data that is collected across the health and care system for other reasons. In all cases we have included the latest available data. The updated indicators may not represent the full end year position as some of the data completion rates are not yet 100% but will be the most up-to-date data available at the statutory deadline. We have identified 'provisional' figures in the report.

13. The remaining performance information in the report relates to the key local indicators and targets developed to monitor progress against our Strategic Plan 2022-25. Our performance indicators illustrate progress against each of the nine strategic priorities. Chapter 4 of the report gives trend data from 2016-17 and uses a Red, Amber, Green status key to show whether we are meeting our targets.

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

Our performance

15. The data shows that throughout 2024-25, we have continued to maintain and deliver safe and effective services to our residents. Our performance information shows that

despite this very challenging period, there has been strong performance across service areas. Over the year, we have seen continuing collaborative working across the HSCP and with our independent, third and community sector partners.

16. Headline performance information by service area is given below.

Supporting children and families

- Percentage of children looked after away from home who experience 1 or more placement moves increased to 27.1% up from 14.4% in previous year (latest data 23/24). This indicator is impacted by small numbers of children.
- 89% of care experienced children supported in community rather than a residential setting (23/24 figure) – a high rate and very slightly better than the Scottish average (88.8%) but performance dropped slightly from the previous year.
- Child protection re-registrations within an 18 month period have returned to 0% from 12.5% in 2022/23. The increase was due to a very small number of children requiring re-registration in the previous year (latest data 23/24).
- Child protection - % of child protection cases assessed as having increased level of safety declined from 100% to 87% for 24/25. Further protection measures were taken by the multi-agency team for all cases where scores decline.

Supporting people to maintain their independence at home

- 63.4% of adults needing care receive personal care at home or direct payments for personal care, consistent with the previous year and meeting our target of 63%.
- 96.8% of local people aged 65+ living in housing rather than a care home or hospital – meeting our target and better than the Scottish average.
- % of people reporting outcome of 'living where you/as you want to live' increased to 95%, up from 91% in 23/24 (and 89% in the pervious year), and ahead of target (90%)
- The percentage of adults who agreed that they are supported to live independently as possible remained at 80.4%. This was the same figure as the previous survey (2021/22) - the national figure was 72.4%.
- 89.6% of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life – up from last survey (83.6%) and compares with Scottish average of 69.8%.
- % of people aged 65+ with intensive care needs (plus 10 hours) receiving care at home dropped from 62.5% to 60% missing our agreed target of 62%. This compares to a national average of 62.6%. The provision of quality care at home to support people to live independently and well in their own homes remains a key priority for the partnership and ongoing improvement of our care at home services continues.
- The number of people self-directing their care through direct payments and other forms of self-directed support declined to 499 for 2024-25 from 548 in 23/24 (but higher than 488 in 22/23). In East Renfrewshire, spend on direct payments for adults as a % of total social work spend for adults was 9% in 23/24 – consistent with previous years and matching the Scottish average (8.7%).
- Reablement performance declined with 43% of care needs reduced following period of reablement – down from 63% and significantly lower than target (60%). The complexity of need of service users has increased meaning less people coming to the service are suitable for reablement.

Supporting mental health and wellbeing and supporting recovery from addiction

- Mental health hospital admissions remain low (at 1.26 admissions per 1,000 population).
- 87% waiting no longer than 18 weeks for access to psychological therapies – a continuing improvement from 84% in 23/24 (and 75% in 22/23). However, this falls just short of the target of 90%.
- 97% people accessing recovery-focused treatment for drug/alcohol within 3 weeks – up significantly from 93% in 23/24 and we are maintaining performance ahead of target (90%).
- 78 alcohol brief interventions undertaken in 24/25 compared with 568 in the previous year. This was due to a temporary reduction in the funding available for commissioning the delivery of ABIs in 2024-25. This funding gap has been resolved for 2025-26 and delivery is expected to return to 23/24 levels.

Meeting healthcare needs and reducing unplanned hospital care

- Discharge with delay including Adults with Incapacity (PHS data) - averaged 13 delays for 24/25 – down from 15 in 23/24 but missing our target of 11. We remain one of the best performing HSCPs in Scotland on this measure.
- Adult bed days lost to delayed discharge reduced slightly to 5,093 from 5,132 for 2023/24 although we are missing our target. This reflects continuing levels of frailty/complexity and pressures in the social care25 sector during the reporting period.
- Adult A&E attendances – 18,211 (2023/24) – up from 17,824 but ahead of target.
- Adult Emergency admissions – 7,002 (2023/24) – again, up slightly from 6,943 and ahead of target.
- Emergency admission rate (per 100,000 pop) – 9,671 up slightly from 9,215 for 22/23.
- Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges) – 72, up from 69 in 22/23.
- Care home attendances reduced to 459 in 2024/25 from 487. However, admissions increased slightly to 254 from 248 in the previous year.
- Proportion of last 6 months of life spent at home or in a community setting – 88.8% up from 87.7% and ahead of target (86%)

Supporting unpaid carers

- 83.6% of those asked reported that their 'quality of life' needs were being met – down slightly from 84.5% in 23/24 but continuing to perform ahead of target (80%).
- % carers who feel supported to continue in their caring role was 28.4% (23/24) consistent with previous survey results and below the Scottish average of 31.2%

Supporting people through criminal justice pathways

- 77% of unpaid work placement completions within Court timescale – down from 89% and below target (80%)
- 65% Community Payback Orders (CPOs) commencing within 7 days – significantly down from 83% in 23/24 and we are missing our target (80%). Primary reason for failure to achieve this target is service users not engaging with instructions from Court and Social Work to attend scheduled appointment.
- Positive employability and volunteering outcomes for people with convictions – 57% (23/24 data) down from 64% in 22/23. Although missing our target of 60% all other participants demonstrated a positive training/education outcome.

- 82% of people reported that their order had helped address their offending – down slightly from 83% and impacted by the low number of people completing the voluntary survey.

Tackling health inequalities and improving life chances

- Our premature mortality rate remains significantly below the national average at 275 per 100,000 (22/23 fig) – down from 333 the previous year. Scotland average is 442 per 100,000.
- 13.1% of infants in our most deprived areas (SIMD 1) were exclusively breastfed at 6-8 weeks (22/23 fig) – down from 19.2% for 23/24 and missing our target of 25%. However, this is impacted by small numbers (reduction of two people). In SIMD 1 specifically, we have seen a large increase in mixed (breast and formula) feeding, from 5.8% in 2022/23 to 14.8% in 2023/24.

Supporting staff resilience and wellbeing

- 88% of staff agreed that “My manager cares about my health and wellbeing” – consistent with the previous iMatter staff survey (89%)
- 72% agreed that "I feel involved in decisions in relation to my job" – down from 75% in previous survey
- 75% agree that “I am given the time and resources to support my learning growth” – down slightly from 77% in previous survey

Protecting people from harm

- Improvement in safety and wellbeing outcomes for women who have experienced domestic abuse – 92% consistent with 23/24 performance (93%) and ahead of target (85%). a total of 1116 women and children were supported across Women’s Aid three core services, helpline and drop in enquiries compared to 1059 during the same period last year- a 5% increase.
- People agreed to be at risk of harm and requiring a protection plan have one in place – continues to be 100% of cases.

17. Following any comments from either the Performance and Audit Committee or the Integration Joint Board on 25 June 2025, we will use the remaining weeks until the publication date to enhance any content and make presentational changes.

CONSULTATION AND PARTNERSHIP WORKING

18. The Annual Performance Report reflects the work of the Health and Social Care Partnership throughout 2024-25. The East Renfrewshire HSCP Participation and Engagement Strategy sets the following objectives for the ways in which we work with our communities:
    - Our communities, our partners, our staff and those who receive support will be engaged with, involved and participate in ways that are meaningful to them.
    - We will deliver a strategy that supports and resources new ways of engagement, and embraces digital platforms.
    - We will deliver a strategy that has a focus on prevention, choice and stronger communities and people will be enabled to share their views.
    - We will have a coordinated approach to community engagement and participation.

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

19. Service managers, planning leads and third sector partners were consulted and have collaborated in the development of the Annual Performance Report.

CONCLUSIONS

20. The Annual Performance Report is the ninth performance report for East Renfrewshire Health and Social Care Partnership. This report provides a comparison of our performance against Scotland and the previous baseline year, recognising the significant pressures being faced by HSCPs across Scotland.

21. The report demonstrates the exceptional work undertaken by the partnership and the continued progress in the delivery of our priority outcomes. It shows that despite the continuing challenges we are facing in terms of demand pressures and increased levels of complexity, we have continued to support our most vulnerable residents and have performed well against many of our outcome-focused performance indicators. Through the continuing delivery of our new HSCP Strategic Plan for 2025-28 we will ensure that our priorities and approaches meet the changing needs of our population.

RECOMMENDATION

22. The Performance and Audit Committee is asked to note and comment on the contents of the Annual Performance Report 2024-25.

REPORT AUTHOR AND PERSON TO CONTACT

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10 June 2025

Chief Officer, IJB: Alexis Chappell

BACKGROUND PAPERS

East Renfrewshire HSCP Annual Performance Report 2023/24

East Renfrewshire HSCP Annual Performance Report 2022/23

East Renfrewshire HSCP Annual Performance Report 2021/22

East Renfrewshire HSCP Annual Performance Report 2020/21

Working Together for East Renfrewshire

East Renfrewshire Health and Social Care Partnership (HSCP) Annual Performance Report 2024-25

Contents

1. Introduction

1.1 Purpose of Report

The Public Bodies (Joint Working) (Scotland) Act 2014 requires Integration Joint Boards to publish an Annual Performance Report, setting out an assessment of performance in planning and carrying out those functions for which they are responsible.

This is the ninth report for the East Renfrewshire Integration Joint Board. It sets out how we delivered on our vision and commitments over 2024-25. As required, we review our performance against agreed local and national performance indicators and against the commitments set out in our 2022-25 Strategic Plan.

The HSCP provides care, support and protection for people of all ages, to enhance their wellbeing and improve outcomes for them as children, young people, families and adults. Over the course of 2024-25, our teams in collaboration with our partners and communities have continued to deliver this work in the context of changing demands on health and care services and pressures on available resources. We continue to respond to higher demands for support, 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 the individuals and families we support.

This report looks at our performance during another challenging year for the HSCP. We continue to see changing patterns of demand and continuing financial constraints for the health and social care sector locally and nationally. The main elements of the report set out:

- the established strategic approach of the East Renfrewshire Health and Social Care Partnership (HSCP);
- how we have been working to deliver our strategic priorities over the past 12 months and additional activity to meet the challenges of the pandemic;
- our financial performance; and,
- detailed performance information illustrating data trends against key performance indicators.

Throughout 2024-25, we have continued to maintain and deliver safe and effective services to our residents. Our performance information shows that despite this very challenging period, there has been strong performance across service areas. Over the year, we have seen continuing collaborative working across the HSCP and with our independent, third and community sector partners. And we are seeing positive performance across many of our strategic performance indicators.

1.2 Local context

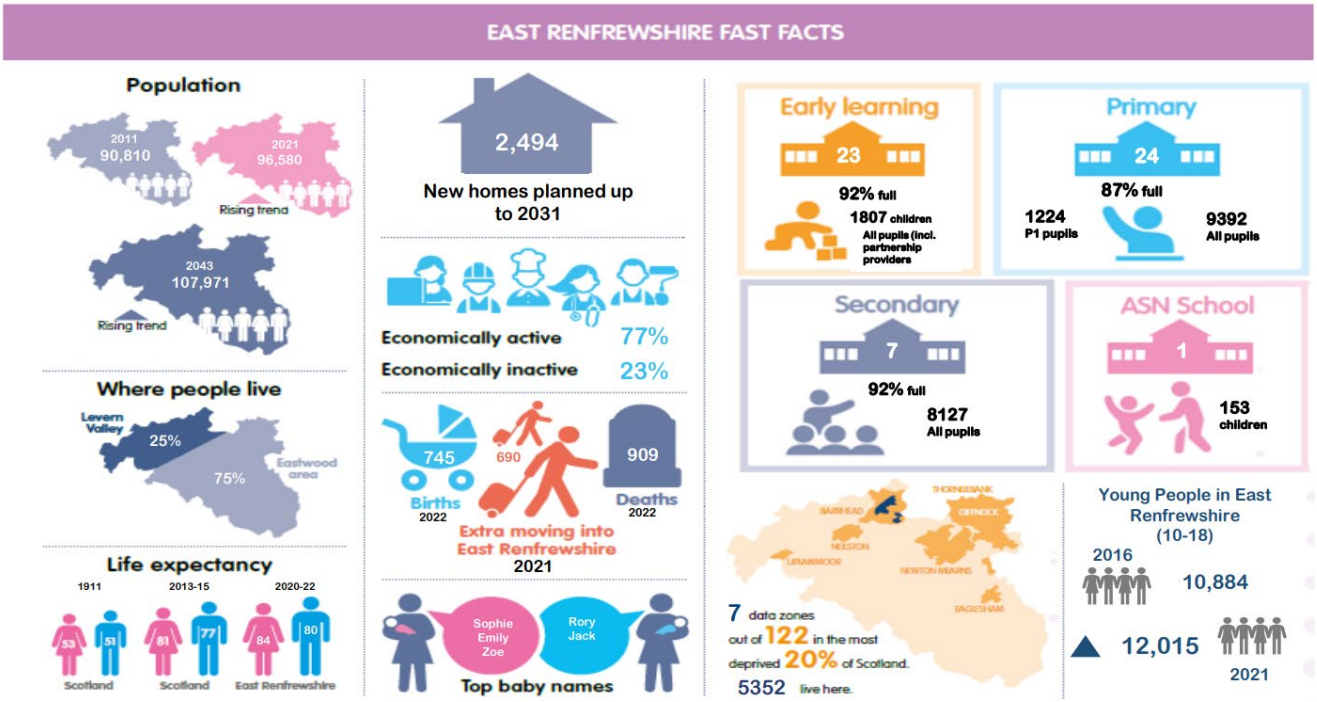
East Renfrewshire covers an area of 174 square kilometres and borders the city of Glasgow, East Ayrshire, North Ayrshire, Renfrewshire and South Lanarkshire.

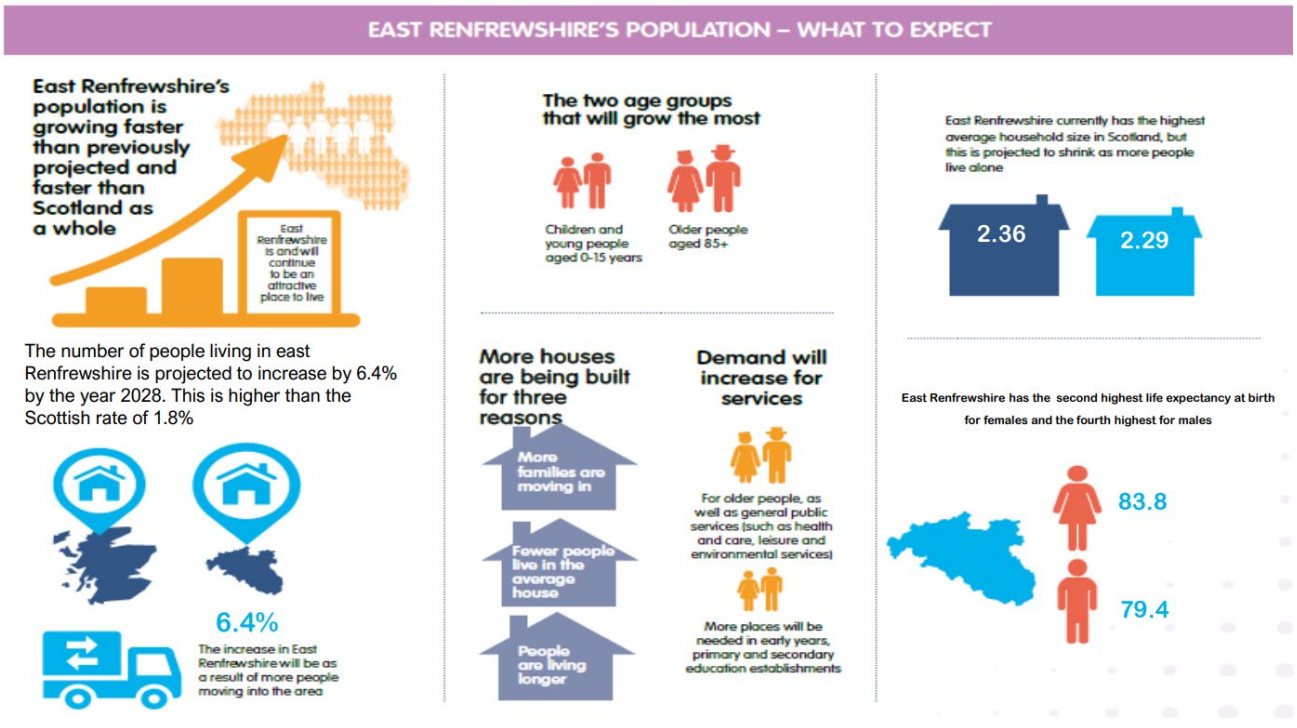
Our population continues to grow and reached 98,600 in 2023. 75% of the population live in the Eastwood area (Busby, Clarkston and Williamwood, Eaglesham and Waterfoot, Giffnock, Netherlee and Stamperland, Newton Mearns and Thornliebank) and 25% live in the Barrhead area (Barrhead, Neilston and Uplawmoor).

East Renfrewshire has an ageing population. By 2043, almost one quarter of East Renfrewshire is projected to be aged 65 or over (23.8%). There has been a 26% increase

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

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





East Renfrewshire Health and Social Care Partnership (HSCP) was established in 2015 under the direction of East Renfrewshire's Integration Joint Board (IJB) and it has built on the Community Health and Care Partnership (CHCP), which NHS Greater Glasgow and Clyde and East Renfrewshire Council established in 2006.

Our Partnership has always managed a wider range of services than is required by the relevant legislation. Along with adult community health and care services, we provide health and social care services for children and families and criminal justice social work.

During the last 19 years our integrated health and social care management and staff teams have developed strong relationships with many different partner organisations. Our scale and continuity of approach have enabled these relationships to flourish. We have a history of co-production with our third sector partners and we are willing to test new and innovative approaches.

East Renfrewshire HSCP is one of six partnerships operating within the NHS Greater Glasgow and Clyde Health Board area. We work very closely with our fellow partnerships to share good practice and to develop more consistent approaches to working with our colleagues in acute hospital services.

The integrated management team directly manages over 900 health and care staff, this includes 75 social workers who are trained and appointed as council officers. ER HSCP has long-established relationships with third and independent sectors to achieve our strategic aims around early intervention and prevention. In addition, the HSCP hosts the Specialist Learning Disability Inpatient Services, Adult Autism Service on behalf of the six HSCPs in NHSGGC and the Scottish Centre of Technology for the Communication Impaired (SCTCI) which provides specialist support for Alternative and Augmentative Communication to 12 Scottish Health Boards. The services within East Renfrewshire are community based with the exception of the inpatient wards for people with learning disabilities. There are no acute hospital sites or prisons in East Renfrewshire.

1.3 Our Strategic Approach

1.3.1 Our Strategic Vision and Priorities

In East Renfrewshire we have been leading the way in integrating health and care services. From the outset of the CHCP we have focused firmly on outcomes for the people of East Renfrewshire, improving health and wellbeing and reducing inequalities. Under the direction of East Renfrewshire's IJB, our HSCP builds on this secure foundation. Throughout our integration journey during the last 19 years, we have developed strong relationships with many different partner organisations. Our longevity as an integrated partnership provides a strong foundation to continue to improve health and social care services.

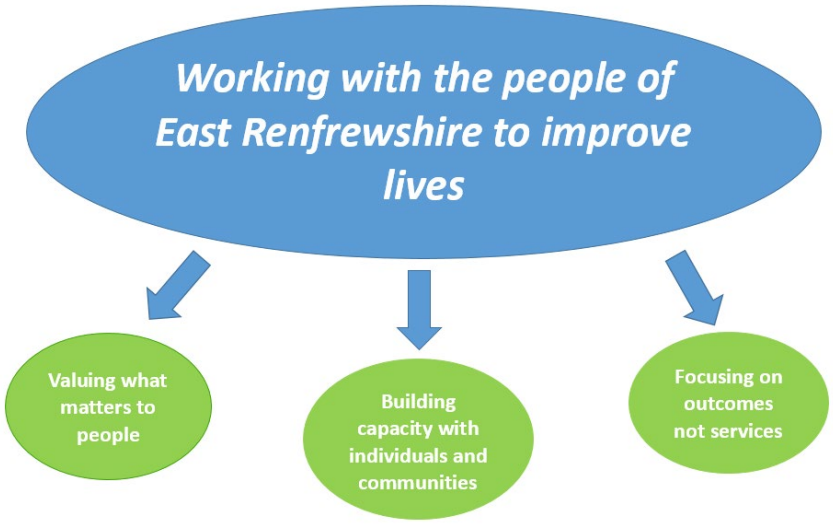
Our Vision

Our vision statement, *"Working together with the people of East Renfrewshire to improve lives"*, was developed in partnership with our workforce and wider partners, carers and members of the community. This vision sets our overarching direction through our Strategic Plan. At the heart of this are the values and behaviours of our staff and the pivotal role individuals, families, carers, communities and wider partners play in supporting the citizens of East Renfrewshire.

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

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

The touchstones keep us focused when we are developing and improving the quality of our service delivery.



Our Strategic Plan

Our first Strategic Plan covered the period 2015-18 and took its priorities from the National Health and Wellbeing Outcomes. It set our high level planning intentions for each priority and was underpinned by an Annual Implementation Plan reviewed and monitored at HSCP level.

Our second Strategic Plan covering 2018-21 recognised that the partnership must extend beyond traditional health and care services to a wide partnership with local people and carers, volunteers and community organisations, providers and community planning partners. The plan placed a greater emphasis on addressing the wider factors that impact on people's health and wellbeing, including activity, housing, and work; supporting people to be well, independent and connected to their communities.

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

Our third 'full' Strategic Plan covered 2022-25. This report reviews our performance for the final year of the plan. The plan was developed in consultation with stakeholders and East Renfrewshire residents, despite the continuing challenges we faced from the pandemic. This included a highly participative engagement process coproduced with wider partners through our Participation and Engagement Network and a comprehensive strategic needs assessment. The consultation found that people were supportive of our strategic priorities and the key areas of focus set out in the plan. Many people emphasised the crucial importance of partnership and collaborative working and there was a focus on ensuring the necessary support is in place for our staff and for local unpaid carers. Key changes we made to our strategic plan in light of the consultation included:

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

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

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

The plan illustrates how the HSCP contributes to the priorities established in the East Renfrewshire Community Plan and Fairer East Ren. Under our strategic priorities we set out our key activities and critical indicators that link to the HSCP contribution to East Renfrewshire Council's Outcome Delivery Plan. The plan also linked to relevant planning at NHSGGC Board level, including the priorities set out in Moving Forward Together, and commitments set out in supporting plans including: the Public Health Strategy, the Adult Mental Health Strategy, the Primary Care Strategy and the Public Protection Strategy.

During 2024/25 the partnership has developed a new Strategic Plan for 2025-28. The new plan is the result of several months of development work as we have collaborated with

colleagues, stakeholders, and local people. The plan reflects the shared priorities of local residents and sets out meaningful commitments for our wide partnership.

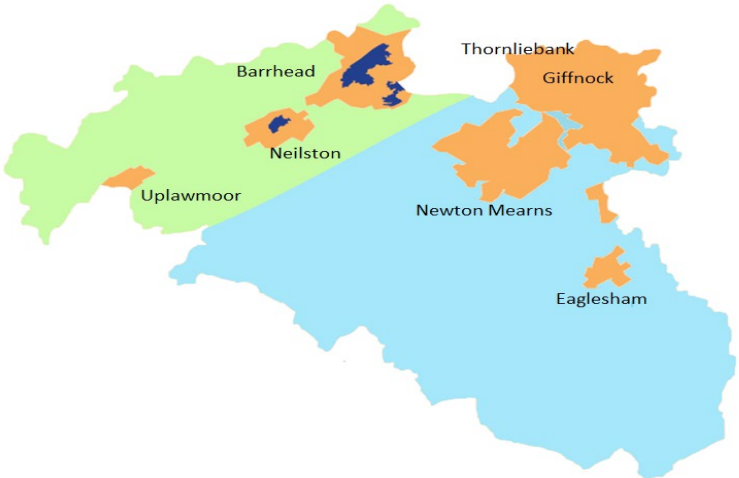
The Strategic Plan 2025-28 builds on our existing vision and priorities established in our long-term strategic planning. It also recognises the changed circumstances for the HSCP since the previous plan was developed, and intends to be open and realistic about the constraints the HSCP is working in. 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). We have streamlined our Strategic Plan to make it more meaningful and more focused around shared priorities. 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.

1.3.2 Locality planning in East Renfrewshire

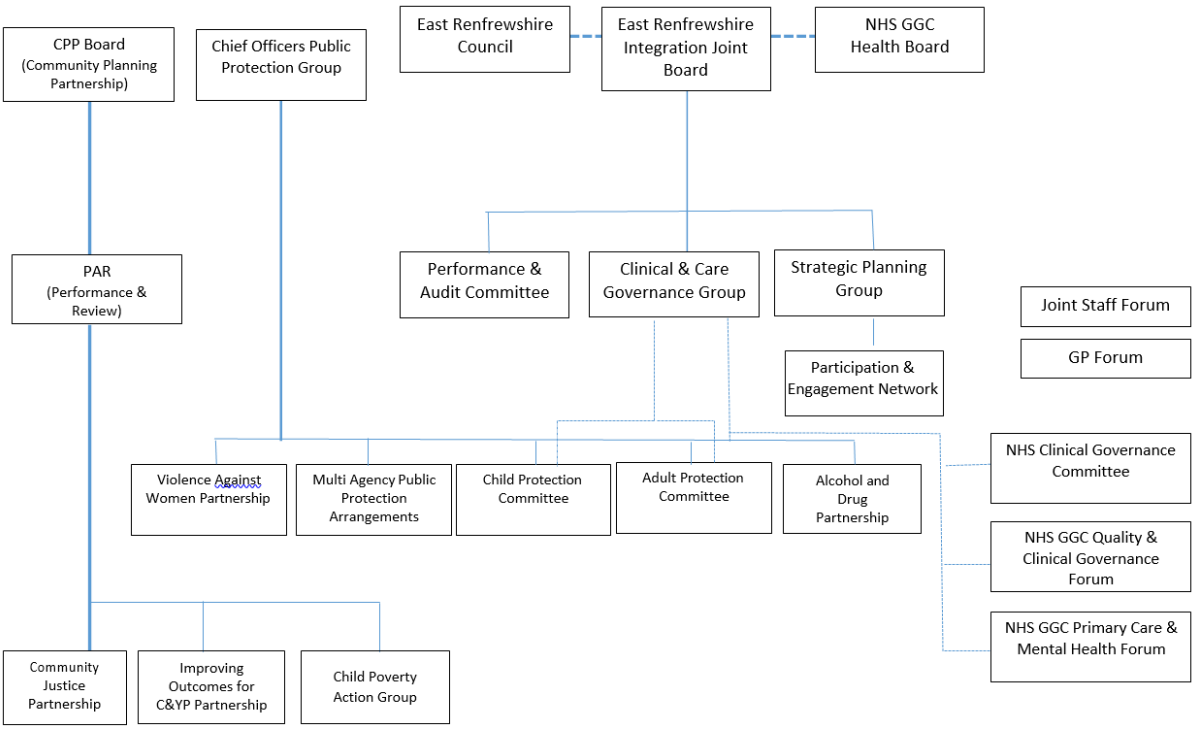
Our previous 2018-21 Strategic Plan reduced our locality planning areas from three to two localities – one for Eastwood and another for Barrhead. This allowed us to coordinate our approach with our local GP clusters while also reflecting the natural communities in East Renfrewshire.

Our locality areas also reflect our hospital flows, with the Eastwood Locality linking to South Glasgow hospitals and the Barrhead Locality to the Royal Alexandra Hospital in Paisley. Our management and service structure is designed around our localities. Our locality planning arrangements continue to develop and will be supported by planning and market facilitation posts and financial reporting at a locality level.



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

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



1.3.3 Our integrated performance management framework

We have a commitment to integrated performance management. Our performance management framework is structured around our Strategic Plan, with all performance measures and key activities clearly demonstrating their contribution to each of our nine strategic planning priorities. The framework also demonstrates how these priorities link to the National Health and Wellbeing Outcomes and East Renfrewshire's Community Planning Outcomes.

We have developed an Implementation Plan and a supporting performance framework accompany our Strategic Plan. Working with key stakeholders in our Strategic Planning Group, we developed these through outcome-focused planning. The plan is presented as a series of 'driver diagrams'. These diagrams show how we will achieve our strategic outcomes through 'critical activities' measured by a suite of performance indicators. This is the basis for strategic performance reporting to the Integration Joint Board (IJB) and it also feeds into East Renfrewshire Council's Outcome Delivery Plan and NHS Greater Glasgow and Clyde's Operational Plan. Our Strategic Performance Reports are presented to the IJB Performance and Audit Committee every six months (at mid and end year). We also provide quarterly updates (at Q1 and Q3) when data updates are available.

Every six months we hold an in-depth Performance Review meeting which is jointly chaired by the Chief Executives of NHS Greater Glasgow and Clyde and East Renfrewshire Council. At these meetings both organisations have the opportunity to review our Strategic Performance Report and hear presentations from Heads of Service, which set out performance progress and key activities across service areas.

The HSCP draws on qualitative and quantitative information from a range of sources. Our main sources of performance data include Public Health Scotland, Scottish Public Health Observatory and National Records Scotland. We also use local service user data and service data from NHS Greater Glasgow and Clyde.

We gather feedback from people who use services from a variety of sources. These include patient/service user surveys through for example, our Primary Care Mental Health Team; community groups; and people who use our integrated health and social care centres. We monitor feedback from residents through the recently established Care Opinion system. We also gather local feedback from East Renfrewshire Council's Citizens' Panel, Talking Points data and the National Health and Wellbeing Survey. We support a local Mental Health Carers Group, where carers are able to raise issues about their needs and the support they receive. We continue to develop our approach to engagement through our multi-agency Participation and Engagement Network, strengthening our methods in drawing in residents' views to our evaluation processes.

1.3.4 Supporting People Framework

East Renfrewshire HSCP has a strong track record in supporting people to live well. We have historically invested significantly in services and support to help people at the earliest opportunity. We will try our best to continue to do this to support people within their communities.

Until 2023-24 East Renfrewshire HSCP had resisted the development of a criteria to determine access to social care. Our approach has been largely outcome focussed whilst adhering to national policy and guidance on care provision such as self-directed support and nursing / residential care for older people. However, in 2023 it was recognised that, due to the resource pressures facing the HSCP, we would have to take a new approach.

The flat cash settlement that East Renfrewshire Council received and passed on to the Integration Joint Board has resulted in us having to fund all of our pressures. These have been particularly challenging in 2023-24 due to the growing demands and complexity of need, alongside pressures relating to pay and inflation. It was recognised that, we simply could not afford to support everyone in the way that we had been doing and we needed to think differently about how we support people and where they get support from.

Our Supporting People Framework sets out our criteria for providing social care; sharing finite resources fairly, and focusing our resources on people assessed as having the highest levels of needs. The Framework supports practitioners to deploy finite resources in a way that ensures that resources are provided to those in greatest need. Lower level need should not automatically be seen as a deficit requiring allocation of resource but should be considered in relation to an individual's personal or community assets holistically. The Supporting People Framework encourages creativity and collaboration to widen and enhance support. The framework will allow access to the most appropriate support in line with levels of risk and need.

The Supporting People framework recognises risk as the key factor in the determination of eligibility for adult social care services. However, we know that risk can increase or decrease and be offset by strengths and protective factors which can be assessed via ongoing assessment and review. Where a person is eligible for a statutory service, the urgency of risk and complexity of need should be borne in mind when determining how and when to respond to their support requirements. The principles guiding our practice when implementing the new Framework are underpinned by the HSCP strategic vision to "work together with the people of East Renfrewshire to improve lives". The principles ensure that support provided by East Renfrewshire HSCP 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.

In managing access to finite resources, the HSCP will focus first on those people assessed as having the most significant risks to their health, wellbeing and independent living. Where people are assessed as being in the *critical* or *substantial* risk categories their needs will generally call for the immediate or imminent provision of support. People experiencing risk at this level will receive that support as soon as reasonably practicable.

Where eligibility is assessed as *moderate* or *low*, the primary response of the HSCP will be to provide the individual with advice/information and/or to signpost to community resources, supporting access to support where practical and practicable.

To ensure support to those at the lower categories of need, the HSCP is continuing to invest in voluntary and community resources that help people to live well and independently.

2 Delivering our key priorities

2.1 Introduction

This section looks at the progress we made over 2024-25 to deliver the key priorities set out in our Strategic Plan and how we are performing in relation to the National Health and Wellbeing Outcomes. For each area we present headline performance data showing progress against our key local and national performance indicators. In addition to an analysis of the data we provide qualitative evidence including case studies and experience from local people engaging with our services. Our intention is to illustrate the wide range of activity taking place across the partnership.

A full performance assessment covering the period 2016-17 to 2024-25 is given in Chapter 4 of the report.

2.2 Working together with children, young people and their families to improve mental wellbeing

National Outcomes for Children and Young People contributed to:
Our children have the best start in life and are ready to succeed
Our young people are successful learners, confident individuals, effective contributors and responsible citizens
We have improved the life chances for children, young people and families at risk

2.2.1 Our strategic aims and priorities during 2024-25

Improving the mental and emotional wellbeing of children and young people continues to be one of the highest priorities for East Renfrewshire HSCP. Our multi-agency approach to supporting the needs of children and young people in East Renfrewshire is set out in "At Our Heart – Next Steps" East Renfrewshire's Children and Young People's Services Plan 2023-2026. Together all partners in East Renfrewshire are building an approach to mental health support for children, young people and families that will ensure they receive the right care and interventions at the right time and in the right place. We aim to provide a holistic range of appropriate supports through our multi-stakeholder Healthier Minds Service which works alongside our Family Wellbeing Service and links to GP practices and the Child and Adolescent Mental Health Service (CAMHS).

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

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

- Protecting our most vulnerable children, young people and families
- Delivering on our corporate parenting responsibilities to our care experienced children and young people by fully implementing The Promise
- Responding to the mental and emotional health and wellbeing needs of children and young people

- Ensuring children and young people with complex needs are supported to overcome barriers to inclusion at home and in their communities

2.2.2 Our performance in 2024-25

During 2024-25 our children's services have continued to see high levels of demand and complexity among referrals. We continue to work with an increasing number of children with diagnosed neurodevelopmental disorders and a high prevalence of families in crisis.

Headline performance data includes:

- Percentage of children looked after away from home who experience 1 or more **placement moves** has increased to 27.1% up from 14.4% in previous year (latest data 23/24). This indicator is impacted by small numbers of children.
- 89% of care experienced children **supported in community** rather than a residential setting (23/24 figure) – a high rate and very slightly better than the Scottish average (88.8%) but performance dropped slightly from the previous year.
- **Child protection re-registrations** within an 18 month period have returned to 0% from 12.5% in 2022/23. The increase was due to a very small number of children requiring re-registration in the previous year (latest data 23/24).
- Child protection - % of child protection cases assessed as having increased **level of safety** declined from 100% to 87% for 24/25. In all cases where safety declined or stayed the same the children were initially registered pre-birth. Further protection measures were taken by the multi-agency team for all cases where scores decline.

2.2.3 Ways we have delivered in 2024-25

East Renfrewshire's multi-agency Children and Young People's Services Plan 2023-2026 "At Our Heart – The Next Steps", recognises mental and emotional wellbeing as a key priority. Since the pandemic we have seen a sustained increase in the number of children and young people experiencing challenges with their mental health and wellbeing and this also includes those who have a neurodevelopmental diagnosis.

During the year we have continued to work in partnership with children, young people, and families/carers to implement **The Promise,** taking a lead role in local implementation. On 5th February 2020, a promise was made to the infants, children, young people, adults and families who have experience of the care system in Scotland. The Promise and its commitments were clear that by 2030 the following would be delivered:

- Love will no longer be the casualty of the 'care system,' but the value around which it operates.
- Wherever safe to do so, Scotland will make sure children stay with their families and families will be actively supported to stay together.
- Children, young people, and their families will be listened to, respected, involved and heard in every decision that affects them.

February 2025 marked the 5th anniversary of The Promise and the mid-way point in the 10 year programme. Through our multi-agency East Renfrewshire Improving Outcomes for Children and Young People Partnership we have worked hard since 2020 to promote and implement The Promise. Firstly by consistently raising awareness of the role of Corporate Parents, we have sought to ensure that partners understand that when a child or young person

becomes looked after – at home or away from home - the local authority, health board, and a large number of other public bodies take on the statutory responsibility of Corporate Parent. Achieving a shared understanding that Corporate Parenting is a collective responsibility is key to successfully keeping The Promise.

Similar to the national picture, over the last decade East Renfrewshire's looked after population of children and young people has been reducing and changing, and this is as a consequence of national as well as local factors. Specifically, changes to how children can access essential services has meant that there has been a cultural and systems shift away from requiring a statutory supervision order to get the help they need and when they need it. Furthermore, the implementation of Signs of Safety and a risk sensible approach has meant children's services work more collaboratively with parents and carers to achieve better outcomes for children.

The delivery of the national **Permanence and Care Excellence (PACE) Programme** has also led to the reduction in this population as more innovative ways of working, informed by children's rights, trauma and relational based practice, have been rolled out. Overall, the strengthening of prevention and early help provision has resulted in need being identified and responded to earlier by universal services in line with the Getting it Right for Every Child approach.

In addition, the characteristics of the looked after population have changed as there is a clear trend towards more children and young people with very complex needs such as neuro divergence and co morbidity mental health, becoming subject to a supervision requirement. Approximately one third of the current looked after population are separated young people (unaccompanied asylum seeking young people) who have a high level of need that we are responding to. Both trends are forecast to continue to increase over the period. It is important to state that although the overall number who are looked after has reduced the actual number of vulnerable children, young people and families who require intervention to prevent them from entering the care system is increasing across all services.

The East Renfrewshire 5th Anniversary Progress Update highlighted further activity that has been undertaken by a range of our corporate parent partner agencies and includes:

- Development of an East Renfrewshire Promise Board;
- Child Friendly Children's Hearings through 'Better Hearings' practice group;
- Imagination Library has delivered 1414 books to 63 children in East Renfrewshire;
- Roll out of Trauma Tier 1 and 2 Training programmes to over 350 staff across the Council workforce;
- Publication of a new Housing and HSCP Protocol to support care experienced young people's access to housing;
- Keeping the Promise Award in settings and schools

East Renfrewshire Promise Board

East Renfrewshire Council approved the development of The Promise Board in September 2024. This is an innovative new approach to engaging with children and families who have experienced the formal care system. The Board membership will comprise of children, young people, families and carers along with Chief Officers, senior officials, and elected members, with a young person and the Chief Executive jointly holding the formal role of Chair to the Board.

The purpose of The Promise Board is to ensure that care experienced children and young people and their families can communicate directly with Council, HSCP, and other Corporate Parents in relation to what is working well and what could be improved. Allowing children, young people and families to participate in setting the agenda will ensure that what

is most important to those with the lived experience of the care system will begin to be addressed in a supportive environment.

Methods of engagement will include play and fun activities, ongoing interactive consultation as well as formal meetings. The first Board formal meeting will take place in Sept 2025. We have already delivered on Promise training and a recent Promise Engagement session brought together key members of board alongside lived experts with a focus was on co-creating a shared set of values, principles and a terms of reference. Commitment to the Promise Board from all East Renfrewshire Council Corporate Management Team, Elected Members, and HSCP is very positive and encouraging.

The Promise Workforce Learning Programme

A three tier Promise Workforce Learning Programme has been devised to support The Promise Keepers, the workforce and all Corporate Parents understand the aim of The Promise and the part they can play in implementation.

The new programme was approved by Council in October 2024 and local partners have agreed to promote the attendance and engagement of their workforce at levels appropriate to roles and responsibilities. Commencement for Tier 1 and 2 was winter 2025, with Tier 3 expected to be delivered by autumn 2025.

Tier 1 is delivered as an East Renfrewshire Council online course with 88 staff across the Council having completed during the last quarter of the year. Workforce Learning Programme Tier 2 was a senior officer face to face programme delivered over a half day in March. This was a very well attended event with 66 participating on the day and similarly high levels of satisfaction with the session.

More events are planned for 2025, in particular bespoke training aimed at specific services who are keen to become more Promise compliant.

We continue our work to alleviate pressure on CAMHS by developing appropriate (Tier 2) alternatives that work with young people and families to support recovery and minimise crisis. A key success is the ongoing development of the multi-stakeholder **Healthier Minds Service** aligned to school communities was developed to identify and ensure delivery of mental wellbeing support to children and families. Referrals come primarily from schools and other agencies including GPs, CAMHS, Social Work, RAMH, Woman's Aid and Children 1st and more importantly includes self-referrals from young people. More than 1,600 children and young people have been referred to the weekly screening hub (since the service began in November 2020). Last year a total of 411 children and young people were referred to and discussed at the Healthier Minds Hub. This year we have seen more primary school boys accessing the service, bring them in line with their female peers. Re-referrals are an ongoing trend highlighting the strengths of the relationships that are developed between the staff member and the child, young person and their family.

Healthier Minds Screening Hub 2024/2025

411 children young people and families were referred to the Healthier Minds Screening Hub during the 2024-25. 19% of those referred to the Hub have a diagnosis of Autism and/or ADHD (since the service began). A further 8% have neurodivergent traits, most of which are awaiting diagnosis. There continues to be a high number of children and young people referred to the service seeking support whilst on a waitlist for diagnosis, support and training is offered to them and their families.

The service continues to see increased levels of distress reflected in the main reasons for referral:

- Anxiety/stress
- Low mood
- Self-harm
- Emotional regulation
- Trauma

97% of children and young people supported by Healthier Minds Team reported improved mental and emotional wellbeing, maintained from previous year.

All parents who completed the parental evaluation reported that they would recommend the service to others.

256 staff from the HSCP, Education and the third sector attended sessions offered through our Healthier Minds calendar. Topics included:

- Understanding Anxiety;
- How to Support Children and Young People aged 10-18 using Cognitive Behavioural Approaches;
- Sleep;
- Autistic Spectrum Condition (ASC) – Supporting Mental and Emotional Wellbeing;
- ADHD – introduction, strategies for support in the classroom, mental & emotional wellbeing;
- Social Media and Mental and Emotional Wellbeing;
- Supporting Boys with Emotional Wellbeing;
- Next Steps & Enhanced Nurture Approaches.

The session evaluated well and feedback was very positive.

We continue to support young people with complex needs as they transition from one life stage to another. We have seen an increase in the numbers of young people being referred for transitions assessment, planning and support, with numbers forecast to continue increasing in future years. The **HSCP Transitions Team** are working alongside 91 young people going through transition to young adulthood. Partnership working is stronger between schools and key services allowing early access to support and links to Community Pathways opportunities. Improved appropriate and relevant information sharing across multi-agency teams is leading to better transition experience for young people and their families. A new transitions pack has been shared with high schools, and contains information for young people and parents to help them through the process.

Supporting independent living – HSCP Children and Families, ERC Housing Services and Aberlour Housing

In 2021 vulnerable young people reported that current provision of housing and support was insufficient and failed to address their needs. A partnership between Aberlour, East Renfrewshire HSCP, and East Renfrewshire Council Housing Services was set up to examine support for independent living, supported accommodation and aftercare/outreach. Led by the principles of Scottish Approach to Service Design, 25 consultations with care experienced young people and foster carers took place, 13 contextual interviews with stakeholders, and 4 multi-agency workshops were delivered. Key areas explored were preparation, support needs, and the leaving care process.

This two year project has culminated in a number of achievements based on the original action plan. The key one being establishment of the Out of Hours Support Service, 365 days a year for young people in emergency and temporary accommodation. Young people also designed housewarming hampers and a tenancy handbook for their peers. A joint protocol was written between HSCP Children and Families and Housing to clarify responsibilities during the journey of a young person moving to independent living. Housing created a new housing process for care experienced young people which has resulted in a specialty priority band which reflected this status. It also developed a pathway for care experienced young people to go on the Housing Allocation List at 16 and defer until they are ready to move in. When they are ready, all the days they have acquired on the list from their 16th birthday will go live and give them greater priority. A pilot 10-week Housing Skills Programme for care experienced young people commenced in January 2025.

The **Big Night In** engagement event was well attended by 72 young people and parents. 46% of those young people were not known to any services, 23% of them were males aged between 18-22 years of age. The event was well evaluated by young people finding it useful to discuss their options for the future. At least 34% of the young people that came along are now in touch with one or more service that attended on the night.

Make it Happen volunteering programme

During 2024-25 VAER have begun delivery of a two-year youth volunteering programme funded through the Young Start, National Lottery fund. The main aim of the Make It Happen programme is to support and guide young people facing personal barriers to grow in confidence, find meaningful opportunities to participate and reconnect with their communities through volunteering.

Programme outcomes:

- We work with young people across East Renfrewshire aged 12-25.
- There are three parts to the programme: one-to-one support, preparation for volunteering and the group opportunities.
- We also support groups and organisations in East Renfrewshire to create youth friendly individual and group volunteering opportunities

In year one we have achieved the following:

- 70 referrals to the programme between June24 - March 25
- Main referrers: Talking Points, Social Work Transitions Team, Enable LAC Team, Work East Ren, SDS, Children 1st and also parent/carers/self-referrals.
- Both Leven Valley and Eastwood are well represented within the referrals.
- We have been experiencing high demand but we remain open to referrals
- Referral form is available on the programme webpage:

eastrencommunityhub.org.uk/make-it-happen

We continue to develop and improve our practice supporting vulnerable children and young people, including the **Signs of Safety** model, led by the Chief Social Work Officer and the Head of Education Services (Equality and Equity). The model supports practice improvement, with a particular focus on developing relational interventions with children, young people, their families and carers in order to reduce risk and improve children's wellbeing. The Signs of Safety approach, rooted in strengths-based and solution-focused social work practice, aligns closely with The Promise. It promotes safe connections and seeks wider participation to promote safety, growth and well-being. Signs of Safety emphasises collaboration with families, recognising their strengths and involving them in solutions, ensuring their voices are central in decision-making, fostering a sense of empowerment and belonging. The programme is currently in seventh year of a ten year implementation plan and roll out with social work and multi-agency training/support is ongoing. In 24-25 over 90 staff and carers underwent training including how to create networks. Evaluation is conducted that indicates the approach continues to keep families together but more evidence based work is planned.

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

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

Similar to all local authorities throughout the UK East Renfrewshire has participated in the mandated Home Office National Transfer Scheme to provide care and support to **separated children and young people (unaccompanied asylum seeking children/young people)**. In early 2025 the number of young people we were supporting was 32 and this now represents approximately one third of our looked after population locally. 82% of these young people have remained in their initial placement. A small number of the young people have been accommodated with foster carers but most are housed in their own accommodation, usually flat sharing who they have been matched with in accordance with their background. The young people are mainly supported by HSCP Children and Families YISS Team and most are on supervision orders due to their vulnerability. CLD colleagues, school, and colleagues have come to offer support and have engaged well with the young people. Schools have provided safe and nurturing spaces for them and CLD staff have created community based youth work opportunities to help with integration, reduce isolation, and improve mental wellbeing.

The **Champions Board** was established over 10 years ago and in that time has become a platform for care experienced young people aged 12-26 years to express their views and what they would like to see change. A central focus is on inclusion and participation allowing looked after young people a meaningful forum to directly influence and, through time, redesign services that affect them in a co-produced way by influencing their corporate parents. They have worked together to explore issues facing care experienced young people and suggest ways to improve the services that are available, for example housing and mental health services have been key issues. Young people have worked directly with Heads of Service and other corporate parents at directorate level to discuss issues affecting them with the aim of influencing changes in policy and practice. There is also a focus on wider participation and engagement activities to promote relationships, connections and the overall wellbeing of our young people.

Champions Board activity 2024-25

The Champions Board were involved in the co-design of our Healthier Minds Service and the mid-year review in October 2024 highlighted that nine Care Experienced young people and 15 Young Carers have been supported so far this year. The current members of the Champions board were equal partners in the 'Moving On' housing project and are currently instrumental in shaping the new Promise Board.

To ensure that, at the highest level, children and young people are heard and engaged, and that they and their families are at the centre of everything that we do, we have developed an East Renfrewshire Promise Board. In addition to children, young people, families and carers the Promise Board will draw its membership from chief officers, elected members, and senior officials from across the local partnership. This is a completely new way of working collaboratively with those who use our services and to encourage meaningful participation a coproduction approach will be adopted. The aim is for those with lived experience of the care system to help set the agenda, communicate what is working well for them, what is not going well, and ultimately help agencies shape better services and responses. The new Board model was approved by Council in October 2024 with Board membership recently agreed. Further development is now taking place with the first board event to take place in 2025 and the full board operational by autumn.

2.3 Working together with people to maintain their independence at home and in their local community

National Health and Wellbeing Outcomes contributed to:
NO2 - People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
NO3 - People who use health and social care services have positive experiences of those services, and have their dignity respected
NO4 – Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services

2.3.1 Our strategic aims and priorities during 2024-25

Ensuring as many East Renfrewshire residents as possible can maintain their independence at home remains a priority of the partnership. 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 with the third sector and our communities and aim to increase the community supports and opportunities available. We will make best use of technology and health monitoring systems to support independence and self-management. We are committed to increasing choice and control and delivering the full potential of Self-directed Support. As more people live longer with more complex conditions it is important that we work collaboratively with housing providers to support independent living in our communities.

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

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

2.3.2 Our performance in 2024-25

Over 2024-25 we have continued to support people to live independently and well at home, despite continuing demand pressures on our services due to more people seeking support at home as well as increased levels of frailty and complexity. During 2024-25 we have seen continuing pressure on our Care at Home service with increased referrals and reducing capacity among partner providers.

Headline performance data includes:

- 63.4% of adults needing care receive personal **care at home or direct payments** for personal care, consistent with the previous year and meeting our target of 63%. (NI8)
- 96.8% of local people aged 65+ living in **housing rather than a care home or hospital** – meeting our target and better than the Scottish average.
- % of people reporting outcome of **'living where you/as you want to live'** increased to 95%, up from 91% in 23/24 (and 89% in the pervious year), and ahead of target (90%)

- The percentage of adults who agreed that they are **supported to live independently** as possible remained at 80.4%. This was the same figure as the previous survey (2021/22) - the national figure for this survey period was 72.4%.
- 89.6% of adults supported at home who agree that their services and support had an impact on improving or maintaining their **quality of life** – up from last survey (83.6%) and compares with Scottish average of 69.8%.
- % of people aged **65+ with intensive care needs** (plus 10 hours) receiving care at home dropped from 62.5% to 60% missing our agreed target of 62%. This compares to a national average of 62.6%. The provision of quality care at home to support people to live independently and well in their own homes remains a key priority for the partnership and ongoing improvement of our care at home services continues.
- The number of people **self-directing their care** through direct payments and other forms of self-directed support declined to 499 for 2024-25 from 548 in 23/24 (but higher than 488 in 22/23). In East Renfrewshire, spend on direct payments for adults as a % of total social work spend for adults was 9% in 23/24 – consistent with previous years and matching the Scottish average (8.7%).
- In the year, **reablement** performance has declined with 43% of care needs reduced following period of reablement – down from 63% and significantly lower than target (60%). The complexity of need of service users has increased meaning less people coming to the service are suitable for reablement.

2.3.3 Ways we have delivered in 2024-25

The HSCP continues to promote community-led support which emphasises more local, personalised and flexible services. We fully recognise the importance of strong community and third-sector links to ensure people can access the supports they need in their community, helping people to live independently and well.

Key to our approach as a partnership is the support provide by our local **Community Hub** which helps residents to access information and signposts to local community services and supports. The Community Hub is a partnership between Voluntary Action East Renfrewshire (VAER), HSCP Talking Points and East Renfrewshire Council Communities and Strategic teams.

Talking Points, which residents can access through the Community Hub**,** continues to be the main route for residents to get advice and support around their health and social care as well as information surrounding accessing community supports. The services has a membership of over 60 local and national organisations that work together to offer the correct support and information as early as possible. This preventative approach is person-centred and is integral in our delivery of Talking Points.

During 2024-25 there has been significant change impacting the design, development and delivery of support for our most vulnerable members of our communities. The implementation of the Supporting People Framework, along with the tightening of public sector budgets has led to significant challenges faced not just by our communities but the organisations that

support them. Development of Talking Points during 2024-25, has focused on re-designing how the collaborative operates as the focus of our referrals has shifted significantly. The Supporting People Framework has resulted in an increase in the number of referrals coming to Talking Points following a review of their care package resulting in a reduction of support, or for some the stopping of all statutory support as they no longer reach/ meet the criteria of substantial/critical for care needs.

Talking Points – ensuring support is available in our communities

Talking Points @ The Community Hub has continued to support local people looking for support within their communities, playing a pivotal role in diverting moderate to low level supports away from the HSCP front door, being picked up and supported by appropriate community and 3rd Sector providers.

In 2024-25 Talking Points @ The Community Hub responded to **627** referrals for help, **516** referrals from organisations and **111** self-referrals from individual residents.
Our top 10 requests for support were as follows:

- Groups & Activities 229
- Befriending 170
- Loneliness 89
- Community Information 62
- Mental Health 60
- Shopping Service/Support 55
- Carer Support 42
- Volunteering 32
- Care Assessment/Support 32
- Transport Enquiry 33

This year our top 3 geographical referrals were split as follows
Org referrals:

- Barrhead 140
- Newton Mearns 115
- Giffnock 75

And Self referrals

- Newton Mearns 33
- Barrhead 16
- Giffnock 15

As well as responding to referrals and direct requests for support, the Talking Points collaborative has also supported the delivery of the following collaborations:

- Networking Breakfast, bringing together 80 organisations across the authority and nationally. The event provided an opportunity for attendees to connect, share information, and explore potential collaborations.
- Dementia Awareness (with Carers Centre):
  10 people booked / 8 attended
  Partners - Inksters (POA), Playlist for Life, The Stables, Alzheimer's, Telecare, Prevention Team, TRFS, MART, HSCP, SDS, Carers Centre & Walking Buddies, TP's
- Health Relationships:
  Values into Action will deliver 4 sessions (2hrs each)

Partners: Enable, Include me 2 and Make it Happen, HSCP (LD team) will have 3 young people each attending sessions - total 12 young people.
Other partners: Police Scotland

Impacts during 2024-25

- Strengthened connections between service providers and support organisations.
- Increased awareness of available services, such as Men Matters.
- Improved signposting, enabling individuals to access tailored support through informed professionals.

A key focus for the partnership is ensuring that the right **health and wellbeing opportunities** are available in our local communities. During the year VAER has continued to offer capacity supports to our local 3rd Sector. Throughout 2024-25 VAER has offered direct Capacity Building supports under the following headings to **177** groups and organisations - 59 Social Enterprises/118 Non-SEs. The team supported these groups and orgs with **185** support interventions on the following topics:

- Funding supports
- Constitution Reviews
- Good Governance and Policy development
- Volunteer Development
- Acting as Custodian holding funds

VAER also provided workshops and training on Good Governance, Effective Evaluation and Sustainable Funding.

The **Community Hub website** offers easy access to information on activities, volunteering opportunities, and community supports for people living and working in East Renfrewshire. The platform fosters better collaboration by providing a central space to share the outputs of our collaborative efforts with local communities. The **Community Activities Directory** includes information about local activities, clubs and community groups in and around East Renfrewshire. As at March 2025, there are 218 local activities, clubs and groups registered on the directory.

The Directory of ASN Activities for Children and Young People provide parents and carers with the information they need, when they need it, which is vital for these groups. As at March 2025, there are 29 listings and 8 links to other relevant resources and supports are registered on the ASN Directory.

The Community Hub website has become a gateway for local people to access other relevant information to support their own health and wellbeing, self-refer to Talking Points or find a support group in their local area. During 2024-25 The Community Hub has continued to develop and support community activities within Barrhead Centre and our new base in Busby Road, Clarkston. Activities developed:

- 19 weekly groups
- 126 people participated
- 11 Community Information weekly drop-ins

A new data sharing platform is in the early stages of development. An initial collaborative session held in Sept 2024 with 3rd Sector partners to explore interest in developing a community Data and Learning hub. This will form the basis for future community-led initiatives, based on local data led by local need and delivered by local groups and organisations.

Learning from experience – the Community Mental Health and Wellbeing Fund

During the year, the VAER team facilitated 3 further **learning hubs** focused on learning from the **Community Mental Health and Wellbeing Fund**. The learning hubs created an open space for grantees to share insights and engage in meaningful discussions about their experiences. Participants were encouraged to reflect on what had gone well during the course of their projects, including successes, positive outcomes, and any unexpected benefits. They also had the opportunity to explore the challenges they had faced, whether related to project implementation, resource allocation, or other operational difficulties. Furthermore, the sessions provided a forum for grantees to identify new opportunities that had emerged as a result of their projects, including potential areas for future growth, collaboration, or expansion. Over the course of these 3 events 21 grant recipients attended.

The partnership continues to work to support the ongoing development and expansion of community-led activities across East Renfrewshire through the **Kindness Collaborative** led by VAER. We are very proud of the progress we have achieved this year, recruiting volunteers, further developing existing collaboratives and creating new collaboratives to meet identified community need. Our Kindness Collaborative Lead has continued to develop work with our hospital discharge team, Talking Points partners and wider third sector partners and members of the community.

During 2024-25, the **Kindness Buddy Project** underwent a significant transformation with the amalgamation of the Live Active and Home from Hospital initiatives under the unified Kindness Buddies banner. This streamlined approach has enabled us to offer more cohesive and responsive support, with Talking Points now serving as our primary referral pathway.

Kindness Buddy activity

Throughout the year, our dedicated Kindness Buddy volunteers have continued to provide invaluable support to individuals:

- **Accessing Vitality classes**, promoting physical and social wellbeing
- **Settling back home after hospital admission**, offering reassurance and practical assistance
- **Shopping support**, particularly where no alternative community organisation was available
- **Befriending**, offering connection and companionship in the absence of other services

In total, **36 referrals** were received in 2024, the majority of which came from the HSCP. Upon contact, a number of referred individuals were found to have:

- Declined support
- Already arranged paid assistance
- Deteriorated in health, requiring statutory services
- Had personal care needs that were redirected to HSCP

For those who did engage, support was delivered either through a matched volunteer or directly by the project Leads, depending on the complexity and immediacy of the need.

The work carried out through the Kindness Buddy Project has revealed several emerging themes and gaps in community support:

- A growing demand for befriending across all age groups, not just older adults

- An increase in referrals for younger adults with additional support needs
- A noticeable rise in individuals aged 40–60 seeking support, highlighting a gap in current service provision
- A significant number of referrals for shopping assistance, with most individuals expressing a strong preference for in-person shopping over online services

Barriers identified include:

- Lack of access to transport
- Visual impairments, mobility issues, and other physical challenges
- Learning difficulties, such as difficulties with reading or understanding pricing

Our experiences echo findings from the Live Active report, which demonstrated the positive impact of volunteer transport—a benefit we believe would also apply to shopping needs.

Looking Ahead
As we move into the next phase of the Kindness Collaborative, our focus will include supporting individuals with "other" shopping needs. We believe that with the right support, many people can maintain greater independence and wellbeing through the simple act of shopping for themselves.

We continue our work with ERCLT with the development of a community chair-based exercise training program. This programme will target organisations, retirement complexes and care homes and provide training to enhance access to exercise without the reliance on transport.

We continue to promote the positive impacts of **digital technology** on living well in East Renfrewshire, including through participation in the East Renfrewshire Digital Inclusion Partnership. We have continued to develop our digital offer, ensuring groups, organisations and individuals have access to the latest information. As part of VAER's Community Hub digital support offer our Digital Champion volunteer has met with 20 participants in one-to-one sessions in our Busby Rd venue. Almost exclusively, older adults sign up for dedicated, bespoke tutorials to develop their digital skills. This comprises of anything from: how to work their devices at the most basic level to support with learning how to use Microsoft software packages.

Digital Champions and promotion digital supports for independence
All partners in East Renfrewshire are given access to training for Digital Champion volunteers, offering support for and with digital technology as well as being active promoters of the benefits of using technology to enhance independent living. VAER supported the delivery of two digital drop-ins offering support for anyone looking to increase their digital confidence. These drop-ins were delivered within the two Market Place venues in Barrhead and The Avenue, Newton Mearns. The Market Place also offered:

- Type2 Diabetes digital support programme: predominantly people referred via the Diabetic Centre at the RAH. Also supported a small peer support group to offer wider health and wellbeing supports as well as digital support for the My Diabetes My Way web programme.
- Two Conversational English drop-ins for anyone with English as a second language, the volunteer lead for this is also linked in with our digital champions.

- VAER have access to Volunteer Translators for when needed to support anyone to access our Digital Supports.

The Digital Partnership agreed a programme of activity to gather and share information about where and how to access Wi-Fi across East Renfrewshire, this will be linked with when and where the digital supports are available. As part of the Digital Inclusion partnership action plan an information leaflet was developed to share information about the benefits of digital technology, what's available and how tech can support living well in East Renfrewshire.

We continue to support the delivery and development of **Technology Enabled Care (TEC)** to support for older people and people with long-term conditions to live independently and well. A dedicated TEC Manager has been appointed as part of the service redesign activity. This role includes managing all aspects of the operational Telecare service as well as focussing on new technology enabled care and innovative ways to deploy this as an alternative to traditional packages of care. A recent example of this involved collaborative working with the HSCP's Learning Disability Team colleagues to install technology, with appropriate response protocols, for a range of individuals in the community to maximise their confidence and independence.

The HSCP and East Renfrewshire Council were awarded the Platinum Digital Telecare Implementation Award from the Scottish Government's Digital Office, in recognition of the completion of their analogue to digital telecare transition project which involved the implementation of a new call handling system and the installation of almost 3000 digital alarms in Telecare customers' homes. To achieve Platinum, a Telecare Service Provider must have successfully rolled out a live digital telecare service to 100% of service users and be operating successfully without serious issues or call failures for at least 8 weeks. This remarkable achievement is the final major milestone in the transition to digital telecare. East Renfrewshire was one of the first Telecare Service Providers to achieve this award.

The new Digital Telecare platform continues to ensure that circa 3,000 vulnerable telecare customers benefit from their lifeline community alarm system. The new system has reduced calls through use of a mobile app as telecare responders receive next-visit routing information direct to the app, freeing-up call-handlers from manually calling responders.

East Renfrewshire HSCP's **Care at Home** service provides care to around 450 East Renfrewshire residents covering on average 8,400 visits and 3,000 hours of care per week. There have been significant capacity issues within Care at Home both locally and across Scotland leading to continuing pressure on the HSCP's in-house care at home service. During 2024-25 we have been working to redesign our care at home service (homecare and telecare) in response to growth in demand, as well as to improve efficiency, maintain the quality of care provided and achieve necessary cost reductions.

East Renfrewshire Care at Home redesign project

The Care at Home in-house service redesign is working to achieve the necessary care and governance standards, support staff retention and skills development as well as creating a sustainable, person-centred, resource and cost efficient operating model for the future.

Design principles have been established for the development of our new practice model:

- The service can respond to the current and anticipated future challenges upon it;
- The service has the ability to operate more dynamically to keep pace with service demands;

- We make the most efficient use of our resources with a strengthened focus on re-ablement at the earliest opportunity and providing high quality end of life care.
- We deliver a care experience (including continuity) which service users and their families rightly expect
- The need for different role focuses and content is recognised, as technology plays a larger and more integral part of our day to day operations
- We continue to demonstrate the standards, requirements and continuous improvement focus demanded by our regulator
- The service develops and retains a sufficiently skilled workforce
- We place a stronger focus on staff morale and wellbeing

As part of the new practice model, the Scheduling and Monitoring function is being strengthened to maximise efficiencies in resource management via forward scheduling of required home care visits and monitoring to ensure that visits are being conducted as expected during the working day.

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.

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

During 2024-25, our community **Learning Disability Health Check Team** has supported the delivery of **health checks** across GGC for people with learning disabilities. The Learning Disability Health Check Team has been providing a fully operational service across GGC since January 2025 (following a successful pilot in 2024) with a very successful 80% rate of uptake. During the year a standard operating procedure, LD Register and Welfare Check Pathway have been created for the service. A National Peer Support Network and GGC toolkit have been established. We are currently trialling a pathway for Transitions Health Checks in East Renfrewshire (and also Inverclyde), reducing duplication during transition to adult LD services.

Our **Transitions Service** continues to support the transition of young people with service and care needs with close collaborative working across children and adult services (health and social work). The priority for the service is to ensure a positive transition for young people. A key area of focus is the prevention of crisis for individuals through early identification of potential placement breakdown. During the year there has been positive partnership working with Barrhead Housing Association and The Richmond Fellowship Scotland to support transition for and individual to their own home after leaving school thereby averting a crisis situation from occurring.

The Coming Home Report is the Scottish Government strategy to prevent placement breakdown for people with learning disabilities that can lead to inappropriate hospital admission or out of area placement. To support this objective for people in East Renfrewshire, we have established a fully operational dynamic support register (DSR) which allows early identification of high risk situations. There has been effective partnership working with ERC Housing, RSLs and service providers (key stakeholders in these situations). We have also

created a High Risk Register for young people identified via Transitions mapping work who are too young for addition to the DSR.

Scottish Centre of Technology for the Communication Impaired (SCTCI) was established in 1987 and exists to provide a high quality, specialist service for Augmentative and Alternative Communication (AAC) assessment for children and adults in Scotland who have complex additional speech, language and communication support needs.

SCTCI is hosted by East Renfrewshire HSCP and provides AAC assessment and equipment provision services throughout NHSGGC and Scotland across all client groups both paediatric and adult. The service works with clients and their teams, families and carers, to find technological solutions to reduce disabilities caused by communication impairments, thereby allowing patients to fully participate in their lives and communities.

The service crosses organisational, geographical, and demographic boundaries. Patients who are referred to the service can be ordinarily resident in any of the twelve health boards which have a service level agreement with SCTCI. Clinicians who refer patients to the service, mainly speech and language therapists, can be employed by local authority, NHS, or HSCP. We work closely with our Health Board partners and other stakeholders to support everyone to meet the legislative duty around AAC and communication equipment.

Last year the service received 131 referrals across all health boards. Most of those referrals resulted in SCTCI recommending a communication device. Professionals feedback "I honestly don’t know what I would do without you guys. Everyone is always so helpful and supportive, and I really appreciate it. Every time I email or call, I always get great advice or support",

SCTCI is a nationally recognised service not only in Scotland but is also represented at many events throughout the UK. It previously received recognition from the Communication Matters Charity as the setting of the year award and the current service manager is a now a trustee of Communication Matters the UK chapter of ISSAAC.

The service regularly travels across Scotland with referrals from remote and rural places including the islands. It has strong networks and links to Speech and Language Therapists from all over Scotland who are in regular contact for all AAC related queries. The service has developed new training which is has been offered to everyone with an SLA.

The CHAT (Communication Help through Assistive Technology) Service Team is a service provided across Greater Glasgow and Clyde, only. It is hosted by SCTCI and is managed by East Renfrewshire HSCP on behalf of the health board.

It was set up in 2020 to support the provision of the Scottish AAC legislation, and to provide equipment for AAC users living in NHSGGC. They work alongside local Speech and Language Therapists to guide Augmentative and Alternative Communication (AAC) implementation, often following assessment by SCTCI. There were 30 requests for support this year. The impact of this service for those requiring AAC in Glasgow has been significant with significantly faster procurement of communication devices for adults and excellent support to use their devices. The impact on the workforce providing long term AAC support has been improved knowledge and confidence.

The service received recognition from the Communication Matters Charity at their 2023 awards ceremony. The CHAT service won The Samantha Hunnisett Access Award. The team was commended for their excellent work in breaking down barriers to ensure equal opportunities and access to AAC assessment and provision. This has meant that this year

56 AAC users in Glasgow alone were provided with the communication aid they required last year, most within three weeks from application.
The service also responded to 77 technical support requests and carried out 108 annual reviews where the safety and suitability of AAC devices were checked.

User feedback from a client with Motor Neurone Disease (MND) 'When this disease has taken everything else away the ability to still communicate using eye gaze means everything to me. Thank you for giving me a voice so quickly when I needed it the most'.

CHAT has a number of projects ongoing which aim to improve procurement of devices and identify the training needs of the workforce in Greater Glasgow and Clyde. The CHAT service model has been recognised across Scotland as excellent example.

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

Macmillan Improving the Cancer Journey (MICJ) – East Renfrewshire

We have entered the 2nd year of funding for ER Macmillan Improving the Cancer Journey (ICJ) programme. In the year, 01/04/25 to 31/03/25, the staff set up 220 electronic needs assessments for 180 individuals.

There was a wide range of concerns expressed but from analysis of the completed eHNA's the main concerns expressed by people included; thinking about the future, moving & feeling tired, exhausted and fatigue, money and finance, uncertainty & worry, fear and anxiety.

All individuals would have been supported with information and advice and 100% of people referred to the ICJ service receive an onward referral to the ERC Money Advice and Rights Team. 70 individuals were too unwell or passed away before there care plan could be completed, however 122 care plans were agreed and locked in the Macmillan system.

Macmillan like many other organisations and experiencing difficult financial challenges, and some of the main resources and supports have been reduced or withdrawn. Cancer Support Scotland is also no longer available to provide the range of emotional and practical supports and the ICJ staff have worked to find alternative supports.
The ICJ lead and staff, contribute to the regional and national communities of practice and we continue to support the roll out of ICJ in other HSCP areas. Hosting visits from staff from the Highlands and Ayrshire and Arran.

For more information about the East Renfrewshire Improving the Cancer Journey Service please see,
Helping you live with cancer - East Renfrewshire Council
Macmillan Cancer Support | The UK's leading cancer care charity

2.4 Working together to support mental health and wellbeing

National Health and Wellbeing Outcomes contributed to:
NO1 - People are able to look after and improve their own health and wellbeing and live in good health for longer.
NO3 - People who use health and social care services have positive experiences of those services, and have their dignity respected
NO4 – Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services

2.4.1 Our strategic aims and priorities during 2024-25

As partnership, we are focused on good mental wellbeing, and on ensuring that the right help and support is available for mental health needs whenever it is needed. We recognise that different types of need will continue to emerge as time passes and that we will need to continually adapt our approach to reflect this. We work with GPs, third sector partners and people with lived experience to develop our approach to ensure people get the right service, in the right place at the right time. We 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.

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.

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

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

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

2.4.2 Our performance in 2024-25

During 2024-25 our teams have continued to deal with increased demand across mental health and addiction services due to increases in complexity. There has been high demand across all teams (Alcohol and Drug Recovery Service, Adult Mental Health Team, Primary Care Mental Health Team, Older Adult Mental Health Team). For older people we continue to see wellbeing impacted by issues such as isolation and reduction in mobility.

Headline performance data includes:

- Mental health **hospital admissions** remain low (at 1.26 admissions per 1,000 population).
- 87% waiting no longer than 18 weeks for access to **psychological therapies** – a continuing improvement from 84% in 23/24 (and 75% in 22/23). However falls just

short of the target of 90%. This was achieved through close monitoring of waiting times on a weekly basis, to address the longest waits, and recruitment to fill key psychology and counselling posts. Demand for psychological therapy continues to be high.

- 97% people accessing recovery-focused treatment for drug/alcohol **within 3 weeks** – up significantly from 93% in 23/24 and we are maintaining performance ahead of target (90%).
- 78 **alcohol brief interventions** undertaken in 24/25 compared with 568 in the previous year. This was due to a temporary reduction in the funding available for commissioning the delivery of ABIs in 2024-25. This funding gap has been resolved for 2025-26 and delivery is expected to return to 23/24 levels.

2.4.3 Ways we have delivered in 2024-25

Our teams continue to experience high demand across mental health and alcohol and drug recovery services due to increases in complexity. We continue to develop our approaches and ways of working to support good mental health and wellbeing, help people manage their own mental health, and build their emotional resilience.

A key priority in delivering our strategy to support better mental health and wellbeing is to ensure staff and volunteers across the wider partnership have the skills, knowledge and resilience to support individuals and communities. We continue to support **training on mental health and wellbeing** for third sector staff and volunteers. During 2024-25, this has included:

- All health and wellbeing information / supports and training is shared and open to both staff and partners to access.
- In 2024, 32 training courses were delivered to 449 staff / partners. This does not include data from national / external webinars which have also been promoted / accessed.
- Six Health Information sessions were delivered to local organisation Men's Shed Barrhead on a variety of topics including: mental health, alcohol, cancer and dementia.
- Two Heart Start training courses were also delivered to both staff third sector and communities with 32 individuals being trained.
- Further training opportunities to support mental health and wellbeing included:
    - Gambling awareness sessions facilitated by our partners RCA Trust.
    - Breathing Space our national partners also provided sessions on digital resources to support mental health and wellbeing

Supporting wellbeing - Health walks and strength & balance sessions

- East Renfrewshire Walking for Health Programme delivers nine weekly community walks across East Renfrewshire. The walks are delivered by twenty four volunteer walk leaders who have been trained by our partner organisation Paths For All.
- In 2024 the programme delivered 385 Health Walks and193 Strength and Balance session. This was delivered by our 24 trained walk leaders with 3,815 individuals attending the walks.
- 2024 saw the introduction of wheelie based walk in Cowan Park Barrhead, this walk is for all individuals who utilise walking aids.
- Alongside the walking for health programme, strength and balance classes were delivered

across East Renfrewshire by our partners such as Mearns Kirk Helping Hands and VAER. On average ninety individuals attended classes on a weekly basis. These community strength and balance classes also provide a next step for those currently engaged in Live Active or rehabilitation programme.

- All walks and classes end with a group get together for tea, coffee and catch up as this alongside the physical activity is vital in promoting mental health and wellbeing and reducing isolation.
- One of our Walk Leader volunteers was awarded with Volunteer of the Year at the HSCP Staff awards in February this year.

We are committed to working together with community planning partners on activities that support mental wellbeing and resilience across our communities. We have continued to support delivery of the **Community Mental Health and Wellbeing Fund** in partnership with VAER successfully implementing the third year of support to local community.

Community Mental Health & Wellbeing Fund (CMHWF) in East Renfrewshire

The HSCP provided support to VAER via promotion / awareness raising of the community fund and was an active part of the panel for the small funds applications. All finances were successfully allocated in line with the indicators and fund requirements.

The Community Mental Health and Wellbeing Fund 2024/25 was vastly oversubscribed with Voluntary Action East Renfrewshire receiving over 79 applications.

Over the last three years, residents of East Renfrewshire have benefited from £946,999.93 through the CMHWF. In 2024/25, East Renfrewshire was awarded **£237,581.87** to distribute to community groups.

Yr 4 amendments included an enhanced focus on activities provided by grassroots groups with a continued response to Cost of Living Support and a focus on collaborative approaches between applicants.

Successful applications:

- 19 Small Grants
- 18 Medium Grants
- 7 Large Grants

Community projects across East Renfrewshire have received money from the fund:

- 15 Barrhead
- 2 Clarkston
- 1 Eaglesham
- 7 East Renfrewshire wide
- 1 Eastwood
- 4 Giffnock
- 3 Neilston
- 3 Netherlee
- 3 Newton Mearns
- 2 Thornliebank

Of the 42 successful projects, it is estimated that over 3,600 people will benefit from the Community Mental Health and Wellbeing Fund for Adults 2024 – 2025.

During the year, HSCP staff supported the roll-out of the **Distress Brief Interventions (DBI)** Service, implemented in April 2024 with local partners RAMH and Police Scotland.

Supporting partners include: National DBI Team / Scottish Ambulance Service/ Fire Scotland. To date, 16 Police Officers have been trained in DBI assessment and referral with five RAMH staff trained in delivery of DBI. Since the DBI service launch in April 2024 24 referrals have been received and we continue to work with Police Scotland on take-up of the service.

East Renfrewshire HSCP staff coordinated **local community consultations** around the Mental Health Strategy plans to reduce mental health in-patient beds while investing further in community based mental health services. Four local consultation meetings were held and views gathered reported back to NHS Greater Glasgow and Clyde. The HSCP will continue to keep local residents informed as plans develop and will work with NHSGGC on proposals to strengthen community based services and reduce and prevent hospital admissions.

During 2024-25, we have progressed the **peer support programme** locally by employing a peer support worker in both the Adult Mental Health Team and the Alcohol and Drug Recovery Service (ADRS). The mental health peer support worker has supported 45 people over the course of 2024-25 in the Adult Mental Health Team in their recovery, such as supporting people to identify their recovery goals and building their confidence to access services and groups in their community. 15 people have completed their support programme in the last year and 30 continue to work with the peer support worker into 2025-26. The ADRS peer support worker was in p[ost from December 2024 and has participated in work to make the service bases more trauma informed and supported work to gather service user feedback to improve the service.

Supporting mental health and wellbeing for our care home population

The Care Home Liaison Team, within East Renfrewshire Older Peoples CMHT is a multidisciplinary team comprising of occupational therapy and nursing. The service provides person-centred care and support to residents of both nursing and residential Care Homes within East Renfrewshire. Reasons for referral may include but are not limited to, seeking stress and distress support, prevention of care home placement breakdown and review of psychotropic medications.

- The team aims to work with care home teams and residents to reduce stress and distress in care homes and improve quality of life of residents.
- The team promote a proactive and preventative model of care. This focuses on non-pharmacological interventions and includes monthly Dementia training for care home teams to better understand dementia and therefore how to prevent stress & distress.
- 115 referrals were received by the team during 2024-25
- Through this model the team have reduced the number of psychiatric hospital admission to 1 over the last 18 months. The input of the team prevented hospital admission in 7 cases and avoided the breakdown of the care home placement for 12 individuals.
- The team collects data monthly to demonstrate the impact of the service – during 2024-25, anti-psychotic medication was able to be reduced for 51 people and stopped for 33 people. This is a 50% reduction of the total number of residents across East Renfrewshire care homes who are prescribed antipsychotic medication.

During the year, Mental Health and Recovery Services has maintained a strong focus on improving the **waiting time for psychological therapy** by ensuring psychology and other resources are in place through recruitment and additional investment. Over the course of 2024-25, 569 people started in treatment. The percentage of people starting treatment within 18 weeks of being assessed increased from 83.2% in March 2024 to 87.5 at the end of March 2025. Improvement in the waiting time peaked at 92.3% in January 2025. The aim is to maintain staffing levels and maintain performance at the 90% target level.

During 2024-25 we have continued to support local people facing issues with alcohol and drug use. We are committed to delivering the priorities set out in the **East Renfrewshire Alcohol and Drugs Plan 2024-27,** with implementation led and overseen by the Alcohol and Drugs Partnership.

Design and development of a **community recovery hub**, to support people in the community recovering from mental health, alcohol and / or drug harms is a major project being progressed as part of the Alcohol and Drugs Plan. In 2024-25, a site for the recovery hub was secured within Barrhead Health and Care Centre and project management support was secured from NHS Greater Glasgow and Clyde. Several community engagement meetings have been held over the course of 2024-25 to keep community members updated on developments. The year ahead will see a community steering group formed and work will progress in designing the community recovery hub.

Alcohol and Drug Recovery Services have supported 24 people to access **residential rehabilitation** over the last three years using specific funding allocated by the Scottish Government for this purpose. Evaluation has shown that 63% of placements were completed in full with individuals reporting impacts such as being able to manage daily routines better, make plans for the future such as undertaking training and preparing for getting back into employment. While completion is positive there can also be good learning and outcomes from shorter placements, such as achieving more stability in community based treatment.

Every journey and destination is unique. Some of the positive outcomes observed through evaluation include:

- Sustained abstinence
- Being able to better manage daily routines
- Getting involved in training and considering getting back into work
- Improved physical and mental health (e.g. reduced medication or care packages)
- Improved engagement with support services
- Reconnecting with family For some a reduction in substance use means a significant reduction in harm and risk
-

The service continues to support people to access residential rehabilitation, subject to available funding, and we will continue to evaluate the outcomes.

Glasgow Council on Alcohol (GCA) are commissioned in East Renfrewshire to deliver **Alcohol Brief Interventions (ABIs)**, alcohol counselling sessions and training on the delivery of ABIs to staff across the HSCP and partners. Over the period January 2024 to March 2025, GCA delivered:

- 247 Alcohol Screenings
- 202 Alcohol Brief Interventions
- 369 Alcohol Counselling sessions (supporting 62 individuals)

Alcohol awareness events have taken place in leisure centres, libraries, Voluntary Action market places, community centres and food banks. Alcohol counselling

sessions are offered in health centres or in GCAs offices. From May 2025, GCA will continue to provide local services with a focus on both alcohol counselling provision and the delivery of Alcohol Brief Interventions.

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

The MAT Standards are assessed through a system or Red, Amber, Green (achieved) or Blue (blue means improvement has been sustained and embedded in services). East Renfrewshire has achieved blue or green status across all ten standards. The Alcohol and Drug Recovery Service has successfully delivered on the rapid access standard, with over 75% of people accessing medication assisted treatment able to start treatment on the same day they request it. The service has demonstrated there is choice of medications and has evidenced robust delivery of assertive outreach to people at risk of harm. Over a three month sampling period, 30 individuals were contacted and supported within 72 hours of identifying risk. This approach has kept people safe from harm and supported back into treatment and recovery (including support with housing, welfare issues, near fatal overdose and missed medication).

76% of staff are trained in trauma sensitive and safety and stabilisation skills and techniques and are putting these into practice.

Service user experiences are gathered and analysed as part of the evaluation of the MAT Standards. This work found that people feel supported in treatment and reported being able to access treatment quickly and within the timescale they requested. Family members are encouraged and supported to be involved in their loved one's treatment and care. People using services feel their emotional wellbeing is supported and their key workers are compassionate and caring.

The evidence gathered has informed improvement plans for 2025-26 including enhancing the wellbeing supports offered and increasing service user and family member awareness and understanding of these, enhancing the interface between mental health and ADRS and refining the approach to assertive outreach and further exploring people's experiences of this.

We continue to work collaboratively with our partners on suicide prevention activities and our commitment and priorities for action are reflected in East Renfrewshire's **Suicide Prevention Strategy and Action Plan 2024-27**, approved in March 2024 following in-depth consultation work.

Our local strategy and action plan was developed following analysis of both local, health board-wide and national data including reviews of local Significant Adverse Events (SAER). The long term vision for the strategy is: *Good Mental Health and Wellbeing for All*. The principle of collaboration and partnership working is key in driving this work forward.

Our local services provide quality care and support for those in need and whom may be at increased risk of suicide. However, local data highlights that only one third of individuals who have died by suicide have been known to services and therefore confirms our principle of collaboration and partnership working. The need for a community-wide approach is critical in relation to awareness raising, training and capacity building. Locally we will continue to work in partnership with NHSGGC and wider partners to achieve the best outcomes for East Renfrewshire residents and communities, focusing on the following priority areas:

- Establish local suicide prevention network;

- Provision of education and training to raise awareness, skills and knowledge in suicide prevention;
- Communications and campaigns;
- Involving communities and lived experience;
- Data analysis and reviews to inform service improvement.

Delivery of the plan is supported by a suicide prevention working group – involving 30 members from the HSCP, East Renfrewshire Council, third sector and community organisations, Police, and people with lived experience.

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

National Health and Wellbeing Outcomes contributed to:
NO2 - People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
NO4 – Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services

2.5.1 Our strategic aims and priorities during 2024-25

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

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

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

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

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

2.5.2 Our performance in 2024-25

Despite continuing pressures on the social care sector and our care at home service during the year, we have seen a more controlled level of delayed discharges and the number of hospital bed days lost to delayed discharge has reduced moderately for 2024-25. We continue to be one of the best performing partnerships for minimising delays in Scotland. We continue to support the hospital discharge efforts by promoting the use of intermediate care beds where a care at home package cannot be immediately accommodated. In East Renfrewshire, unplanned hospital attendances and admissions are stable (having increased slightly but remaining within target) and have not returned to pre-Covid levels. Hospital attendances from our care homes reduced during 2024-25 reflecting the level of support the partnership is

providing in these settings.

Headline performance data includes:

- **Discharge with delay** (NHSGGC data) – averaged 7 delays for 24/25 – meeting our target (7) and unchanged from the previous year. We remain one of the best performing HSCPs in Scotland on this measure.
- Discharge with delay including AWI (PHS data) - averaged 13 delays for 24/25 – down from 15 in 23/24 but missing our target of 11.
- Adult **bed days lost to delayed discharge** reduced slightly to 5,093 from 5,132 for 2023/24 although we are missing our target. This reflects continuing levels of frailty/complexity and pressures in the social care sector during the reporting period.
- Adult **A&E attendances** – 18,211 (2023/24) – up from 17,824 but ahead of target.
- Adult **Emergency admissions** – 7,002 (2023/24) – again, up slightly from 6,943 and ahead of target.
- Emergency admission rate (per 100,000 pop) – 9,671 up slightly from 9,215 for 22/23.
- Emergency **readmissions** to hospital within 28 days of discharge (rate per 1,000 discharges) – 72, up from 69 in 22/23.
- **Care home attendances** reduced to 459 in 2024/25 from 487. However, **admissions** increased slightly to 254 from 248 in the previous year.
- Proportion of **last 6 months of life** spent at home or in a community setting – 88.8% up from 87.7% and ahead of target (86%)

2.5.3 Ways we have delivered in 2024-25

During 2024-25 the HSCP has continued to work with other partnerships and acute services in the Glasgow area to develop services and pathways to prevent admissions and support people return home following a stay in hospital.

Our dedicated **Home from Hospital** service facilitates the most complex hospital discharges. This includes a home first ethos but also ensuring the appropriate and effective use of intermediate and interim care beds when appropriate. When the level of homecare package required is not immediately evident or available, or ongoing rehabilitation and assessment is needed, by carrying out this activity in this setting versus hospital, it delivers improved outcomes. The targeted work by the team focuses on multidisciplinary and multiagency support of requests for intermediate care beds, care home liaison, occupancy tracking, data collation, arranging interventions / reablement and carrying out outcome-focussed reviews and care planning. The collaborative working between these teams has ensured that delays in hospital discharges have been minimised and kept within manageable levels. During 2024-25 there has been continued progression of the Discharge Without Delay workstream between Acute Services and the Home from Hospital Team. There has been an ongoing focus on **Planned Date of Discharge** and robust pathways across the **whole system** to minimise delays for individuals and ensure **person-centred discharge planning** with destination of home at earliest possible opportunity.

We are also working to implement our **discharge to assess** protocol to help minimise discharges with delay. There has been ongoing joint working between Acute Services and Home from Hospital Team, Intermediate Care and Rehabilitation Service to support individuals to be discharged home or to alternative community setting to ensure safe discharge without delay and ongoing assessment. We continue to provide **enhanced community support** and **intermediate care models** in partnership with HSCPs across Glasgow. To support timely discharge from hospital through intermediate ('step-down') provision in Bonnyton Residential Home and block, or 'spot' purchase additional beds for intermediate care in local Care Homes. Ongoing use of two dedicated beds in Bonnyton supported by social work, community nursing, reablement/ rehabilitation and primary care services remains

in situ. These continue to support the Discharge to Assess agenda and prevention of admissions.

The **Community Rehabilitation Service** has been reshaped to manage the increased demand that we have been experiencing in recent years and is the only fully integrated Rehabilitation and Community OT service within Greater Glasgow; which allows individuals to have fully integrated, holistic assessment and interventions while minimising handovers between teams. The service also works closely with the East Renfrewshire Culture and Leisure Trust and other partners across the area.

Community rehabilitation in East Renfrewshire

The Community Rehabilitation Service has 40 WTE (46 staff) across two locality teams - Barrhead and Eastwood. The service includes:

- Physiotherapy
- Occupational Therapy
- Rehabilitation Nurses
- Dietitians
- Advanced Frailty Practitioners (a new role in GGC)
- Rehabilitation Assistant Practitioners (newly developed role in East Ren with competency framework now shared across GGC and with NHS Education Scotland)
- Rehabilitation Support Workers
- Speech and Language Therapy through Renfrewshire & Glasgow City teams

In addition, there is professional support to and close working with other Allied Health Professional (AHP) staff within partnership including Reablement, Moving and Handling, Initial Contact Team, Learning Disability and Children's Services.

Functions of the Community Rehab Service:

- Prevent avoidable admission to hospital; this includes delivery of unscheduled care pathways eg urgent primary care referrals, Community Integrated Falls and Frailty SAS Pathways, Home First Response, Intermediate Care, and supporting rapid discharge from Emergency Department and Assessment Units;
- Facilitate and support discharge home following hospital admission;
- Provide rehabilitation (short and longer term) to regain and optimise function, mobility, physical activity and independence;
- Maximise individuals' abilities and safety to allow them to remain in their home or a homely setting including for palliative/ end of life;
- Falls and frailty identification and management;
- Assessment for and provision of aids, equipment, minor adaptations;
- Assessment for, and through to the completion of, all major adaptations- including stairlifts/ wet floor showers/ ramps etc;
- Provision of information, support, liaison with and referral to other specialist health, social care and community services as required.

Community Rehab Service support to our **care homes**:

- The service has introduced a Community Rehab Team Physiotherapist and Occupational Therapist aligned to each Care Home;
- Provide proactive support to Care Homes, reinforcing existing pathways for referrals of individual residents, and earlier identification of any support needed;
- Falls prevention/ transfers/ mobility/ M&H/ encouraging meaningful activity/ postural supports and seating;
- Rehabilitation and support for individuals to live a fulfilling life in the care home environment;

- Improved communication, regular support and strengthened relationships between Care Home staff/ Care Home Liaison Nurses/ Community Rehabilitation/ OPMHT and wider services.

During the past year we have continued our work to implement frailty pathways and support initiatives to address frailty in our communities. There has been ongoing development of **Home First Response/Frailty service**. Two WTE Advanced Practitioners in Frailty are aligned to the Community Rehab Multidisciplinary team. There has been further development of the **community falls and frailty pathways** across the HSCP to identify and provide appropriate guidance, support and interventions both for complex community referrals and hospital discharges.

Our frailty matrix detailing appropriate services across the frailty pathway was reviewed during 2024-25 and we have seen increased use of the Rockwood Dalhousie Frailty Scoring; this helps identify need and is now recorded on Carefirst/CNIS and in Future Care Plans.

The community falls pathway with **Scottish Ambulance Service (SAS)** has been extended now to include frailty presentations, where conveyance to hospital is not required but further assessment and input is necessary to support an individual safely at home. This pathway is fully embedded, with next working day response for all referrals from SAS to Community Rehab.

During the year there has been ongoing close working with primary care colleagues identifying opportunities for proactive management of frailty presentations, and proactive review of individuals who have had multiple presentations at hospitals over previous 12 months.

To prevent crisis and emergency use of acute services, we continue to work to improve the quality and quantity of **Future Care Plans**. East Renfrewshire HSCP continues to meet quarterly targets for the provision of Future Care Plans. The East Renfrewshire Future Care Plan audit team meet quarterly to submit audits to central team and the quality remains high.

East Renfrewshire local Future Care Plan group continues to meet every 12 weeks and staff training across HSCP is ongoing to increase spread of staff groups completing. District nurses and advanced frailty practitioners are undertaking the majority of Future Care Planning. Care home liaison nurses have been supporting care homes to record Future Care Plans on clinical portal. The pathway for the East Renfrewshire Carers Centre to make referrals for future care plans for carers and those they care for, continues to be well utilised.

To support our local **care homes** and minimise hospital attendances and admissions we have established a **Call Before You Convey (CB4YC)** pathway providing enhanced senior clinical decision making support over 7 days for Care Home staff to access when identifying a deterioration in a resident's health. Between April 2024 and March 2025 - 47 calls came through East Renfrewshire's CB4YC pathway. Over 85% of residents were able to be supported to remain within the care home and avoid conveyance to hospital. Over 260 AHP assessments were undertaken of residents of Care Homes for support with transfers/ mobility/ equipment/ seating/ rehabilitation.

Supporting local care homes

Our partnership works closely with local care home providers which include both independent and charity sectors. Fortnightly multidisciplinary Care Home Assurance Meetings are held to provide clinical support, advice and oversee the implementation of national policy and guidance as required as well as discussing local intelligence and risk

assessing each care home on a RAG status as part of corporate reporting to the Scottish Government.

Support is provided to care homes through Contracts & Commissioning weekly welfare calls, or more often if needed and regular support meetings take place with care homes experiencing any issues/risks. The HSCP Adult Support and Protection team work closely with homes advising and investigating to keep the most vulnerable individuals safe from harm. The HSCP Care Home Liaison Nursing staff support homes seven days a week through Call Before your Convey (CB4YC). The Older Adult Mental Health Team support residents within our Care Homes and have been running 'New to Skilled' (Stress & Distress dementia resource) training for staff which has been well attended and received by Care Home Staff. The HSCP Rehab team offer Physio and OT support and advice to all homes. A number of training programmes have been carried out by the Care Home Collaborative within care homes as well as them providing useful resources.

The Contract and Commissioning team also supports the yearly Care Home Assurance visits, alongside the clinical nursing team and senior managers from Localities. HSCP staff and care home Management also provide input at various internal and external meetings, such as the weekly vaccination meeting, Greater Glasgow care home assurance group and NHS GGC Care Home Framework sub groups.

In June 2024, the partnership introduced a new enhanced phlebotomy service, **Bloods and Go** to support people requiring bloods to be taken and address the issue that 60% of phlebotomy work continued to take place within GP practices. The service has had positive feedback from both patients and GPs, as well as positive results updates in the Health and Care Experience (HACE) survey results and the Medication Assisted Treatment (MAT) standards. Ratings for MAT standards are either 'green' or 'provisional green' which is the highest possible assessment for these standards at present.

East Renfrewshire Blood and Go service

The new service is 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.

During the first 6 months of the service (the evaluation) from July – December 2024 we were seeing an average of 294 patients for bloods per week across both sites.

Since 1st April 2025 we have been seeing and average of 424 per week across both sites which is an increase of 44%.

"I have had nothing but praise for the Bloods & Go team. My patients have all been so impressed at how efficient it is. They all feel this is a real positive in their care pathway and said how slick it was". (GP)

"Friendly & efficient - Visit to the doctor's resulted in bloods being taken for Diabetes and Anaemia and I was directed to Bloods on the Go at Eastwood Health Centre. Nurses were friendly and efficient and I left feeling comfortable having all my questions answered. Would like to express my gratitude and it makes all the difference being listened to". (Patient - Care Opinion)

2.6 Working together with people who care for someone ensuring they are able to exercise choice and control in relation to their caring activities

National Health and Wellbeing Outcomes contributed to:
NO6 - People who provide unpaid care are supported to look after their own health and wellbeing, including support to reduce any negative impact of their caring role on their own health and wellbeing

2.6.1 Our strategic aims and priorities during 2024-25

Unpaid carers are essential to our social care system and the daily efforts of families and loved ones to support those in need is fully recognised by the partnership. During and after the Covid pandemic, unpaid carers have taken on increased caring responsibilities and have faced additional pressures. The ongoing work of the East Renfrewshire Care Collective has demonstrated the need to maintain and strengthen our approach to involving carers throughout the planning process in identifying the outcomes that matter to them and by ensuring carers voices are valued and reflected within our strategic planning work.

Our Carers Strategy 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 (ER Carers) to improve access to accurate, timely information. We will continue to encourage collaboration between support providers for advice, information and support for carers ensuring local provision that best meets carers needs. We will provide information and training to raise awareness of the impact of caring responsibilities. We will continue to support the expansion of personalised support planning in collaboration with our unpaid carers and ensure that self-directed support options are offered to all adult carers who have been identified as eligible for support.

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

Our aim is to **ensure people who care for someone are able to exercise choice and control in relation to their caring activities**, by:

- Ensuring staff are able to identify carers and value them as equal partners;
- Helping carers access accurate information about carers' rights, eligibility criteria and supports;
- Ensuring more carers have the opportunity to develop their own carer support plan.
- Ensuring more carers are being involved in planning the services that affect them and in strategic planning

2.6.2 Our performance in 2024-25

Through our new Carers Strategy and working in partnership with East Renfrewshire Carers Centre, we have continued to ensure that carers have had access to guidance and support throughout the year. Training and awareness-raising on the issues affecting carers have been

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

Headline performance data includes:

- 83.6% of those asked reported that their **'quality of life'** needs were being met – down slightly from 84.5% in 23/24 but continuing to perform ahead of target (80%).
- % carers who feel supported to continue in their **caring role** was 28.4% (23/24) consistent with previous survey results and below the Scottish average of 31.2%

2.6.3 Ways we have delivered in 2024-25

Throughout 2024-25 we have continued to work in close partnership with the **East Renfrewshire Carers Centre (ER Carers)**, delivering community-based integrated support for carers in East Renfrewshire including access to tailored advice, support, planning and community activities.

In partnership with the ER Carers we ensure **information and training** is available to raise awareness of the impact of caring and requirements of Carers Act. Carer awareness training has now been incorporated into the induction training for newly qualified social workers employed by HSCP. The Equal Partners in Care (EPIC) Training Programme and resources were put on hold during 2024 to undergo a redesign. EPIC training was relaunched at end of November 2024 and staff have been made aware that the resources are available on the staff intranet and TURAS.

A new **eligibility framework for carers** was introduced to sit alongside the HSCP's Supporting People Framework. Info sessions on the framework have been delivered to all staff with input into our locality teams, hospital team, mental health and learning disability teams.

We continue to work with partners to ensure carers are being in planning the services that affect them. The **East Renfrewshire Carers Screening Group** continued to meet fortnightly and carers centre/carers lead attend the HSCP's Peer Professional Review Group. The Carers Centre is a key partner in Talking Points and participate in carer awareness raising sessions through the Talking Points partnership.

East Renfrewshire Carers Collective had a leading role in influencing the most recent Carers Strategy. Thereafter carers were a priority group for engagement re the Supporting People Framework, updated strategic plan and most recently the proposed charging policy. Membership of the Carers Collective is currently under review. Membership has fluctuated as people's caring role has stopped/changed or carers own circumstances have changed. Three members of the Carers Collective set up the Autistic Collective which has become the main community support for carers of someone with autism/neurodiversity. Upon review, the Collective will work with the HSCP carers lead to design the service specification for carers' support that will be implemented in a new tender/contract from April 2026.

All carers referred to the Carers Centre are informed of their rights during the initial meeting and provided with information resources that explain **carers' rights** in relation to the main duties of the Carers Scotland Act. Information on rights is developed further if carers progress with an Adult Carers Support Plan. The Carers Centre secured funding for an **SDS worker** who provides advice on SDS options particularly in relation to short breaks and respite. Specific group sessions are run throughout the year on carers rights and rights are also

threaded through other training such as dementia awareness and training for care home staff. Over 100 carers have attended group sessions in the last year.

We continue to implement carers' support planning including planning for emergencies with individual carers. **Adult Carer Support Plans (ACSPs)** are now submitted to a screening group who assess whether the plans meet the eligibility criteria to be submitted to Resource Enablement Group (REG). The HSCP have seconded a social work practitioner to work with the carers lead and support/build the capacity of the Carers Centre to undertake ACSPs. As a result of the Supporting People Framework and charging policy proposal, the ACSP process will be reviewed as part of the development of the next service specification from April 2026 onwards. Emergency plans are incorporated into Adult Carer Support Plans and the Centre is the main source of referral into the HSCP for the completion of Future Care Plans. An abbreviated ACSP is also available for carers with no requirement for statutory support from the HSCP. This allows the Carers Centre to record support plans for all carers referred for support. A total of 140 support plans were created last year.

Throughout the ACSP process, carers are informed about their options and how SDS budgets can be used flexibly. Through **Time to Live Funding** and similar sources, the Carers Centre has made 192 grants to support carers short breaks: funding breaks away, health and wellbeing sessions, equipment, vouchers.

Short Breaks are an essential support to ensure carers can maintain their caring role while maintaining their own health and wellbeing and having a life away from being a carer. A Short Breaks statement for East Renfrewshire was produced at the end of 2023; this is due to be updated in light of the Supporting People Framework and proposal to introduce charges for non-residential care.

A **short breaks working group** has been established involving the HSCP, Carers Centre and carers. The group has been taking forward the proposal to increase the use of volunteers to support carers' short breaks. The group also supported the design of a funding application that developed the **Dementia Walking Buddies** project that the Centre continues to run with 20 volunteers being matched to 24 people with dementia. Advice about short breaks for carers is one the main roles of the Carers Centres SDS Worker. A **Short Breaks newsletter** was circulated twice to staff and a specific section on carers support and short breaks is included in the staff guidance in relation to SPF and HSCP processes. A Short Break feature in the carers centre newsletter was shared with carers and staff across HSCP and voluntary sector. The Carers Centre work with Shared Care Scotland to provide good practice examples and case studies.

Short Breaks Statement

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

- Carers will be recognised and valued as equal partners in planning for Short Breaks.
- Planning and assessment will be outcomes focused to ensure that we focus on what both the carer and the cared for person wants to happen.
- By using our eligibility framework we will have an equitable and transparent system for determining eligibility for funding Short Breaks that is consistent and easily understood.
- There will be timely decision making.
- Planning a short break will be a safe, respectful and inclusive process with every carer treated equally.

- When planning a Short Break questions about needs and outcomes will have a clear purpose for carers, not just to inform the support system.
- Prevention will be key. Planning and assessments for support should prevent deterioration in the carer's health or the caring relationship.

Our Short Breaks Statement will be refreshed during 2025/26.

We continue to work with partners to ensure supports are available to carers to minimise the impact of **financial hardship** as a result of caring. The Carers Centre provide benefits information particularly on new Carers Support Payment, Young Carers Grant and Attendance Allowance, and work with partners such as Social Security Scotland, Money Advice and Rights Team (MART) and Citizens Advice Bureau (CAB) for more detailed benefits queries. The Centre also secured funding from the Covid Recovery Funding to work in partnership with CAB to distribute £25,000 in grants to carers affected by cost of living and increased cost/reduced income of carers.

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

National Outcomes for Community Justice contributed to:
Prevent and reduce further offending by reducing its underlying causes
Safely and effectively manage those who have committed offences to help them reintegrate into the community and realise their potential for the benefit of all

2.7.1 Our strategic aims and priorities during 2024-25

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

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

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

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

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

2.7.2 Our performance in 2024-25

We continue to support the delivery of community based sentences (Community Payback Orders (CPOs)) ensuring they are supervised and supported appropriately to protect the public, promote desistence from offending and enable rehabilitation. Timescales for commencement and completion of CPOs declined during the year due to operational factors. We continue to support people with convictions into employment and volunteering with positive outcomes for participants.

Headline performance data includes:

- 77% of unpaid work **placement completions** within Court timescale – down from 89% and below target (80%)

- 65% Community Payback Orders (CPOs) **commencing** within 7 days – significantly down from 83% in 23/24 and we are missing our target (80%). Primary reason for failure to achieve this target is service users not engaging with instructions from Court and Social Work to attend scheduled appointment.
- Positive **employability and volunteering outcomes** for people with convictions – 57% (23/24 data) down from 64% in 22/23. Although missing our target of 60% all other participants demonstrated a positive training/education outcome.
- 82% of people reported that their order had **helped address their offending** – down slightly from 83% and impacted by the low number of people completing the voluntary survey.

2.7.3 Ways we have delivered in 2024-25

Community justice is principally about organisations working together to ensure that people who have offended address the underlying causes of their behaviour and pay back to the community where appropriate. It aims to encourage rehabilitation, reduce reoffending, and protect the public, leading to fewer victims and safer communities.

This requires a strong partnership working approach at each point of the justice system, from the point of arrest, through to integration into the community. Public protection remains our priority, with robust risk management systems in place to ensure that, where appropriate, those who have committed offences can be managed safely and effectively in the community. In the long term, our ambition is to use prison only for those who pose a risk of serious harm.

The Justice Social Work Service is continually exploring new opportunities for **unpaid work placements**. This has included some short-term opportunities whilst longer-term additional placements are reviewed. The service maintains close contact with existing personal placements and has strengthened partnerships with Environment and Employability services within the Council to deliver wider supports to residents.

The HSCP delivers accredited programmes aimed at reducing reoffending in partnership with East Renfrewshire Council. During 2024-25 we continued to deliver this activity in a group work capacity and we have overseen the transition of the programme from Moving Forward, Making Changes (MFMC) to **Moving Forward 2 Change (MF2C)**. During the year staff attended training for the new programme (MF2C). For the transition, participants with elements of MFMC remaining were supported to complete their programme requirements. MF2C will be delivered for all new Court Orders as of 1st April 2025.

The HSCP works to deliver a whole systems approach to diverting both young people and women from custody. The Justice Social Work Service continue to provide assessments and interventions within the **Diversion from Prosecution scheme**. Staff continue to utilise Justice Social Work Reports to explore all available **community-based options** where appropriate.

Structured Deferred Sentences

Women and young people continue to be clear priorities in the use of Structured Deferred Sentences. The Structured Deferred Sentence is a low-tariff intervention providing structured social work intervention for offenders post-conviction but prior to sentencing. It is a sentencing option in all court reports for people under 25 and women who are appearing for sentencing. It is also intended for offenders with underlying problems such as drug or alcohol dependency, mental health or learning difficulties or unemployment that might be

addressed through social work intervention. This outcome is promoted whenever appropriate within Criminal Justice Social Work Reports.

The Justice Social Work Service now runs both Bail Supervision and Electronic Monitoring Services. Due to staffing requirements, these are currently being managed by an Advanced Practitioner and existing staff. Additional recruitment is being underway to build capacity for this service.

We aim to ensure that people subject to statutory and voluntary supervision including licence have early access to community mental health, alcohol and drug recovery services. Staff continue to work closely with colleagues in the Alcohol and Drug Recovery Service (ADRS) and Adult Services to provide **holistic supports** to individuals. Staff regularly liaise with colleagues in mental health services whenever it is identified as necessary for successful outcomes for service users.

New staff have accessed **Trauma Informed Practice training** as it has become available. All Justice Social Work Staff have completed their Level 3 Trauma training. This has been complemented by all staff undertaking a range of training including CBT work.

It is important that people are able to find positive alternatives to offending. The Justice Social Work Service continue to work closely with the East Renfrewshire Employability Partnership, utilising the existing pipeline to refer people for assistance with **employability-related supports** and those for further **education/training**. We have sought to draw upon a wide-range of employability services to accomplish this and have connected with employability services to deliver input to our Moving Forward Making Changes programme for specialist supports. The Justice Social Work Service are active partners with our colleagues in Employability services. We continue to access UKSPF (UK Shared Prosperity Funding) funding which has been in place since April 2023, initially for a two year period with this being funded for an additional period. This has enabled us to continue co-facilitating a role for an employability worker with our colleagues in Work EastRen Employability Services. Referrals continue to be made where appropriate to our colleagues in employability services.

A new **Community Justice Outcome Improvement Plan** is being finalised for 2025-2030. Delivery of the plan will be led by the East Renfrewshire Community Justice Partnership (ERCJP) which was established in 2017. A broad range of statutory and third sector partners contribute to the achievement of community justice outcomes and play a vital role both in the planning and delivery of services. A key feature of the ERCJP is the effective collaboration and strong commitment from all our partner agencies.

The draft plan sets out 13 priority actions to be progressed over the life of the plan. They are:

1. *Diversion from prosecution* - Enhance intervention at the earliest opportunity by ensuring greater consistency, confidence in and awareness of services which support the use of direct measures and diversion from prosecution.
2. *Police custody* - Improve the identification of underlying needs and the delivery of support following arrest by ensuring the provision of person centred care within police custody and building upon referral opportunities to services including substance use and mental health services.
3. *Bail supervision and electronic monitoring* - Support the use of robust alternatives to remand by ensuring high quality bail services are consistently available and delivered effectively.

4. *Bail supervision and electronic monitoring* - Strengthen options for safe and supported management in the community by increasing and widening the use of electronic monitoring technologies.
5. *Community based sentences* - Ensure those given community sentences are supervised and supported appropriately to protect the public, promote desistence from offending and enable rehabilitation by delivering high quality, consistently available, trauma-informed services and programmes.
6. *Restorative justice* - Ensure restorative justice is available across Scotland to all those who wish to access it by promoting and supporting the appropriate and safe provision of available services.
7. *Access to health and social care* - Enhance individuals' access to health and social care and continuity of care following release from prison by improving the sharing of information and partnership working between relevant partners.
8. *Housing* - Ensure that the housing needs of individuals in prison are addressed consistently and at an early stage by fully implementing and embedding the Sustainable Housing on Release for Everyone (SHORE) standards across all local authority areas.
9. *Employability* - Enhance individual's life skills and readiness for employment by ensuring increased access to employability support through effective education, learning, training, career services and relevant benefit services
10. *Voluntary throughcare* - Enhance community integration and support by increasing and promoting greater use of voluntary throughcare and third sector services.
11. *Effective leadership and governance* - Deliver improved community justice outcomes by ensuring that effective leadership and governance arrangements are in place and working well, collaborating with partners, and planning strategically.
12. *Partnership planning and implementation* - Enhance partnership planning and implementation by ensuring the voices of crime, survivors, those with lived experience and their families are effectively incorporated and embedded.
13. *Community justice workforce* - Support integration and reduce stigma by ensuring the community and workforce have an improved understanding of and confidence in community justice.

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

National Health and Wellbeing Outcomes contributed to:
NO1 - People are able to look after and improve their own health and wellbeing and live in good health for longer.
NO3 - People who use health and social care services have positive experiences of those services, and have their dignity respected
NO4 – Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
NO5 – Health and social care services contribute to reducing health inequalities

2.8.1 Our strategic aims and priorities during 2024-25

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 continue to work together with community planning partners to improve health and wellbeing outcomes for our most disadvantaged localities and those who have been disproportionally impacted by the pandemic. We will also work collaboratively with local and regional partners to develop our understanding of health inequalities in East Renfrewshire and changing patterns of need as we recover from the pandemic.

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

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

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

2.8.2 Our performance in 2024-25

As a partnership we are focused on tackling health inequalities and improving life chances for our residents. Although we remain below our target, we continue to support breastfeeding in our most disadvantaged neighbourhoods. The premature mortality rate has dropped significantly and East Renfrewshire has the lowest rate in Scotland.

Headline performance data includes:

- Our **premature mortality rate** remains significantly below the national average at 275 per 100,000 (22/23 fig) – down from 333 the previous year. Scotland average is 442 per 100,000.

- 13.1% of infants in our most deprived areas (SIMD 1) were exclusively **breastfed** at 6-8 weeks (22/23 fig) – down from 19.2% for 23/24 and missing our target of 25%. However, this is impacted by small numbers (reduction of two people). In SIMD 1 specifically, we have seen a large increase in mixed (breast and formula) feeding, from 5.8% in 2022/23 to 14.8% in 2023/24. The gap between the most affluent (SIMD 5) and the most deprived (SIMD 1) areas in East Renfrewshire is 38.4% and this is an all-time high.

2.8.3 Ways we have delivered in 2024-25

Following publication of the 2022/23 **NHSGGC Health & Wellbeing Survey (HWBS) Report** for East Renfrewshire, the HSCP Health Improvement (HI) Lead secured a small grant of £20k to support dissemination of the results. The East Renfrewshire data was presented to IJB in September 2024 and a further information session held with elected members in April 2025 to review and discuss re-framing our local health priorities through epidemiology evidence and community feedback. Information Sessions have also be delivered with key partners such as the Alcohol and Drug Partnership and Barrhead Housing Association Board Members.

To help disseminate and continue collating health information with the public, a HWBS toolkit has been developed supporting discussion and improvement work.. Two development sessions have delivered with the **Health Improvement Collaborative** (HI Leads, staff from Leisure Trust, VAER, Strategic Services, Oral Health Smoking Cessation) to empower staff to use the toolkit and champion the data and supporting services. An online **Health Improvement Notice Board** has been developed to support local signposting.

As part of our tailored health improvement programmes we continue to focus on interventions to tackle **childhood obesity** and support **better nutrition**.

- 81.5 % of P1 children had a BMI in a healthy weight category. (875 Children)
- 10.2% of P1 children are at risk of being overweight (110) children
- 6.8 % of children were in the at risk of obesity category (73 Children)
- 1.5% of children were at risk of underweight (16 children)

The **Thrive Under 5 programme**, supported by VAER, was launched in October 2024. The programme aims to support families to live a healthy lifestyle with year one focusing on enhancing cooking skills and food education. Family engagements have been very encouraging with:

- 17 self-referrals for information and support.
- 4 x 6 weekly sessions with Totnosh with 80 families in Mearns and Busby, Eaglesham & Thornliebank.
- 64 delegates family cooking class in the Crookfur Family Centre and Madras (school delivered).
- Two Starting Solids Sessions were delivered in Busby and Barrhead with 41 Parents and carers attending with 31 babies.
- 8 families attended the first Family Growing Network cooking session and more in 2025.
- 21 adults and 24 children attended a Thrive Under 5 community event aimed at supporting signposting families in the community. Multi-agencies attendee included Families First, Childsmile, MART, Community Chef Food Demos and Work ER, Active School s SLT, CAB and Smoking cessation.
- Two blocks of Yoga Bellies delivered with 16 families.
- 10 Community Chefs trained.

- 19 individuals attending Food Hygiene training provided by Nutrition Scotland (7 in Barrhead & 12 in Clarkston).

The **Peas Please** Pilot, delivered by Nourish Scotland and ERC Catering Services encourages more vegetable consumption.

- 834 young people in ten early years establishments received cooking sessions that include a portion of vegetables along with cooking pack and equipment to future proof activities. Staff received training from the nutritionists and 32 elementary food hygiene training to additional EY establishments.

The **Mini Master Chef** programme was funded by the Community Nutrition Framework and developed by ERC Catering Services to build on Peas Please, incentivising young people to try new foods.

- 1515 young people received mini master chefs sessions to an additional 26 early years establishments, including 4 private providers with 258 staff trained in food hygiene #ERCMiniMasterChef

The **HENRY programme** is being delivered in partnership with NHS GGC and Early Years Scotland. HENRY aims to support families to adopt healthier eating and lifestyle habits; addressing issues such as parenting, wellbeing, self-esteem and confidence. Group block sessions (over 8 weeks) have been delivered from Early Years Scotland. HENRY will continue over 2025-26 and work is ongoing with Busby Nursery and Primary School and Mearns Primary School.

Weigh to Go is a service for 12-18 years olds to support healthy weight. Led by the Youth Health Service, sessions are available weekly in Eastwood Health Centre and Barrhead Health Centre. YHS are working on providing HSCP level attendance data. 12- 15 year olds are offered nurse-led lifestyle support and 16-18 get Slimming World membership in addition to nurse-led lifestyle support.

Barrhead is an area of higher deprivation within the HSCP with SIMD 1 and 2 with lower **breastfeeding** rates in comparison to our Eastwood area. The Barrhead Health Visiting team continue to follow an enhanced pathway in the early postnatal weeks to provide additional support for mothers within areas of SIMD 1 and 2 to provide extra support to mothers that are breast feeding.

Supporting breastfeeding in our disadvantaged communities

Unicef Accreditation for Gold Standard has been achieved for 2024.

East Renfrewshire displays above average breastfeeding rates when compared to Scotland and Greater Glasgow as a whole, with 75.4% of babies reported to have ever breastfed and 41.3% exclusively breastfed at primary visit. This year we have seen a decrease in performance to 13.1%, down from 19.2% in 2022/23. (Small population, in raw numbers, this is a decrease from 10 to 8). In SIMD 1 specifically, we have seen a large increase in mixed (breast and formula) feeding, from 5.8% in 2022/23 to 14.8% in 2023/24.

The gap between the most affluent (SIMD 5) and the most deprived (SIMD 1) areas in East Renfrewshire is 38.4% and this is an all-time high. (Source: PHS Nov 2024)

Health Improvement sit on the Scottish Government Breastfeeding Friendly Scotland Group and NHSGGC Breastfeeding Public Acceptability Group. HI Launched the new Early Years Breastfeeding Accreditation programme at the ELC Forum (March 24). Work is ongoing to

support the 37 nurseries through accreditation process. Two information session have been delivered by the Community Nursery Nurse

Training is underway for the Thrive Under 5 coordinator to support delivery of the Breastfeeding Friendly Scotland programme to local organisations.

Dunterlie Breastfeeding group has been led by National Childbirth Trust and supported by the Community Nursery Nurse. The number of attendees have improved as the group has become more established. NCT & the HL Lead attended the Dunterlie Group Parliament day and met with the Presiding Officer and local MSPs to discuss local issues and the benefits of the community group. However, the Scottish Government have recently withdrawn funding for third sector infant feeding groups, and this group will finish in May 2025.

We have continued our work to ensure people in our most disadvantaged community are able to access **digital opportunities** that support health and wellbeing. Activity during 2024-25 includes:

- The newly developed Health Visiting app has been launched and now live on the Health Improvement Scotland Right Decisions website. Work is ongoing to raise awareness of the app and ensure activities and key messages are disseminated online.
- There is ongoing collaboration with the NHSGGC Public Health Inequalities Group and the Digital Public Health Group, sharing best practices and opportunities.
- A literature review on “Social media – its use and impact on mental health and wellbeing among young people” was shared with the Young Persons Sub-Group including recommendations for Young People.
- In partnership with BIG Health, the Health Improvement team continue to monitor uptake of new digital resources to support mental health. Sleepio and Daylight is regularly promoted as an evidence based solution to sleep issues/anxiety.
- SilverCloud app supporting mental health and wellbeing is being promoted to young people.

Smoking Cessation clinics are held weekly in Barrhead Health Centre and outreach sessions held at Dunterlie Food Share weekly. Target quits at 3 month follow-ups in the 40% most deprived areas of East Renfrewshire was 51% (14 People) which is above target (April 24 – March 25). The **Jenny and the Bear resource** is a story which is part of a coordinated programme and aims to increase awareness about the effects of second hand smoke on children and what parents/carers can do to ensure their children are not exposed to its harmful effects. P1 at Cross Arthurlie Primary School were the 2024 Jenny and the Bear winner.

During the year, the HI Lead worked in partnership with NHSGGC Improvement Team for **Sexual Health** to support development of the Sandyford Good Practice Guide for Carers and Staff. The Sandyford Toolkit was launched in June 24 and HI have been prominent in promoting the use and availability, introducing the resource with IOCYP members and presenting it at the Deputy Head Teacher Meetings. Work is ongoing to share this quick reference guide to support every day conversations.

- East Renfrewshire has the third lowest teenage conception rates (under 20) in Scotland, at 13.1 per 1000 women (2022).
- Conception rates for women under 18 have increased from 5.0 to 6.0 in rates per 1000 women, from 2021 to 2022 (an increase from 28 to 34 people).
- STI rates in 13-17 years olds have increased from 2023-24.

The Culture and Leisure Trust continue to work closely with HSCP to support optimal access to leisure facilities across the community. Live Actvie referrals are made from GP Practice staff and aim to support people with a medical condition or mobility issue.

Live Active support 2024/25

- 365 new patients into service – 106% of NHS East Ren annual target
- 2419 patient contacts – 11% increase on 23/24

During the year we have continued to explore additional funding opportunities to support targeted health improvement interventions.

- Glasgow Council on Alcohol (GCA) were supported by the HI Lead to apply for funding via Community Health and Wellbeing Fund and Big Lottery. GCA were successful in securing Big Lottery Funding to deliver a **Youth Peer Support Service** commencing May 2025. GCA have been recommissioned to deliver local **Alcohol Brief Interventions** and **Alcohol Counselling Service**. GCA also support local event / communities and third sector partners by promoting their services and providing alcohol awareness opportunities.
- VAER were commissioned to support delivery of **Walking for Health Programme** alongside support from HSCP/ NHSGG&C and Paths For All.
- Health Improvement supported NHSGGC to commission training with Cancer Research UK. **Talk Cancer session** was delivered on 27th March 2025, with the course full with 20 delegates attending. An online course was offered to Primary Care colleagues on 23rd April 25.
- Via the Vaping and Young People Steering Group, Talk About Trust were commissioned to develop lesson plans for **vaping workshops** with schools. Health Improvement will offer out training to education in August 25. Work is ongoing to circulate the new NHSGGC Vaping resources for adults and young people and raise awareness of the risks.
- The **Childsmile** Tooth brushing programme in East Renfrewshire is delivered in early years establishments and primary schools. Health Improvement link in with the Oral Health Directorate to ensure Thrive Under 5 complements Childsmile and has consistant messaging. A small working group has been set up to improve interface with the Oral Health Directorate.
- Health Improvement sit on the Scottish Government **Infant Food Insecurity Group** and implement sections from the national food insecurity toolkit, aligned to Cash First principles.

We continue to work with our partners to tackle inequalities and support residents with a number of long term conditions.

The **Health Improvement Collaborative** meets bi-monthly including partners from ERC, ER Culture and Leisure Trust, VAER and the HSCP. The collaborative offers a forum for partners to discuss funding collaborations, intelligence and opportunities for joint working. The HWBS report has helped demonstrate the local impact of long-term conditions and is support planning.

The Scottish Cardiac Programme report showed an increase in coronary heart disease (CHD) among East Renfrewshire residents from 2022/23 to 2023/24. CHD rates increased from 258.4 per 100,000 to 280.5 per 100,000 in both males and females and showed a sharp increase in males from 346.6 per 100,000 to 401.9 per 100,000.

Scoping work is underway with an increase in heart attacks, notably in men from SIMD 1 and disadvantaged areas.

East Renfrewshire are meeting target for all **adult screening programmes** (Abdominal Aortic Aneurysm, Bowel & Breast) with the exception of cervical screening. Uptake for cervical screening is 76.9% and target is 80%. This equates to 5863 people with a cervix not screened in East Renfrewshire. During Cervical Cancer Prevention Week (Jan) Health Improvement delivered an online campaign with PHS promoting local case studies, sharing digital assets sharing key messages on “What to expect” and FAQs.

Health Improvement sit on the National Screening Equity Network and the NHSGGC Screening Inequalities Group – Health Services developed dashboards that show update by datazone. Barrhead HCC hosted the **Breast Screening Unit** for three months. A call to action was made to support breast screening uptake in areas where uptake was as low at 50%. The HI team also delivered two webinars for HSCP staff and supporting partners. Posters were placed on areas of low uptake and digital assets where shared.

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

National Health and Wellbeing Outcomes contributed to:
NO8 – People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide

2.9.1 Our strategic aims and priorities during 2024-25

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

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

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

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

2.9.2 Our performance in 2024-25

Supporting staff wellbeing remains a key priority of the partnership, particularly following the experience of the Covid pandemic. The way staff have been working changed significantly with hybrid (home/office) becoming the norm for large groups of employees. In the years after the pandemic we supported the implementation and delivery of wellbeing programmes across the health and social care landscape. Support has been made available to HSCP staff, Care Homes, Primary Care, Care Providers, Third and Community Sector (staff and volunteers). Our iMatter staff engagement survey has produced positive feedback despite taking place during a period with significant pressures on our workforce.

Headline performance data includes:

- 88% of staff agreed that "My manager cares about my **health and wellbeing**" – consistent with the previous iMatter staff survey (89%)
- 72% agreed that "I feel **involved in decisions** in relation to my job" – down from 75% in previous survey
- 75% agree that "I am given the time and resources to support my **learning growth**" – down slightly from 77% in previous survey

2.9.3 Ways we have delivered in 2024-25

Despite no longer being able to fund a dedicated Wellbeing Lead Officer, responsibility for promoting staff wellbeing has been added to existing roles and we have continued to ensure that all staff have access to universal information with regard to health and wellbeing across the partnership's services. Both formal and informal communication methods are used to communicate the health and wellbeing offer to staff. Our HI Lead and Communications Officer promote and share staff **wellbeing opportunities** and supports as and when they are available from the Council, NHS and other national and local agencies. Throughout the year there has been ongoing promotion of information, support and training opportunities to staff and partners on wellbeing related topics such as: mental health; physical activity; finance etc. There has been continual promotion of NHSGGC-wide **Active Staff** opportunities including weekly **Eastwood fitness class**. During 2024-25 staff have been able to access **relaxation, emotional support, physical activity** opportunities and practical support across the partnership.

There has been ongoing focused work to engage managers to develop **leadership competencies** relating to wellbeing. We have continued to promote of training / awareness raising opportunities for managers and team leaders on how to support staff in relation to wellbeing and resilience. During the year we continue to encourage regular wellbeing conversations with staff and teams and have also promoted the peer support programme and offer of support to individual staff members.

Active staff – supporting positive health and wellbeing

Active Staff opportunities are included in the HSCP Staff Bulletin. HSCP staff receive discounted **gym membership** within East Renfrewshire gyms. Both the Council and NHS are members of the **Cycle to Work Scheme**.

The **workforce health and wellbeing programme** continues to provide a wide and diverse range of activities and resources. This includes **physical activity** options, **peer support**, and access to a comprehensive list of **wellbeing resources** and websites. ERC's wellbeing offering for 2024/2025 has included free health check opportunities, team development days, hands-on cooking classes, sound bath sessions, book club, wellbeing walks at lunch, Seasons for Growth groups, 1:1 wellbeing conversations. Training has been available on wellbeing and resilience and there has been sharing of resources via teams and emails. This includes promotion of national campaigns and raising awareness of important topics related to health and wellbeing.

iMatter is an **employee engagement** continuous improvement tool which aims to give staff a voice and help individuals, teams and managers understand and improve experiences at work. During the year, staff engagement levels were similar to previous years with a 65% response rate to the 2024 survey with 88% of teams completing an Action Plan. Particularly worth noting is an Equality Index Score of 78 which demonstrates staff are treated fairly and consistency, with dignity and respect, in an environment where diversity is valued.

The HSCP was be included within the Council's Employee Survey this year which is an important way of finding out how employees across the Council feel. The survey has widened in scope for this year to include additional questions about engagement and the general experience of working for East Renfrewshire Council alongside wellbeing questions.

The HSCP has made some significant changes to the way many of its employees carry out their work, with large numbers of staff undertaking **hybrid working** and using more **digital** means of communication. By developing a more flexible workforce, which is able to deliver services through different ways of working, this has created a means to better support the work-life balance of employees. This is helping accommodate those needing reasonable adjustments due to caring responsibilities or disability for example.

Enhanced safety and wellbeing for care staff – new legislation

The Health and Care (Staffing) (Scotland) Act 2019 provides a statutory basis for the provision of appropriate staffing in health and care services, enabling **safe and high quality care** and **improved outcomes for service users**. It builds on existing policies and procedures within both health and care services and effective implementation aims to embed a **culture of openness** and transparency, ensuring **staff are informed** about decisions relating to staffing and **able to raise concerns**. Having been delayed by the Covid-19 pandemic, the Act came into effect in April 2024.

East Renfrewshire HSCP established a **Safer Staffing Implementation Group**, chaired by the Chief Nurse, to coordinate the implementation of the Act with representatives across relevant health and social care teams.

In relation to care services, the Act places duties on local and integration authorities when "planning or securing the provision of a care service from another person under a contract, agreement or other arrangement". These are that such authorities must have regard to:

(a) the guiding principles for health and care staffing; and,
(b) the duties relating to staffing imposed on persons who provide care services.

The Act also places a duty on authorities to "as soon as reasonably practicable after the end of each financial year" to publish information on:

- the steps they have taken; and,
- any ongoing risk that may affect their ability to comply with Section 3(2) of the Act.

The HSCP Commissioning team have updated documents under our Contract Management arrangements to ensure alignment with the Act. The Risk Assessment for services under the Contract Management arrangements has been similarly aligned with the Act. This ensures that risk assessments for purchased services include clear and direct reference to the duties under the Act.

The Scottish Government has produced a template for the reporting duty under the Act which consists of two questions which reflect Section 2(5) of the Act:

- Please detail the steps you have taken as an organisation to comply with section 3(2) of the Health and Care (Staffing) (Scotland) Act 2019:
- Please detail any ongoing risks that may affect your ability to comply with the duty set out in section 3(2).

The completed template for ERHSCP is included at Appendix Two of this report. Following approval by the committee the report will then be sent to the Scottish Government via their nominated email address. Together with publication of the paper on the ERHSCP website for the committee meeting, this will meet ERHSCP's duty under Section 3(6) of the Act.

NHS community services delivered through the HSCP are also subject to oversight and coordination as part of the ERHSCP Safer Staffing Implementation group. The IJB received a report in 26th March 2025 providing assurance on the progress made in the

implementation of the Act. The ERHSCP implementation group is aligned and reports to the NHSGGC whole-system planning programme and was included in the first report to the Scottish Government on 30 April.

The purpose of the annual reporting requirement is to:

- enable impact monitoring of the legislation on quality of care and staff wellbeing;
- identify areas of good practice that can be shared;
- identify challenges relevant organisations are facing in meeting requirements in the Act and what steps they have taken / are taking to address these;
- identify any improvement support required; and
- inform Scottish Government policy on workforce planning and staffing in the health service, alongside other sources of information and data.

2.10 Protecting people from harm

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

2.10.1 Our strategic aims and priorities during 2023-24

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

2.10.2 Our performance in 2024-25

- Improvement in safety and wellbeing outcomes for women who have experienced **domestic abuse** – 92% consistent with 23/24 performance (93%) and ahead of target (85%). a total of 1116 women and children were supported across Women's Aid three core services, helpline and drop in enquiries compared to 1059 during the same period last year- a 5% increase.
- People agreed to be at risk of harm and requiring a **protection plan** have one in place – continues to be 100% of cases.

2.10.3 Ways we have delivered in 2024-25

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

Recent work to improve our processes has included revising ASP procedures, adopting a national ASP dataset, and developing local learning review procedures. Multiagency cooperation has been enhanced, notably with the inclusion of the Scottish Ambulance Service in the Adult Protection Committee (APC). Data reporting and analysis have been enhanced to better track performance and address challenges. Strong communication channels have been established between partners, care providers and the third sector, fostering collaboration and early risk identification. The ASP team is recognised for their supportive role in early risk identification. Continued multi-agency and partnership efforts, including engagement with the Scottish Ambulance Service and support for staff wellbeing, remain priorities. The HSCP is committed to sustaining these improvements and addressing future challenges.

Our approach to protecting vulnerable adults

We have established strong relationships between partner agencies, promoting an approach to **adult support and protection (ASP)** that keeps all partners involved and

included in discussions and planning, particularly in our routine ASP work and in the undertaking of Large Scale Investigations. In recent years, we have seen increased partnership working with a focus on keeping adults and their families and carers engaged and informed.

We operate a single point of contact for all ASP and adult welfare concern referrals. Created in June 2020 the dedicated ASP team was established as a test of change to strengthen our initial response to harm during the early stages of the pandemic. This dedicated team has greatly strengthened our response to ASP activity locally and led improvements across the HSCP. Due to the success of this model and positive feedback from colleagues and partners across East Renfrewshire, we resourced this model on a permanent basis (funded by SG Strengthening Adult Social Work funding stream) from November 2021 onwards.

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

The HSCP has seen a steady increase in demand from ASP activity over a number of years and this continued into 2024-25. There were 1,716 **ASP referrals** during 2024-25, up 16% from the previous year, with 1,475 referrals in 2023-24.

ASP inquiries increased slightly during the year – 1,146 compared with 1,107 for 2023-24. The number of **ASP investigations** decreased compared with the previous year – 152, down from 228.

We have also seen a significant increase (65.7%) in **welfare concerns** for the period 2022-24 compared with 2020-22. These include specific welfare referrals from Police Scotland, the Scottish Fire and Rescue Service and referrals screened by our ASP team manager which do not meet the threshold for inquiry under the 2007 Act.

Training, Learning and Development - Public Protection Development Programme

In this period we improved and delivered our rolling programme of ASP training as part of the Public Protection Development Programme. This programme set out a multi-levelled structure of training, developed to support staff at all levels of knowledge and involvement to identify the right training for their role. This programme included the following courses:

- Introduction to ASP (open to all HSCP, partners and service providers)
- ASP for council officers and second workers
- Risk Assessment and Management for ASP
- Investigative Interviewing
- Adult Support and Protection Notifications Involving Commissioned Services

The suite of training materials drew on learning from our previous LSI and supporting organisations to improve their practice. This has provided a range of introductory and more detailed training events that focused on supporting improved practice.
We have promoted the identification and communication of harm, effective risk assessment and risk management strategies, effective protection planning and preparation for case conference. The training sought to embed collaboration as a foundation of our practice and put the adult at the heart of our involvement and planning.

Across the five courses offered, 210 colleagues and partners took part in training during this period. This included HSCP staff (both social work and health), providers, third

sector/community partners and Foster Carers. The courses have been well evaluated and feedback from attendees has been positive and constructive.

Supporting partners learning

We have continued to provide flexible and adaptable training opportunities to support staff, partners and providers, developing a strong partnership approach. These courses are provided both as a part of our Public Protection Development
Programme, but also as bespoke session for partners and providers to support their improvement.

These courses have been offered and delivered to partners and providers in response to LSI's, contract monitoring and ASP activity. They have also been delivered at partner/providers request to assist in developing their staff group.

We are confident that the improvement activities undertaken to date have had a positive impact on the individuals we support and the delivery of our services. However, we see many areas for ongoing improvement and are focused on delivering these in the coming months. Our **priorities moving forward** include:

- Delivering shared approaches to quality assurance/quality improvement and audit. As we move forward, we will work to develop a program which includes partners and supports joint approaches to improvement.
- Implementing improvements to chronologies, drawing from national learning and moving towards quality improvement approach.
- Continuing to develop and expand our lived experience group and seek out new opportunities to hear the voices of those who use our services in a meaningful way.
- Creating spaces for colleagues from different agencies to share experience and learn together through our regular forums.
- Working with partners to develop approaches which will allow us to respond to the needs of adults at risk of harm with limited resources.
- Implementing a new information management system within the Health and Social Care Partnership by April 2025.

Domestic abuse continues to be the predominant reason for referral to our children's services and features as one of the most common concerns within child protection interagency referral discussions. Through our multi-agency approach we work collaboratively to deliver a significant range of actions to ensure an effective and sustainable approach to preventing, reducing and responding effectively to domestic abuse and all forms of violence against women and girls. This includes the implementation of **Routine Sensitive Enquiry**, **Multi Agency Risk Assessment Conference (MARAC)** and **Safe and Together** practice to ensure a perpetrator pattern based, child centred, survivor strengths approach to working with domestic abuse. We 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 work collaboratively with our partners in Rape Crisis Glasgow and Clyde to provide a sexual violence outreach support service in East Renfrewshire for women and girls (age 13+). This is an important addition to the specialist support available for women and girls who have experienced rape, sexual assault or sexual abuse. The outreach service operates monthly in Barrhead Health and Care Centre and Eastwood Health and Care Centre.

As part of our work to protect people from harm and abuse, we have established and continue to support a MARAC in East Renfrewshire for high-risk domestic abuse victims. In 2024-25

we continued to see an increase in support required as a result of domestic abuse with 182 victims and 263 children discussed at MARAC. This is an increase of 17.4% and 1% respectively in cases discussed compared to the previous year. The number of BAME victims increased by 14% and victims with a disability by 13%. This demonstrates continued improved referral by services and recording.

We continue to roll out comprehensive training for staff to identify risk and refer to the appropriate support. We have one of the highest referral rates to MARAC from our universal services which demonstrates the positive impact of training and continued awareness of domestic abuse across all our staff groups.

We continue to work together with **East Renfrewshire Women's Aid Service** to provide direct support for women and children who have experienced domestic abuse. During the period, East Renfrewshire Women's Aid Service supported 1116 women and children across the three core services and helpline in 2024-25, a 5% increase from the previous year.

Women's Aid delivered a new Children Experiencing Domestic Abuse Recovery (CEDER) Programme. This is a 10 week group work programme for women and children to support their recovery from domestic abuse. Over the course of the year two programmes which included 13 families and 17 children. This was positively received and evaluated by all participants.

Training and Capacity Building

Domestic Abuse, Risk Assessment, MARAC and Safe and Together training continues to be delivered in addition to the provision of bespoke sessions tor key partners. Over the course of the last year 100 staff were trained across a range of organisations and disciplines.

We have implemented a series of in person and online training on the Domestic Abuse Homicide Timeline delivered by international expert Professor Jane Monkton Smith.

Additionally domestic abuse training sessions were delivered to HR and managers to support the implementation of the new domestic abuse policy. Since the launch of the policy 1040 staff have completed the Domestic Abuse Induction Training and 28 senior managers have undertaken the policy training.

We participated in the national campaign 16 Days of Action to end violence against women and girls by developing a specific local programme of key messaging and campaign activity delivered through-out the 16 days

2.11 Hosted Services – Specialist Learning Disability Service

We continue to host the **Specialist Learning Disability Inpatient Service** that supports people requiring a hospital admission. The service works in partnership to manage demand and ensure appropriate support is available in the community on discharge.

Our Assessment and Treatment Services, based at Blythswood House and Claythorn House, has 27 beds across the two sites. The service is available to people with a learning disability residing in nine Health and Social Care Partnerships, six of which are within the NHSGGC boundary and three of which are provided via service level agreements in areas outwith NHSGGC.

The number of admissions increased by one in 2024/25, but overall figures remain just under 50% of the 2022/23 total. This trend is largely due to a significant drop in discharges from 15 in 2022/23 to just 7 in 2023/24.

Progress has been made in reducing delayed discharges this year with a total of 15 discharges. However, eight of the individuals discharged during 2024/25 had support packages dating back from previous years, four from 2022/23 and four from 2023/24 and.

Only three individuals were able to return to homes they were admitted from. Despite the increased number of discharges in 2024/25, prolonged hospital stays due to delayed discharge continue to impact a number of people and remain a key area for further improvement.

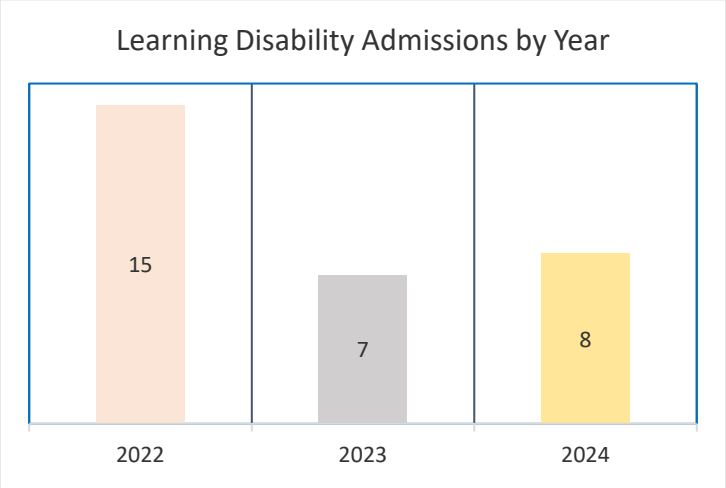
People are still more likely to be discharged within a reasonable timescale if their primary reason for admission is due to mental ill health and/or they have an established home to return to.

Establishing a new package of care and support is the primary reason for delays.

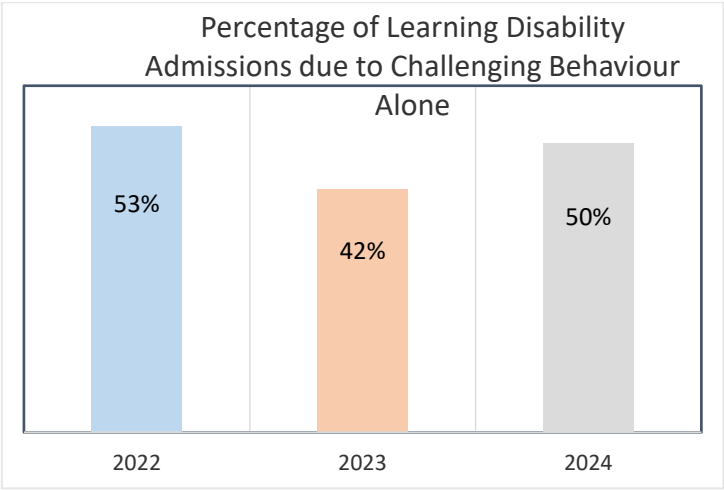
A high number of delayed discharges means we have a higher number of patients living together who do not want to be there/should not be sharing with others; and as a result there is a high level of interpersonal risks that are difficult to manage.

When patients remain in hospital for extended periods and interpersonal risks escalate, this can complicate discharge planning as providers may become increasingly concerned about managing those risks in a community setting. We know with the right support, transitioning to the community-based support remains a safe positive step to improve a person's quality of life.

2.11.1 Admissions

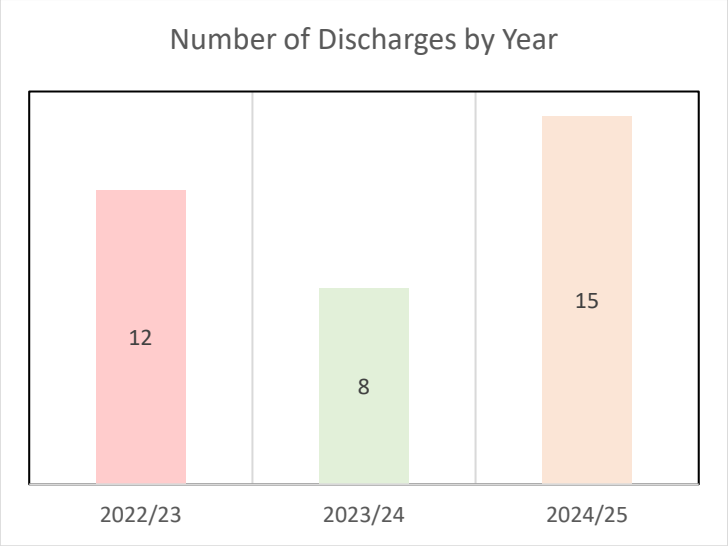


The service received 21 referrals for admission to the LD inpatient service in 2024/25, but only a total of eight people were admitted. The data indicates a slight increase in referrals, suggesting a consistent demand for the service. However, the admissions trend from 23/24 remains, with the service experiencing low numbers of admissions as only one more person was admitted in 24/25. The service continues to face challenges related to discharges and length of stay, which impacts on the number of admissions. Of the eight admissions the age range was between 24 – 61 years.



In 2024/25, 50% of admissions were due to long-standing challenging behaviour (four out of eight), compared to 42% in 2023 and 53% in 2022. Most admissions for behaviours that challenge are linked to instability in community support, with staffing and recruitment issues in the third sector being a key factor.

2.11.2 Discharges

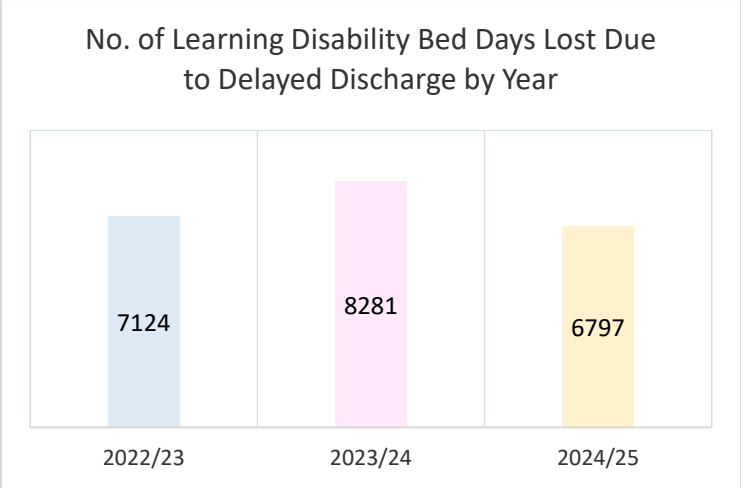


In 2024/25, a total of 15 patients were discharged from the LD inpatient service, representing a significant increase compared to previous years with eight discharges in 2023/24 and 12 in 2022/23. This marks a 53% rise from the previous year and reflects notable progress. The improvement is largely attributed to some individuals having appropriate placements to return to, shorter hospital stays due to admissions focused on assessment and treatment rather than placement breakdown, and discharge planning had already begun for some people in 2022/23 and 2023/24. However, challenges remain, with several patients continuing to experience prolonged hospital stays due to the absence of clear discharge plans.

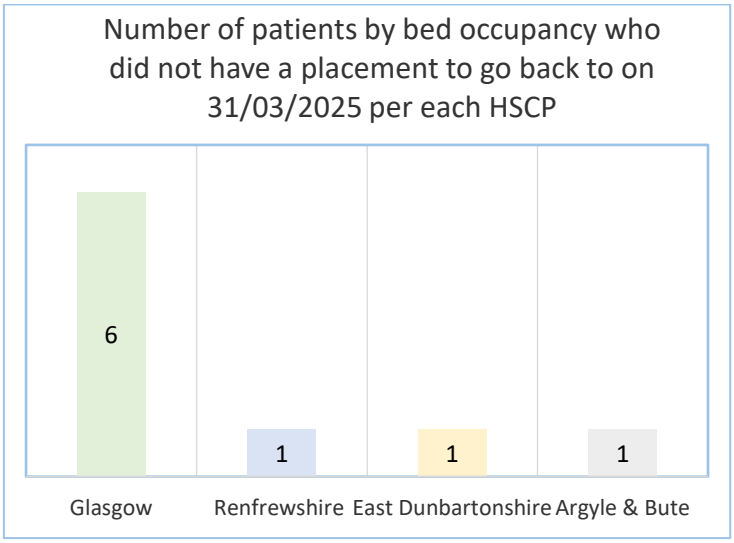
In addition to these, four long stay patients were discharged following the closure of the Netherton Unit in October 2024. All Netherton patients were temporarily transferred to Blythswood House due to delays with the completion of the new community placement. Three of the five transferred patients, and one long stay patient already accommodated in Blythswood House were discharged in December 2024 with four contingency beds being held for a period of three months. One patient remained in Blythswood due to legal complexities and the legal issues remained unresolved on the 31/03/25.

Overall, the average length of stay counting all assessment and treatment LD patients discharged during 2024/25 was 145 days with a range between 0 – 358 days.

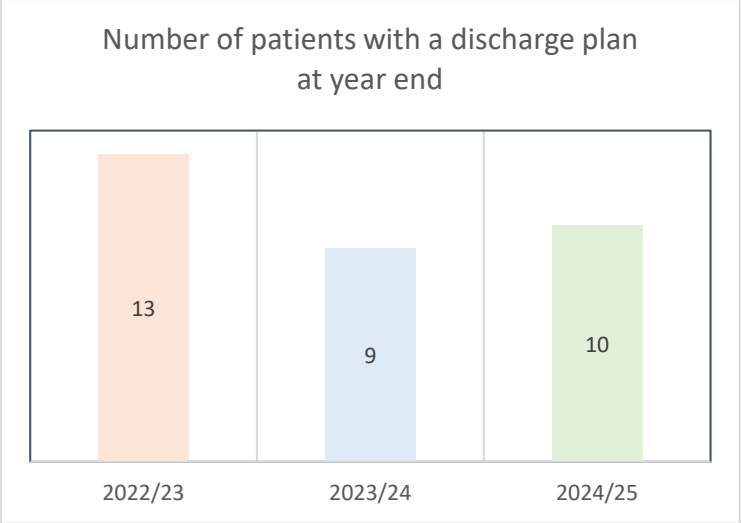
There is a correlation between the length of stay and accommodation status on admission. Of the fifteen discharges, three were returning to the home they were admitted from, with an average length of stay of 48 days. Eight had packages initiated in 2022/23 and 2023/24, three had new support packages identified in 2024/25 and one patient was transferred to IPCU. For these twelve patients during their admission the average length of stay was 567 days. This demonstrates patients that do not have appropriate accommodation and support packages experience prolonged hospital stays.



Between 2023/24 and 2024/25, the number of bed days lost due to delayed discharges decreased by 20%, reversing the previous year's trend which saw a 14% increase from 2022/23 to 2023/24. When compared to 2022/23, the latest figures represent a 5% reduction in bed days lost indicating a positive trend.



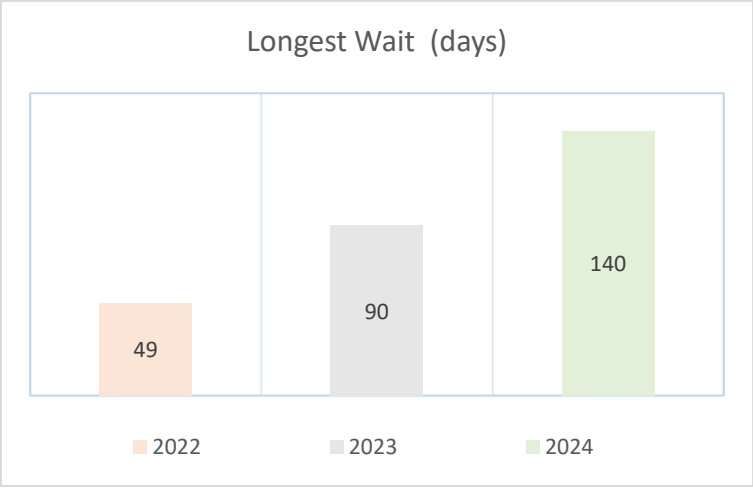
On 31st March 2025 nine patients who were ready for discharge did not have a discharge plan / community placement.



As of 31st March 2025, 10 out of 19 patients (53%) in LD inpatient services had an active discharge plan, showing slight improvement from 9 out of 26 (35%) in 2024. Despite this small progress, unacceptable delays in discharge remain a persistent issue, particularly for patients with longer hospital stays. These delays are often due to complex needs and difficulty finding appropriate community placements. The prolonged delays in the ward contribute to increased interpersonal risks, including a rise of incidents in violence and aggression. These risks are managed through heightened levels of observation, placing additional strain on staff and resources.

The longer patients remain in hospital, the harder it becomes to identify suitable accommodation. This is partly due to a growing perception that their risks can only be managed in a hospital setting, which further complicates discharge planning and reinforces the cycle of delays.

2.11.3 Waiting times



The longest wait for admission to a learning disability inpatient bed was 140 days. A group of people were removed from the waiting list as admission was no longer required or an alternative had been established before a bed became available for them.

3 Financial performance and Best Value

National Health and Wellbeing Outcomes contributed to:
NO9 - Resources are used effectively and efficiently in the provision of health and social care services

3.1 Introduction

This was another challenging year for the HSCP as we worked to meet the demand for services whilst delivering on our significant savings challenge. We set a savings target of £11.8 million, which was £2 million higher than needed to balance our budget as part of our forward planning to mitigate legacy pressures in future years and work towards sustainability and building back reserves, following our financial recovery in 2023/24.

Significant progress was made during 2024/25 on embedding the Supporting People Framework, which is our criteria based approach to achieve the required savings, as a key element of the savings programme. With the exception of prescribing costs, where a c£2 million recurring gap has added to the 2025/26 challenge all other savings have been realised on a recurring basis going into 2025/26.

In recognition of thee pressure that prescribing costs had on our operational budget NHS Greater Glasgow and Clyde provided an additional £1 million funding during the year, on a non-recurring basis.

We ended the year with an operational surplus of £1.482 million which has been added to our general reserve.

3.2 Financial Performance 2024/25

The annual report and accounts for the IJB covers the period 1st April 2024 to 31st March 2025. The budgets and outturns for the operational services (our management accounts) are reported regularly throughout the year to the IJB, with the final position summarised:

Service	Unaudited Budget	Spend	Variance (Over) / Under	Variance (Over) / Under
	£ Million	£ Million	£ Million	%
Children & Families	13.272	12.190	1.082	8.15%
Older Peoples Services	30.717	28.684	2.033	6.62%
Physical / Sensory Disability	6.341	6.127	0.214	3.37%
Learning Disability – Community	21.449	22.127	(0.678)	(3.16%)
Learning Disability – Inpatients	10.874	11.178	(0.304)	(2.80%)
Augmentative and Alternative Communication	0.291	0.303	(0.012)	(4.12%)
Intensive Services	16.836	18.149	(1.313)	(7.80%)
Mental Health	5.916	5.514	0.402	6.80%
Addictions / Substance Misuse	2.224	2.086	0.138	6.21%
Family Health Services	33.809	33.868	(0.059)	(0.17%)
Prescribing	18.808	19.954	(1.146)	(6.09%)
Criminal Justice	0.033	0.033	-	0.00%
Finance and Resources	10.177	9.052	1.125	11.05%
Net Expenditure Health and Social Care	**170.747**	**169.265**	**1.482**	**0.87%**
Housing	0.501	0.501	-	-
Set Aside for Large Hospital Services	31.435	31.435	-	-
Total Integration Joint Board	**202.683**	**201.201**	**1.482**	**0.87%**

The operational underspend is £1.482 million (0.87%) and is better than the last reported position taken to the IJB which was based on January forecasts and projected an underspend of £0.288 million. The main variances to the budget were:

- £1.082 million underspend within Children & Families reflecting the profile of care costs during the year, additional income from the Home Office and staff turnover.
- £2.033 million underspend with community based care for adults and older people is primarily from nursing and residential care and staff turnover. In 2025/26 there has been some budget realignment to Intensive Services.
- £1.313 million overspend within Intensive Services from in-year savings shortfalls and service pressures from meeting demand.
- £1.146 million overspend in Prescribing from continued costs and volume pressures combined with legacy pressures, this is net of £1 million non-recurring support from NHS Greater Glasgow and Clyde.
- £1.125 million underspend within Finance and Resources in the main reflects the non-recurring pension gain, offset in part to meet HSCP wide in-year savings shortfalls and pressures.

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

2023/24 £000	Services Prvided to East Renfrewshire IJB by Other IJBs within NHSGGC	2024/25 £000
556	Physiotherapy	523
68	Retinal Screening	58
520	Podiatry	580
318	Primary Care Support	341
457	Continence	512
603	Sexual Health	603
1,597	Mental Health	1,503
899	Oral Health	950
479	Addictions	347
223	Prison Health Care	224
185	Health Care in Police Custody	200
5,197	Psychiatry	5,792
3,344	Specialist Childrens Services	4,063
14,446	**Net Expenditure on Services Provided**	**15,696**

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

2023/24 £000	Learning Disability In-Patient Servies Hosted by East Renfrewshire IJB	2024/25 £000
9,010	Glasgow	8,471
1,370	Renfrewshire	1,095
97	Inverclyde	385
658	West Dunbartonshire	427
-	East Dunbartonshire	800
11,135	Learning Disability In-Patients Services Provided to other IJBs	11,178
195	East Renfrewshire	0
11,330	**Total Learning Disability In-Patient Services**	**11,178**

2023/24 £000	Augmentative and Alternative Communication (AAC) Hosted by East Renfrewshire IJB	2024/25 £000
93	Glasgow	165
55	Renfrewshire	45
10	Inverclyde	20
6	West Dunbartonshire	16
23	East Dunbartonshire	16
187	AAC Services Provided to other IJBs	262
32	East Renfrewshire	41
219	**Total AAC Services**	**303**

3.3 Reserves

We used £0.966 million of reserves in year and we also added £2.297 million into earmarked and general reserves.

	£ Million	£ Million
Reserves at 31 March 2024		1.864
Planned use of existing reserves during the year	(0.966)	
Funds added to reserves during the year	2.297	
Net decrease in reserves during the year		1.331
Reserves at 31 March 2025		3.195

The reserves of the IJB fall into three types:

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

As part of the financial recovery process for 2023/24 the IJB used all possible reserves available to mitigate cost pressures. This means the only reserves brought into 2024/25 were for specific funding initiatives set by the Scottish Government or where funding is committed within an existing project.

The underspend from 2024/25 will be added, in the first instance, to the IJB general reserve.

Ring-Fenced Reserves
The spend in year was £0.310 million on existing initiatives and £0.371 million was added towards the end of the year for non-recurring prescribing support £0.359 million as part of the 2025/26 budget and £0.012 million for national IT projects. The funding to support the development of a Recovery Hub at £0.489 million, brought forward from 2023/24 is the other reserve taken into 2025/26.

Earmarked Reserves
Our earmarked reserves are in place to support projects and timing differences for specific funding. We used £0.172 million during the year and added £0.444 million to support the ongoing programme of Learning Disability Health Checks across the health board area (£0.082 million), the implementation of the case recording system (£0.250 million), fostering and adoption (£0.100 million) and cancer screening inequalities (£0.012 million).

This means we will take £0.853 million into 2025/26. This balance supports existing commitments already in place for the whole family wellbeing project and trauma informed practice.

General Reserves
Our general reserve is £1.482 million reflecting the underspend from 2024/25 and whilst this is an improved position from the previous year the IJB is not compliant with its Reserves Policy which advocates a 2% of budget should be the level of reserves held.

The use of reserves was reported to the IJB within our routine revenue reporting and during 2024/25.

3.4 Prior Year Financial Performance

The table below shows a summary of our year-end under / (over) spend by service and further detail can be found in the relevant Annual Report and Accounts and in year reporting.

SERVICE	2024/25 (Over) / Under £ Million	2023/24 (Over) / Under £ Million	2022/23 (Over) / Under £ Million	2021/22 (Over) / Under £ Million	2020/21 (Over) / Under £ Million
Children and Families	1.082	0.788	0.460	(0.020)	0.410
Older Peoples & Intensive Services	0.720	(2.719)	0.888	0.194	0.392
Physical / Sensory Disability	0.214	(0.114)	0.219	0.031	0.099
Learning Disability - Community	(0.678)	(0.439)	(0.727)	0.458	(0.267)
Learning Disability - Inpatients	(0.304)	(1.371)	(0.032)	0.000	0.000
Augmentative & Alternative Communication	(0.012)	0.076	0.000	0.000	0.000
Mental Health	0.402	0.541	0.337	0.136	0.192
Addictions / Substance Misuse	0.138	0.262	0.083	0.021	0.052
Family Health Services	(0.059)	(0.064)	0.002	0.000	0.000
Prescribing	(1.146)	(2.462)	(0.774)	0.000	0.000
Justice		(0.012)	0.030		0.011
Management and Admin / Finance & Resources	1.125	0.762	0.104	0.017	(0.056)
Net Expenditure Health and Social Care	**1.482**	**(4.752)**	**0.590**	**0.837**	**0.833**
Additional Funding ERC		**2.657**			
Additional Funding NHSGGC		**2.095**			
Net Expenditure Health and Social Care	**0.000**	**0.000**			

3.5 Best Value

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

3.6 Future Challenges

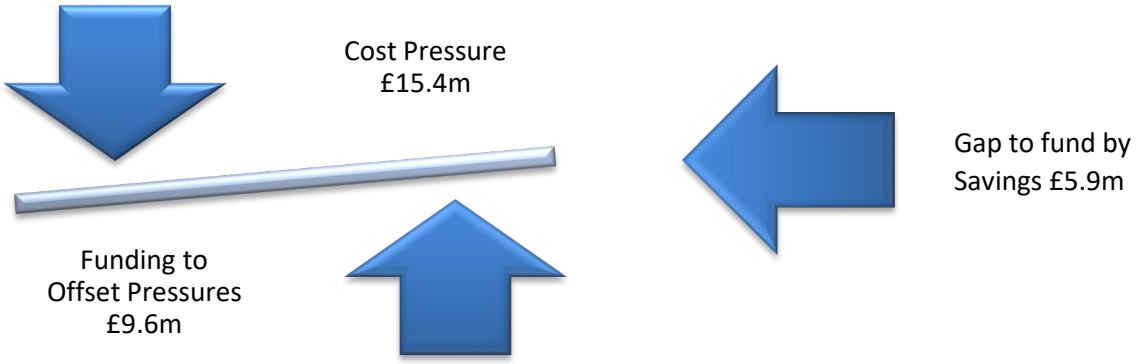
The IJB continues to face a number of challenges, risks and uncertainties in the coming years and this is set out in our current Medium Term Financial Plan (MTFP) for 2025/26 to 2029/30 and our Strategic Plan for 20225 to 2028. These key strategies also inform our strategic risk register and collectively support medium-term planning and decision making.

The IJB operates in a complex environment with requirements to ensure statutory obligations, legislative and policy requirements, performance targets and governance and reporting criteria are met whilst ensuring the operational oversight of the delivery of health and care services. UK and Scottish Government legislation and policies and how they are funded can have implications on the IJB and how we use our funding over time.
The most significant challenges for 2025/26 and beyond include:

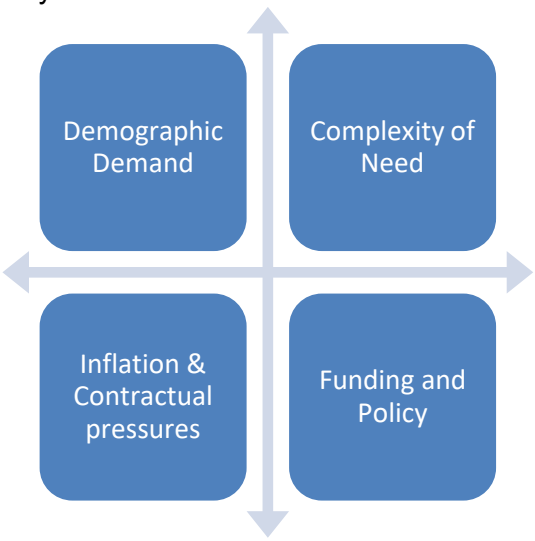
- continued delivery of savings to support financial sustainability, recognising this is at odds with a focus on prevention and the difficulty increases as the cumulative savings increase
- “doing more of the same” in identifying savings will not work, we need to review every service in detail as part of a Change and Improvement programme of work to be developed
- working with the Scottish government recognising the national scale of the challenge across health and social care, in the context of a collective £0.5 billion shortfall
- managing the real tension between reduced service capacity as a result of the cumulative impact savings in prior years whilst maintaining system wide services including discharge without delay from hospital
- understanding the longer term impacts of Covid-19 on mental and physical health in the longer term, we are seeing increased levels of complexity and acuity of need
- continued recruitment and retention of our workforce within the HSCP and our wider partner workforce, recognising the risk of market sustainability challenges
- managing prescribing demand and costs in partnership with our GPs and wider population
- supporting the physical and mental health and wellbeing of our workforce and our residents
- meeting increased demand for universal services without funding for growth, including increased population demand and new care homes opening within the area

The IJB agreed its budget for the financial year 2025/26 on 27th March 2025 recognising the significant improvement from savings delivered in 2024/25, however recognising new demand and cost pressures for 2025/26 and beyond.

Within our 2025/26 budget of £202.4 million the estimated cost pressures are £15.412 million, offset in part by available funding of £7.485 million and the non-recurring pension gain of £2.067, million leaving a funding gap for the year of £5.860 million to be closed through savings.



Our cost pressures are driven by:



Revenue Budget Pressures	ERC	NHS	Total
	£m	£m	£m
1. Cost Pressures			
Pay	1.553	1.552	3.105
Inflation & Living Wage	5.396	0.000	5.396
Demographic & Demand	2.230	0.200	2.430
Service Pressures	0.595	0.100	0.695
Prescribing		3.786	3.786
	9.774	**5.638**	**15.412**
2. Funding available towards pressures			
Recurring Policy Funding	(3.253)	(2.238)	(5.491)
Additional Funding from Partners	(1.309)	(0.685)	(1.994)
	(4.562)	**(2.923)**	**(7.485)**
3. Non-Recurring Pension Gain	**(2.067)**		**(2.067)**
4. Unfunded Cost Pressures	**3.145**	**2.715**	**5.860**
5. Proposals to Close the Funding Gap			
Savings Programme identified	(1.645)	(1.515)	(3.160)
Savings in Development - Prescribing		(1.200)	(1.200)
Non Recurring Support - Deferred Charging	(1.500)		(1.500)
	(3.145)	**(2.715)**	**(5.860)**
Remaining Gap 2025/26	**0.000**	**0.000**	**0.000**
Recurring Gap 2025/26	**1.676**	**0.683**	**2.359**

Whilst the budget for the year is balanced this included a number of non-recurring elements and when these are stripped out the underlying position is a recurring gap of £2.359 million and work is ongoing to ensure plans are in place to address this before April 2026.

Summary Table	ERC	NHS	Total
	£m	£m	£m
Cost Pressures	9.774	5.638	15.412
Funding Offsets	(4.562)	(2.923)	(7.485)
Non-Recurring Pension Gain	(2.067)		(2.067)
Savings - existing	(1.645)	(2.715)	(4.360)
Savings - Support for deferred charging*	(1.500)		(1.500)
Gap 2025/26	**0.000**	**(0.000)**	**(0.000)**
Recurring Gap			
Remove pension gain	2.067		2.067
Remove Care at Home delay pressure	(0.391)		(0.391)
Remove non prescribing initiative reserve		0.359	0.359
Remove non recurring turnover / underspend		0.324	0.324
Recurring Gap**	**1.676**	**0.683**	**2.359**
**** Assumes non residential charging of £1.5m in place for 2026/27**			
*** Support of up to £1.5m in 2025/26**			

We have minimal reserves to offset any shortfall, following our financial recovery process in 2023/24.

The budget agreed by the IJB on 26h March 2025 sets out the detail behind each of the cost pressures and it is important to note that these include contractual and policy requirements that must be met.

Whilst the scale of this challenge is significant to East Renfrewshire, particularly as one the smaller HSCPs this is not unique; the national position across all public sector services shows a challenging financial outlook, with funding pressures including; pay, inflation, demand and complexity, demographics, transitions from child to adult services, prescribing costs & volume and recruitment & retention challenges.

During the period of this plan we will implement any policy decisions as directed by the Scottish Government along with any recommendations or specific actions that may arise from the national care service advisory board.

We continue to work alongside our partners to deliver our respective services with a fully integrated approach recognising our collective outcomes to deliver the best services we can for our residents.

Whilst the 2025/26 budget is a great improvement on the prior year this will still be a challenging year, with a difficult medium term outlook.

Looking Ahead to 2026/27 to 2029/30 the level of potential cost pressures set out in the scenarios in the MTFP are based on “what if” percentage levels of pressure and are not an indication of where any settlement or agreement may crystallise. This allows the IJB to look forward using the current year and the latest intelligence to plan for possible scenarios. The further ahead we look the less certainty of any assumption; even short term assumptions carry a high degree of uncertainty in the current climate.

It also needs to be recognised that these scenarios are showing the potential level of cost pressure and do not make any allowance for any funding that may offset a future cost. Again given the current levels of uncertainty it is unwise to assume anything beyond a flat cash approach at this time, with the exception of the Scottish Government indication that the cost of the pay award will be funded for our NHS workforce.

In the event that additional funding becomes available this will reduce the level of cost pressure, depending on the nature and requirements that may be attached. By illustrating this “flat cash” approach this allows the IJB to see the scale of the challenge ahead, recognising this may be mitigated in the event of any increase in funding.

The scenarios below show that in any of the next four years the modelled cost pressure could range from £3.6 million to £8.6 million depending on the combination of factors set out in the low, medium and high illustrations.

The cumulative pressures could range from £18.4 to £32.6 million over the four years to 2029/30 without any significant change in funding.

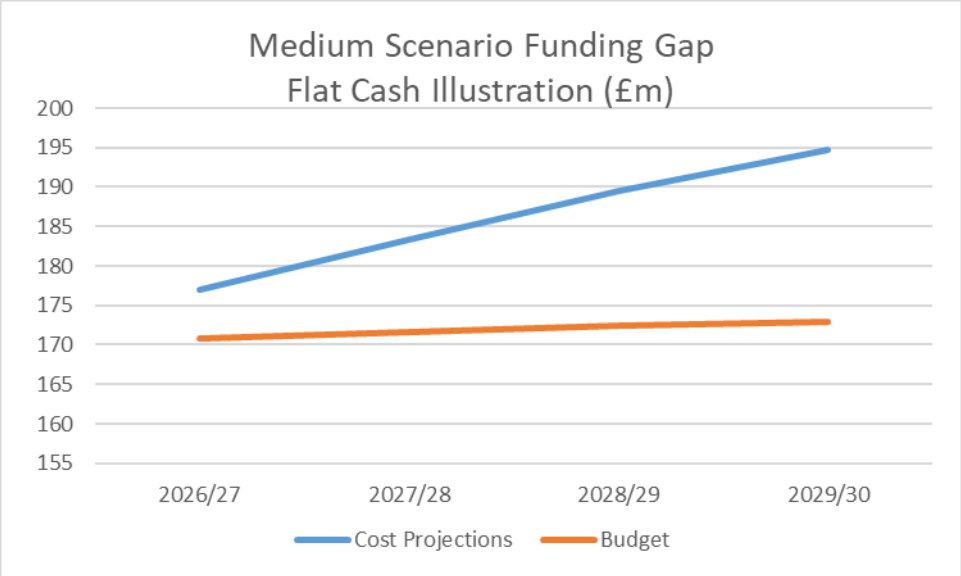
The assumptions are predicated on full and recurring delivery of the 2025/26 savings including the underlying shortfall.

There is always a possibility that the Scottish Government budget settlement may allow for some funding and / or the IJBs funding partners are in a position to support with additional funding to the IJB and all scenarios are subject to the terms of the Scottish Government budget settlement.

It is also assumed that any policy changes determined by the Scottish Government should be cost neutral.

We remain in a difficult economic climate and the financial impacts of delivering service to people are dynamic. Our forward planning assumptions will be updated as issues emerge and become clearer. The resulting funding gap in each year will ultimately be determined by the difference between pressures and the funding settlement agreed with our partners, including any policy funding or directives as part of the Scottish Government budget settlement for that year.

Using the medium term scenario above the gap between costs and funding will grow as every year passes:



There are a number of areas where caseload numbers or staffing ratio to patients will determine necessary changes to the workforce.

We are at the stage where we cannot do “more of the same” in our approach to savings and a more radical approach is required. We will need to develop a programme of review across all services. We will continue to work with a range of partners to look at any system wide opportunities to minimise costs and mitigate, as best we can, the impact resulting from increasing demand versus reducing resources.

The pay increases for 2025/26 have not yet been agreed for part of our workforce so the impact to the current and future years may require review. The working assumption is the costs of pay increases for our NHS employed staff will be funded by the Scottish Government.

Inflation for care costs needs to allow for fair work policies, workforce and economic challenges, where funded policies allow for this. For the 2025/26 budget settlement the Scottish Living Wage increased from £12.00 to £12.60 per hour and as with prior years this

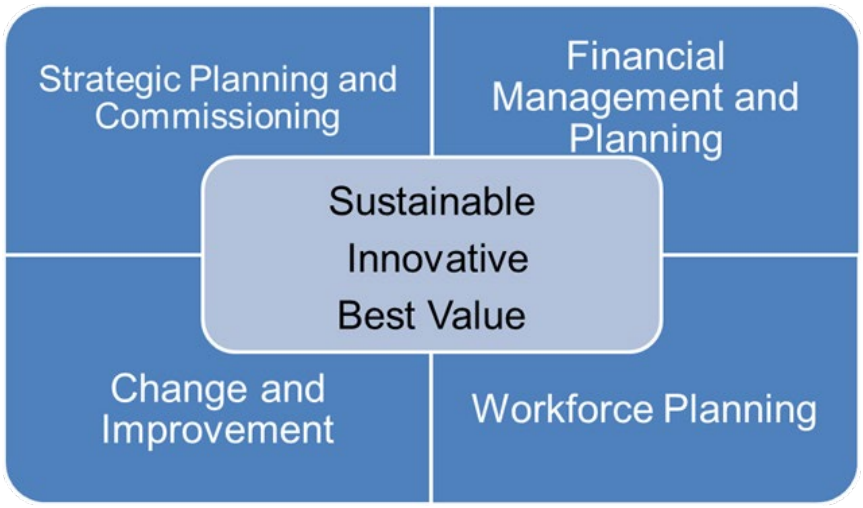
has been applied to pay element of the contract hourly rate as directed by Scottish Government. The Scottish Government will determine the Living Wage rate as a policy decision along with any associated funding.

Demographic and Demand recognises both changes in population and in acuity of need. This also includes the cost of young people moving to adult care. The long-term post Covid-19 impact on complexity and demand is still unclear, however the population in East Renfrewshire continues to grow particularly at the older and younger ends of the age spectrum. We are seeing increasing complexity of need across a range of care groups.

The changes in our population also impact on General Practice, Dental and other family health services within East Renfrewshire.

Prescribing will not only rise in line with population increases but is also subject to many other factors. This area is so volatile it is difficult to accurately predict however system wide work is in place across NHS Greater Glasgow and Clyde to support the delivery of a range of actions to mitigate some of the cost pressures we are seeing.

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



- The Supporting People Framework, our criteria based approach to care prioritisation, is fully embedded. We must continue to monitor and assess demand, capacity and funding against this criteria.
- Work is ongoing in relation to the introduction of non-residential charging.
- Our existing Recovery and Renewal programme has delivered much of the programme and the key project remains the implementation of Mosaic, our case recording system, due to go live in October 2025. A new Change and Improvement programme of work will be developed, alongside our new Chief Officer to support a review of all services to promote and ensure continued efficiency and allow us to continue to evolve, adapt and innovate. This will support and mitigate, where possible, our increasing cost pressures. We will continue to work with partners on wider redesign and strive to be as efficient as we can. We need to be a part of the national solution needed to ensure our services can be funded at a sustainable level to meet the needs of our population.
- Audit Scotland's Finance Bulletin report relating to IJBs financial position recognised ***"IJBs need to be working collaboratively with each other and with their NHS and council partners to find ways to transform services so that they are affordable. Investment in prevention and early intervention is needed to help slow the ever-***

increasing demand for services, the cost of more complex care and, improve the experience and outcomes for people."

- Delivery of the required savings for 2025/26 to balance the budget and address the underlying shortfall is fundamental to establish a solid foundation for 2026/27 and beyond. Continuing to build on our tentative recovery would enable some flexibility if we can reinstate reserves.
- Funding discussions with the Scottish Government are fundamental recognising the national shortfall in health and social care is currently estimated at c£0.5 billion.
- Successfully implement the case recording system and maximise the associated benefits
- We will update our Medium-Term Financial Plan on a regular basis reflecting assumptions and projections as issues become clearer; this will also inform planning for our 2026/27 budget and beyond.
- We will continue to monitor the impacts of Covid-19, economic and inflationary factors along with operational issues through our financial and performance monitoring to allow us to take swift action where needed, respond flexibly to immediate situations and to inform longer term planning.
- We will complete the review of our Integration Scheme; work has progressed during 2024/25 and this should be finalised in 2025/26 with partners.
- We routinely report our performance to the IJB with further scrutiny from our Performance and Audit Committee and our Clinical and Care Governance Group, including follow up from any inspections. The service user and carer representation on the IJB and its governance structures is drawn from Your Voice which includes representatives from community care groups, representatives from our localities and representatives from equality organisations including disability and faith groups.
- Workforce planning will continue to support identification of our current and future requirements. Recruitment and retention of staff is key to all service delivery and we have mitigated as far as possible by minimising the use of temporary posts and developing our workforce and organisational learning and development plans. We are refreshing our 3-year workforce plan. This will also include any implications from the Health and Care Staffing (Scotland) Act 2019.
- We will continue with the redesign of the Learning Disability Inpatient bed model.
- Governance Code; we have robust governance arrangements supported by a Governance Code.
- The IJB continues to operate in a challenging environment and our financial, risk and performance reporting continue to be a key focus of each IJB agenda.

The future challenges detailed above and our associated response include the main areas of risk that the IJB is facing. The uncertainty of the current economic climate, the longer term impact of Covid-19 on our population, the capacity for the HSCP and its partners to meet continued demand and complexity whilst delivering such challenging savings remain significant risks.

4 Performance summary

4.1 Introduction

In the previous chapters of this report we have focused on the key areas of work carried out by the HSCP over the course of 2024-25. In this final chapter we draw on a number of different data sources to give a more detailed picture of the progress the partnership has been able to make against our established performance indicators. Quantitative performance for many of our performance indicators continue to reflect ongoing challenges being faced locally and nationally in the aftermath of the Covid pandemic.

The sections below set out how we have been performing in relation to our suite of Key Performance Indicators structured around the strategic priorities in our Strategic Plan 2022-25. We also provide performance data in relation to the National Integration Indicators and Ministerial Steering Group (MSG) Indicators. Finally, we provide a performance summary relating to recent inspections of our in-house services.

4.2 Performance indicators

Key to performance status	
Green	Performance is at or better than the target
Amber	Performance is close (approx 5% variance) to target
Red	Performance is far from the target (over 5%)
Grey	No current performance information or target to measure against

Direction of travel*	
↑	Performance is IMPROVING
–	Performance is MAINTAINED
↓	Performance is WORSENING

*For consistency, trend arrows **always point upwards where there is improved performance** or downwards where there is worsening performance including where our aim is to decrease the value (e.g. if we successfully reduce a value the arrow will point upwards).

Strategic Priority 1 - Working together with children, young people and their families to improve mental and emotional wellbeing											
Indicator	**2024/25**	**Current Target**	**2023/24**	**2022/23**	**2021/22**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
% Looked After Children with more than one placement within the last year (Aug-Jul). (LGBF) *(Aim to decrease)*	n/a	Data only	**27.1%**	14.4%	20.8%	20%	18.8%	24.5%	29.1%	19.6%	↓
Percentage of children looked after away from home who experience 3 or more placement moves *(Aim to decrease)*	**1.28%**	11%	0%	0%	1.8%	1.2%	0.0%	1.4%	1.2%	7.1%	↓
Children and young people starting treatment for specialist Child and Adolescent Mental Health Services within 18 weeks of referral *(Aim to increase)*	**93.5%**	90%	99%	86%	55%	61%	78%	74%	89%	90%	↓
Child & Adolescent Mental Health - longest wait in weeks at month end *(Aim to decrease)*	**16**	18	18	24	41	35	33	34	35	31	↑
Balance of Care for looked after children: % of children being looked after in the Community (LGBF) *(Aim to increase)*	n/a	Data only	**89%**	92.2%	93.8%	91.1%	94.9%	98.0%	93.6%	91.5%	↓
Percentage of children with child protection plans assessed as having an increase in their scaled level of safety at three monthly review periods. *(Aim to increase)*	**86.96%**	100%	100%	100%	84%	87.5%	n/a	n/a	n/a	n/a	↓

Strategic Priority 1 - Working together with children, young people and their families to improve mental and emotional wellbeing											
Indicator	**2024/25**	**Current Target**	**2023/24**	**2022/23**	**2021/22**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
% Child Protection Re-Registrations within 18 months (LGBF) *(Aim to decrease)*	n/a	Data only	**0**	12.5%	0	0	15.8%	7.7%	0%	9%	↑

Strategic Priority 2 - Working together with people to maintain their independence at home and in their local community											
Indicator	**2024/25**	**Current Target**	**2023/24**	**2022/23**	**2021/22**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
Number of people self-directing their care through receiving direct payments and other forms of self-directed support. *(Aim to increase)*	**499**	600	548	488	458	551	575	514	491	364	↓
Percentage of people aged 65+ who live in housing rather than a care home or hospital (MSG) *(Aim to increase)*	n/a	97%	**97%**	97%	97%	97%	97%	95.9%	96.6%	96.8%	–
The number of adults (18+) receiving personal care at home or direct payments for personal care, as a percentage of the total number of adults needing care. *(Aim to increase)* NI-18	**63.4%**	63%	62.5%	64.4%	65.2%	58%	57%	64%	64%	63%	↑

Strategic Priority 2 - Working together with people to maintain their independence at home and in their local community											
Indicator	**2024/25**	**Current Target**	**2023/24**	**2022/23**	**2021/22**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
People reporting 'living where you/as you want to live' needs met (%) *(Aim to increase)*	**95%**	90%	91%	89%	89%	91%	88%	92%	84%	79%	↑
SDS (Options 1 and 2) spend as a % of total social work spend on adults 18+ (LGBF) *(Aim to increase)*	n/a	Data Only	**9.0%**	9.3%	8.86%	8.69%	8.44%	8.15%	7.5%	6.6%	↓
Percentage of people aged 65+ with intensive needs receiving care at home. (LGBF) *(Aim to increase)*	n/a	62%	**59.9%**	62.5%	64.4%	62.2%	57.6%	57.5%	62.5%	61.1%	↓
Percentage of those whose care need has reduced following re-ablement *(Aim to increase)*	**43%**	60%	63.9%	48%	60%	31%	67	68	62	64	↓

Strategic Priority 3 - Working together to support mental health and well-being											
Indicator	**2024/25**	**Current Target**	**2023/24**	**2022/23**	**2021/22**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
Mental health hospital admissions (age standardised rate per 1,000 population) *(Aim to decrease)*	n/a	2.3	**1.2**	1.2	1.2	1.4	1.6	1.5	1.5	1.5	-
Percentage of people waiting no longer than 18 weeks for access to psychological therapies *(Aim to increase)*	**87%**	90%	84%	75%	76%	74%	65%	54%	80%	56%	↑

Strategic Priority 3 - Working together to support mental health and well-being											
Indicator	**2024/25**	**Current Target**	**2023/24**	**2022/23**	**2021/22**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
Achieve agreed number of screenings using the setting-appropriate screening tool and appropriate alcohol brief intervention, in line with SIGN 74 guidelines. *(Aim to increase)*	**78**	419	568	173	0	5	33	93	331	468	↓
Percentage of people with alcohol and/or drug problems accessing recovery-focused treatment within three weeks. *(Aim to increase)*	**97%**	90%	93%	96%	95%	95%	89%	95%	87%	96%	↑

Strategic Priority 4 - Working together to meet people's healthcare needs by providing support in the right way, by the right person at the right time											
Indicator	**2024/25**	**Current Target**	**2023/24**	**2022/23**	**2021/22**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
People (18+) waiting more than 3 days to be discharged from hospital into a more appropriate care setting including AWI *(Aim to decrease)* (NHSGGC data)	**7**	**7**	**7**	8	7	2	2	4	4	4	-
People (18+) waiting more than 3 days to be discharged from hospital into a more appropriate care setting	**13**	11	15	11	12	7	5	6	5	6	↑

Strategic Priority 4 - Working together to meet people's healthcare needs by providing support in the right way, by the right person at the right time											
Indicator	**2024/25**	**Current Target**	**2023/24**	**2022/23**	**2021/22**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
including AWI (PHS data) *(Aim to decrease)*											
Acute Bed Days Lost to Delayed Discharge (Aged 18+ including Adults with Incapacity) *(Aim to decrease)* (MSG data)	**J-Dec 24 5,320***	1,893	5,132	4,625	4,546	2,342	1,788	2,284	1,860	2,704	↓
No. of A & E Attendances (All ages) *(Aim to decrease)* (NHSGGC data)	**22,642**	Data only	22,075	21,913	20,813	18,091	23,934	24,830	23,220	22,238	↓
Number of Emergency Admissions: Adults *(Aim to decrease)* (NHSGGC data)	**6,608**	Data only	6,595	6,185	7,372	6,217	6,859	6,801	6,916	6,908	↓
No. of A & E Attendances (adults) *(Aim to decrease)* (MSG data)	**J-Dec 24 18,414***	18,335	18,211	17,356	16,877	13,677	20,159	20,234	19,344	18,747	↓
Number of Emergency Admissions: Adults *(Aim to decrease)* (MSG data)	**J-Dec 24 7,139***	7,130	7,002	6,692	7,894	7,281	7,538	7,264	7,432	8,032	↓
Emergency admission rate (per 100,000 population) for adults *(Aim to decrease)* NI-12	**J-Dec 24 9,628***	11,492	9,634	9,215	9,414	9,210	10,441	10,345	10,304	11,427	↑
Emergency bed day rate (per 100,000 population) for adults *(Aim to decrease)* NI-13	**J-Dec 24 104,377***	117,000	106,610	108,721	108,448	97,806	106,296	110,749	120,265	121,099	↑
Emergency readmissions to hospital within 28 days of discharge (rate per	**J-Dec 24 70***	100	72	69	77	98	78	79	79	83	↓

Strategic Priority 4 - Working together to meet people's healthcare needs by providing support in the right way, by the right person at the right time											
Indicator	**2024/25**	**Current Target**	**2023/24**	**2022/23**	**2021/22**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
1,000 discharges) *(Aim to decrease)* NI-14											
A & E Attendances from Care Homes (NHSGGC data) *(Aim to decrease)*	**459 ****	Data only for 24/25	487	390	252	236	394	429	541	n/a	↑
Emergency Admissions from Care Homes (NHSGGC data) *(Aim to decrease)*	**254 ****	Data only for 24/25	248	188	141	154	233	261	338	166	↓
% of last six months of life spent in Community setting *(Aim to increase)* MSG	N/a	86%	**88.8%**	87.7%	89.4%	89.8%	88.3%	86.2%	85.0%	85.8%	↑

* Full year data not available for 2024/25. Provisional figure relates to 12 months Jan-Dec 2024. Data from PHS release, 7 May 2025

**In 2024 NHSGGC revised data for care home admissions and attendances to include previously omitted care homes. Target under review for these performance measures.

Strategic Priority 5 - Working together with people who care for someone ensuring they are able to exercise choice and control in relation to their caring activities											
Indicator	**2024/25**	**Current Target**	**2023/24**	**2022/23**	**2021/22**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
People reporting 'quality of life for carers' needs fully met (%) *(Aim to increase)*	**83.6%**	80%	84.5%	80%	92%	91%	92%	78%	72%	70%	–

Strategic Priority 5 - Working together with people who care for someone ensuring they are able to exercise choice and control in relation to their caring activities											
Indicator	**2024/25**	**Current Target**	**2023/24**	**2022/23**	**2021/22**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
Total combined % carers who feel supported to continue in their caring role *(Aim to increase)* NI 8	n/a	Data only	**28.4%**	n/a	28.4%	n/a	35.3%	n/a	37.5%	n/a	-

Strategic Priority 6 - Working together with our community planning partners on effective community justice pathways that support people to stop offending and rebuild lives											
Indicator	**2024/25**	**Current Target**	**2023/24**	**2022/23**	**2021/22**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
Community Payback Orders - Percentage of unpaid work placement completions within Court timescale. *(Aim to increase)*	**77%**	80%	89%	83%	81%	75%	71%	84%	92%	96%	↓
Criminal Justice Feedback Survey - Did your Order help you look at how to stop offending? *(Aim to increase)*	**82%**	100%	83%	100%	100%	92%	100%	100%	100%	100%	↓
% Positive employability and volunteering outcomes for people with convictions. *(Aim to increase)*	**68%**	60%	57%	67%	56.5%	66%	65%	55%	n/a	n/a	↑

Strategic Priority 7 - Working together with individuals and communities to tackle health inequalities and improve life chances.											
Indicator	**2024/25**	**Current Target**	**2023/24**	**2022/23**	**2021/22**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
Breastfeeding at 6-8 weeks most deprived SIMD data zones *(Aim to increase)*	n/a	25%	**13.1%**	19.2%	17.9%	7.5%	15.4%	22.9	27.3	17.2	
Premature mortality rate per 100,000 persons aged under 75. (European age-standardised mortality rate) *(Aim to decrease)* NI-11	n/a	Data Only	**275**	264	333	334	295	308	301	297	
Percentage of adults able to look after their health very well or quite well *(Aim to increase)* NI-1	n/a	Data Only	**92.7%**	n/a	92%	n/a	94%	n/a	94%	n/a	

Strategic Priority 8 - Working together with staff across the partnership to support resilience and well-being											
Indicator	**2024/25**	**Current Target**	**2023/24**	**2022/23**	**2021/22**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
% Staff who report 'I am given the time and resources to support my learning growth'. *(Aim to increase)*	**75%**	90%	77%	74%	75%	n/a	77%	76%	70%	n/a	
% Staff who report "I feel involved in decisions in relation to my job". *(Aim to increase)*	**72%**	Data Only	75%	71%	72%	n/a	n/a	69%	n/a	n/a	

Strategic Priority 8 - Working together with staff across the partnership to support resilience and well-being											
Indicator	**2024/25**	**Current Target**	**2023/24**	**2022/23**	**2021/22**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
% Staff who report "My manager cares about my health and well-being". *(Aim to increase)*	**88%**	Data Only	89%	85%	88%	n/a	n/a	85%	n/a	n/a	↓

Strategic Priority 9 - Protecting people from harm											
Indicator	**2024/25**	**Current Target**	**2023/24**	**2022/23**	**2021/22**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
% Change in women's domestic abuse outcomes *(Aim to increase)*	**92%**	85%	93%	90%	87%	84%	79%	64%	65%	66%	↓
People agreed to be at risk of harm and requiring a protection plan have one in place. *(Aim to increase)*	**100%**	100%	100%	100%	100%	100%	100%	100%	n/a	n/a	-

Organisational measures											
Indicator	**2024/25**	**Current Target**	**2023/24**	**2022/23**	**2021/22**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
Percentage of days lost to sickness absence for HSCP NHS staff *(Aim to decrease)*	**7.9%**	4.0%	8.3%	7.5%	6.9%	5.5%	7.3%	6.8%	8.5%	7.2%	↑

Organisational measures											
Indicator	**2024/25**	**Current Target**	**2023/24**	**2022/23**	**2021/22**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
Sickness absence days per employee - HSCP (LA staff) *(Aim to decrease)*	**14.5**	18.2	19.5	20.3	14.7	13.6	19.1	16.4	13.0	13.6	

4.3 National Integration Indicators

The Core Suite of 23 National Integration Indicators was published by the Scottish Government in March 2015 to provide the basis against which Health and Social Care Partnerships can measure their progress in relation to the National Health and Wellbeing outcomes. As these are derived from national data sources, the measurement approach is consistent across all Partnerships.

The Integration Indicators are grouped into two types of measures: 9 are based on feedback from the biennial Scottish Health and Care Experience survey (HACE) and 10 are derived from Partnership operational performance data. A further 4 indicators are currently under development by NHS Scotland Information Services Division (ISD). The following tables provide the most recent data for the 19 indicators currently reportable, along with the comparative figure for Scotland, and trends over time where available.

4.3.1 Scottish Health and Care Experience Survey (2023-24)

Information on nine of the National Integration Indicators are derived from the biennial Scottish Health and Care Experience survey (HACE) which provides feedback in relation to people's experiences of their health and care services. The most recent survey results for East Renfrewshire relate to 2023-24 and are summarised below.

The results show that we performed better than the Scottish average for eight of the nine indicators and performed close to the national rate for the remaining PI. Performance improved or remained the same for six of the indicators at the national level since the previous survey, and declined for three indicators.

National indicator	2023/24	Scotland 2023/24	2021/22	2019/20	2017/18	2015/16	East Ren trend from previous survey	Scotland trend from previous survey
NI-1: Percentage of adults able to look after their health very well or quite well	**92.7%**	90.7%	91.9%	94%	94%	96%	↑	↓
NI-2: Percentage of adults supported at home who agreed that they are supported to live as independently as possible	**80.4%**	72.4%	80.4%	78%	74%	80%	-	↓
NI-3: Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	**75%**	59.6%	73.8%	75%	64%	77%	↑	↑
NI-4: Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	**63.6%**	61.4%	65.1%	62%	60%	69%	↓	↓
NI-5: Total % of adults receiving any care or support who rated it as excellent or good	**74%**	70%	75.5%	70%	77%	82%	↓	↓
NI-6: Percentage of people with positive experience of the care provided by their GP practice	**74.9%**	68.5%	69.7%	85%	84%	88%	↑	↑
NI-7: Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	**89.6%**	69.8%	83.6%	78%	76%	79%	↑	↓
NI-8: Total combined % carers who feel supported to continue in their caring role	**28.4%**	31.2%	28.4%	35%	37%	45%	-	↑
NI-9: Percentage of adults supported at home who agreed they felt safe	**79.5%**	72.7%	90.5%	81%	82%	82%	↓	↓

Data from PHS release, 7 May 2025. Latest available survey data relates to 2023/24.

4.3.2 Operational performance indicators

National indicator	2024/25	Scotland 2024/25	2023/24	2022/23	2021/22	2020/21	2019/20	2018/19	2017/18	2016/17	Trend from previous year
NI-11: Premature mortality rate per 100,000 persons	n/a	442	**275**	264	338	334	259	308	301	297	↓
NI-12: Emergency admission rate (per 100,000 population) for adults	**J-Dec 24 9,628 ***	**J-Dec 24 11,445 ***	9,634	9,215	9,414	9,210	10,439	10,345	10,497	11,427	↑
NI-13: Emergency bed day rate (per 100,000 population) for adults	**J-Dec 24 104,377 ***	**J-Dec 24 109,822 ***	112,251	108,721	108,448	96,914	105,544	110,0628	119,011	121,099	↑
NI-14: Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges)	**J-Dec 24 70 ***	**J-Dec 24 103 ***	72	68	77	98	78	79	79	83	↑
NI-15: Proportion of last 6 months of life spent at home or in a community setting	**J-Dec 24 89% ***	**J-Dec 24 89.4% ***	88.8%	88.2%	89.5%	89.8%	88%	86%	85%	86%	↑
NI-16: Falls rate per 1,000 population aged 65+	**J-Dec 24 24.2 ***	**J-Dec 22.4 ***	24.7	24.1	25.1	21.5	22.6	23.4	22.4	21.2	↑
NI-17: Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	n/a	**XX** (Latest year for scot av?)	89.3%	86.9%	79.0%	84%	84%	84%	88%	88%	↑
NI-18: % of adults with intensive care needs receiving care at home	**J-Dec 24 63% ***	**J-Dec 24 64.7% ***	63.4%	65.0%	62.0%	58.4%	57.1%	63.6%	63.3%	58.0%	↓

NI-19: Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	**315**	**952**	397	415	342	189	156	170	117	228	
NI-20: Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	n/a	24% (2019/20)	n/a	n/a	n/a	n/a	**20.9%**	20.8%	22.4%	22.2%	

Data from PHS release, 7 May 2025.
*Full year data not available for 2024/25. Provisional figure relates to 12 months Jan-Dec 2024.

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

National indicators in development
NI-10: Percentage of staff who say they would recommend their workplace as a good place to work
NI-21: Percentage of people admitted to hospital from home during the year, who are discharged to a care home
NI-22: Percentage of people who are discharged from hospital within 72 hours of being ready
NI-23: Expenditure on end of life care, cost in last 6 months per death

4.4 Ministerial Strategic Group Indicators

A number of indicators have been specified by the Ministerial Strategic Group (MSG) for which cover similar areas to the above National Integration Indicators.

MSG Indicator	2024/25	Target 24/25	2023/24	2022/23	2021/22	2020/21	2019/20	2018/19	2017/18	2016/17	2015/16	Trend from previous year
Number of emergency admissions (adults)	n/a	7,130	**7,002**	6,564	6,767	6,517	7,538	7,264	7,432	8,032	7,922	↓
Number of emergency admissions (all ages)	n/a	8,331	**8,079**	7,847	7,860	7,281	8,645	8,246	8,513	9,199	9,123	↑
Number of unscheduled hospital bed days (acute specialties) (adults)	n/a	57,106	**70,723**	70,064	67,267	58,333	62,861	60,953	62,967	62,901	58,271	↓
Number of unscheduled hospital bed days (acute specialties) (all ages)	n/a	58,899	**72,613**	72,458	67,136	59,593	59,764	64,407	64,769	64,455	60,064	↓
A&E attendances (adults)	n/a	18,335	**18,211**	17,355	16,877	13,697	20,159	20,234	19,344	18,747	18,332	↓
A&E attendances (all ages)	n/a	25,299	**25,671**	25,202	24,270	17,843	27,567	27,850	27,011	25,888	25,300	↓
Acute Bed Days Lost to Delayed Discharge (Aged 18+ including Adults with Incapacity)	n/a	1,893	**5,132**	4,652	4,546	2,342	1,788	2,284	1,860	2,704	2,366	↓
% of last six months of life spent in Community setting (all ages)	n/a	86%	**88.8%**	87.7%	89.5%	89.8%	88.3%	86.2%	85.0%	85.8%	85.6%	↑
Balance of care: Percentage of population at home (supported and unsupported) (65+)	n/a	Data only	**96.8%**	96.8%	96.7%	96.6%	96.5%	95.9%	95.8%	95.7%	95.6%	-
Balance of care: Percentage of population at home (supported and unsupported) (all ages)	n/a	Data only	**99.2%**	99.2%	99.2%	99.1%	99.2%	99.0%	99.0%	99.0%	99.0%	-

Latest data from PHS release, 27 March 2025. (MSG Indicators)

4.5 Inspection performance

East Renfrewshire HSCP delivers a number of in-house services that are inspected by the Care Inspectorate. The following table show the most up to date grades as of March 2025.

Service	Date of Last Inspection	How well do we support people's wellbeing?	How good is our leadership?	How good is our staff team?	How good is our setting?	How well is care and support planned?
Adoption Service CS2004082369  Adoption.pdf	06/02/2025	5 (very Good)	Not assessed	Not assessed	Not assessed	5 (Very Good)
Bonnyton House CS2003045155  InspectionReport-317155.pdf	26/09/2023	4 (Good)	4 (Good)	Not assessed	Not assessed	Not assessed
Care at Home CS2005096979  Care at Home.pdf	30/01/2025	4 (good)	3 (Adequate)	4 (Good)	Not assessed	3 (Adequate)
Community Pathways CS2003000808  InspectionReport-318885 (2).pdf	25/03/2024	5 (Very Good)	5 (Very Good)	Not assessed	Not Assessed	Not Assessed

Fostering Service CS2004082421 Fostering.pdf	06/02/2025	5 (Very Good)	Not assessed	Not assessed	Not assessed	5 (Very Good)
HSCP Adult Placement Centre CS2017357290 Adult Placement.pdf	06/02/2025	5 (very Good)	Not assessed	Not assessed	Not assessed	5 (Very Good)
	Date of Last Inspection	**How good is our care, play and learning?**	**How good is our leadership?**	**How good is our staff team?**	**How good is our setting?**	
HSCP Holiday Programme CS2003003951 Holiday Programme.pdf	26/07/2022	5 (Very Good)	4 (Good)	5 (Very Good)	5 (Very Good)	

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

Service	**Date of Last Inspection**	**Evaluation of the impact on children and young people**			**Inspection Report**
Joint Inspection of adult support and protection	June 2023				East Renfrewshire adult support and pro

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

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

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

Evaluation of quality indicator 2.1: Excellent

4.6 Use of Directions during 2024-25

Directions are the means by which the Integration Joint Board tells the Health Board and Local Authority what is to be delivered using the integrated budget and for the IJB to improve the quality and sustainability of care, as outlined in its strategic commissioning plan. Directions are a key aspect of governance and accountability between partners. Directions issued in 2024-25 are given below.

March 2025	Budget 2025/26	ERC	Direction issued to East Renfrewshire Council to carry out each of the functions listed within the Integration Scheme in a manner consistent with: the existing policies of the Council and any relevant decisions of the Council in relation to the revenue budget; and with the Integration Joint Board's strategic plan.
March 2025	Budget 2025/26	NHS	Direction issued to NHSGGC to carry out each of the functions listed within the Integration Scheme in a manner consistent with: the existing policies of the Council and any relevant decisions of the Council in relation to the revenue budget; and with the Integration Joint Board's strategic plan.

Appendix One - National Outcomes

The National Health and Wellbeing Outcomes prescribed by Scottish Ministers are:

1. People are able to look after and improve their own health and wellbeing and live in good health for longer.
2. People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
3. People who use health and social care services have positive experiences of those services, and have their dignity respected.
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
5. Health and social care services contribute to reducing health inequalities.
6. People who provide unpaid care are supported to look after their own health and wellbeing, including support to reduce any negative impact of their caring role on their own health and wellbeing.
7. People using health and social care services are safe from harm.
8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
9. Resources are used effectively and efficiently in the provision of health and social care services.

The National Outcomes for Children are:

- Our children have the best start in life and are ready to succeed.
- Our young people are successful learners, confident individuals, effective contributors and responsible citizens.
- We have improved the life chances for children, young people and families at risk.

The National Outcomes for Criminal Justice are:

- Prevent and reduce further offending by reducing its underlying causes.
- Safely and effectively manage those who have committed offences to help them reintegrate into the community and realise their potential for the benefit of all.

Appendix Two - East Renfrewshire Health & Social Care Partnership - Health and Care (Staffing) (Scotland) Act 2019: Annual Report

Declaration

Name of local authority / integration authority: East Renfrewshire Health & Social Care Partnership

Report authorised by:

Name: Julie Tomlinson

Designation: Chief Nurse

Date: 1st June 2025

Details of where the report will be published:

https://eastrenfrewshire.gov.uk/integration-joint-board

Information Required

1. Please detail the steps you have taken as an organisation to comply with section 3(2) of the Health and Care (Staffing) (Scotland) Act 2019:

ERHSCP has included the following care services, as defined in the Health and Care (Staffing) (Scotland) Act 2019 that have been planned and secured within the relevant reporting period (April 2024 – March 2025):

Route	No. of Services Planned & Secured
Direct award of social care contracts without prior advertisement	1
Extension/modification of existing social care contracts	1

In planning and securing these services, ERHSCP has taken account of the general principles of the Health and Care (Staffing) (Scotland) Act 2019. ERHSCP has also taken into account of the duties relating to staffing imposed on care service providers by virtue of subsection 3(1) and sections 7 to 10 of the Health and Care (Staffing) (Scotland) Act 2019.

ERHSCP has robust governance processes in place with each care service noted above being subject to the East Renfrewshire's Standing Orders on Contracts and Scheme of Delegation.

Each service is subject to approval by the Directorate Management Team following submission of a detailed proposal paper. Prior to submission to Directorate Management Team proportionate due diligence checks are undertaken by Commissioning, Operational, and Finance staff within ERHSCP to ensure that the proposed service meets the needs of service users while being sustainable.

Following approval by Directorate Management Team, submission to the Council's Cabinet or relevant Committee may also be required as directed by the Standing Orders on Contracts.

Commissioning staff will work with service providers to ensure that the commencement of the service is undertaken with appropriate, safe and effective

staffing in place. Services are subject to contract management through the HSCP's Contract Management arrangements which has been aligned with the duties under the Health and Care (Staffing) (Scotland) Act 2019.
The Commissioning staff have close working relationships with provider organisations and out with formal contract monitoring visits, there can be multiple points of contact with providers in a period of a week. Each point of contact represents an opportunity to discuss any issues which may be impacting upon a provider's ability to deliver services effectively and to improve outcomes for individuals.

2. Please detail any ongoing risks that may affect your ability to comply with the duty set out in section 3(2) (as specified above)

The duties under the Act remain relatively new and guidance and practice in relation to staffing for both providers and integration authorities continue to evolve. Further guidance on a consistent approach to the Act, including the reporting duty, would be welcome. ERHSCP has mature and well embedded processes for obtaining staffing information from providers but, where required, this could be enhanced through improved information sharing between statutory partner organisations (e.g. Care Inspectorate) while avoiding duplication in roles and responsibilities.

The current financial context for East Renfrewshire IJB and the cost pressures facing local commissioned providers is projected to require further difficult decisions to be made regarding overall health and social care service provision. Recent changes to National Insurance with uncertainty about equivalent funding has added to these pressures.

Recruitment issues within social care have been prominent for some time and continue to inhibit the ability of the market to respond to the requirements for services. Ongoing challenges in staff recruitment and retention in commissioned services may lead to a reliance on agency staffing models, with potential impact on (i) the continuity of care for service users and residents and (ii) the benefit to individuals outcomes which derives from strong relationships and understanding with staff.