AGENDA ITEM No.8

EAST RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

East Renfrewshire Council

NHS Greater Glasgow and Clyde

Meeting of East Renfrewshire Health and Social Care Partnership **Held on**	Integration Joint Board 27 June 2018
Agenda Item	8
Title	Annual Performance Report 2017/18

Summary

This report advises the members of the Integration Joint Board of the development of the Annual Performance Report for the Health and Social Care Partnership for 2017/18. This year is the final year of the current strategic plan and the second Annual Performance Report. The Annual Performance Report is a high level report and more detail of local targets and activities is available in the Health and Social Care Partnership Implementation Plan Performance Report for 2017/18

Presented by	Candy Millard Head of Adult Health and Social Care Localities

Action Required

The Integration Joint Board is asked to

- Note and comment on the contents of the report
- Remit the Chief Finance Officer to include relevant financial information from the Annual Accounts into the Annual Performance Report.
- Remit the Head of Adult Health and Care Localities to update information on National Indicators when available into the Annual Performance Report.
- Approve the final report being shared with East Renfrewshire Council and NHS Greater Glasgow and Clyde
- Remit the Chief Officer to work with the Communications Team to consider a range of media to engage with the public, illustrate performance and disseminate the Performance Report for the statutory deadline of 31 July 2018.

Implications checklist – check box if applicable and include detail in report

☐ Finance/Efficiency	☒ Policy	☒ Legal	☒ Equalities
☐ Risk	☐ Staffing	☐ Property/Capital	☐ IT

EAST RENFREWSHIRE INTEGRATION JOINT BOARD

27 JUNE 2017

Report by Chief Officer

ANNUAL PERFORMANCE REPORT 2017/18

PURPOSE OF REPORT

1. This report advises the members of the Annual Performance Report for the Health and Social Care Partnership for 2017/18.

RECOMMENDATION

2. The Integration Joint Board is asked to:-
   - Note and comment on the contents of the report.
   - Remit the Chief Finance Officer to include relevant financial information from the Annual Accounts into the Annual Performance Report.
   - Remit the Head of Adult Health and Care Localities to update information on National Indicators when available into the Annual Performance Report.
   - Approve the final report being shared with East Renfrewshire Council and NHS Greater Glasgow and Clyde.
   - Remit the Chief Officer to work with the Communications Team to consider a range of media to engage with the public, illustrate performance and disseminate the Performance Report for the statutory deadline of 31 July 2018.

BACKGROUND

3. The Public Bodies (Joint Working) (Scotland) 2014 Act requires each Integration Authority to publish a Performance Report for each reporting year setting out an assessment of performance in planning and carrying out the integration functions for which they are responsible. The report must be published by 31 July. 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).

4. 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.
   - Details of any review of the strategic plan.

REPORT

5. This year is the final year of the current strategic plan and the second Annual Performance Report. The Annual Performance Report is a high level report and more detail of local targets and activities is available in the Health and Social Care Partnership Implementation Plan Performance Report for 2017/18.

6. The report is set out under the National Health and Wellbeing Outcomes as well as those for Criminal Justice and Children and Families. Each section has an overview of national performance indicators, community planning and East Renfrewshire Council indicators and NHSGGC indicators. The sections also give an overview of work undertaken to deliver the strategic planning priorities with some additional data where relevant.

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

8. The national outcome measures are based on survey feedback available every 2 years from a national survey of people taken from a random sample based on GP practice populations. These people have not necessarily used HSCP services. Since the survey was last carried out in 2015, both the questions and the weightings used to calculate the percentages have been reviewed and updated. This has changed some of the reporting of results. For example, analysis has shown that older people are more likely to report a positive experience and we know that older people are also more likely to respond to the survey, the new weightings adjust for this.

9. The HSCP collects local data of people who have used our services and supports. This is included in the report as it is collected throughout the year and can be tracked over a longer time period. We believe better reflects outcomes achieved by the Health and Social Care Partnership.

10. The national organisational measures are taken from data that is collected across the health and care system for other reasons. If the measure is shown in grey we do not yet have data but will update this as soon as it is available to us. (Due to be released by ISD on 26 June 2017). 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.

11. We have also included in the report information about our performance on the key local indicators and targets we have agreed with East Renfrewshire Council (ERC) and NHS Greater Glasgow and Clyde (NHS GGC).

12. There are additional sections:
    - On Locality Planning giving an overview of the Community Led Support locality conversations and the development of GP clusters.
    - On our hosted Learning Disability Inpatient service.
    - On the review of the Strategic Plan for 2015-18.

13. The data in the report is the most up to date local and national data available. A further update on the core suite of integration indicators is expected from ISD before the statutory report deadline. This should enable end of year performance data for the majority of indicators highlighted in grey in the report to be included in the finalised report.

FINANCE AND EFFICIENCY

14. This report in its current format relates to health and social care performance. A separate Annual Accounts Report is on the agenda. Following approval of these reports the Chief Finance Officer will incorporate the relevant financial end of year performance information into the Annual Performance Report.

CONSULTATION AND PARTNERSHIP WORKING

15. The Annual Performance Report reflects the work of the Health and Social Care Partnership throughout 2017/18. Through our Strategic Plan we make a commitment to working together:
    - With individuals as partners in planning their own care and support.
    - With carers and families as partners in the support they provide to the people they care for. We will ensure the supports carers and families can sometimes require themselves are recognised.
    - With communities as partners in shaping the care and supports available and in providing opportunities for people to get involved in their communities.
    - With organisations across sectors, including our Community Planning partners and the Third Sector. We will work in partnership to co-commission, forecast, prioritise and take action together.

16. There are multiple examples of this commitment in action throughout the report.

IMPLICATIONS OF THE PROPOSALS

Staffing

17. One of the national outcomes is '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. There is a section in the report on this outcome.

Legal

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

Equalities

19. The Integration planning and delivery principles include a requirement that Integration Joint Boards:
    - Take account of the particular needs of different service-users.
    - Takes account of the particular needs of service-users in different parts of the area in which the service is being provided.
    - Take account of the particular characteristics and circumstances of different service-users.
20. There are examples of this throughout the report.

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

CONCLUSIONS

22. The Annual Performance Report is the second 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. The Annual Performance Report is a high level report and more detail is provided in the Implementation Plan Report for 2017/18.

RECOMMENDATIONS

23. The Integration Joint Board is asked to:-
    - Note and comment on the contents of the report.
    - Remit the Chief Finance Officer to include relevant financial information from the Annual accounts into the Annual Performance Report.
    - Remit the Head of Adult Health and Care Localities to update information on National Indicators when available into the Annual Performance Report.
    - Approve the final report being shared with East Renfrewshire Council and NHS Greater Glasgow and Clyde.
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REPORT AUTHOR AND PERSON TO CONTACT

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June 2018

HSCP Chief Officer: Julie Murray

BACKGROUND PAPERS

http://www.gov.scot/Resource/0047/00473516.pdf

Annual Performance Report 2016/17

East Renfrewshire Health and Social Care Partnership

Annual Performance Report

2017/18

Introduction to East Renfrewshire Health and Social Care Partnership Julie Murray, Chief Officer

In East Renfrewshire we have been leading the way in integrating health and care services. Our Community Health and Care Partnership (CHCP), between East Renfrewshire Council and NHS Greater Glasgow and Clyde, was established in 2006. Our Partnership has always managed a much wider range of services than is required by the legislation. Along with community health and care services, we provide health and social care services for children and families and criminal justice social work. Over the last ten years our integrated health and social care management and staff teams have developed strong relationships with many different partner organisations.

Our new Health and Social Care Partnership (HSCP) was established in 2015 under the direction of East Renfrewshire's Integration Joint Board, has been able to build on this successful foundation. This is the final year of our first Strategic Plan than ran from 2015- 2018 and this is our second full annual performance plan.

In our Strategic Plan we set out our partnership vision of how we will achieve this

Working together with the people of East Renfrewshire to improve lives

by:

Valuing what matters to people

Building capacity with individuals and communities

Focusing on outcomes, not services

Our commitment to working together is:

With individuals - as partners in planning their own care and support.

With carers and families - as partners in the support they provide to the people they care for. We will ensure the support carers and families can sometimes require themselves are recognised.

With communities - as partners in shaping the care and support available and in providing opportunities for people to get involved in their communities.

With organisations - across sectors, including our Community Planning partners and the Third Sector. We will work in partnership to co-commission, forecast, prioritise and take action together.

With our staff - as partners in developing and delivering our vision, valuing their knowledge, skills and commitment to health and social care.

Background to the report and performance measures

This annual performance report gives us an opportunity to demonstrate how we have delivered on our vision and commitments over 2017/18. It provides information about the progress we are making towards achieving the national outcomes for children, the national health and wellbeing outcomes, and criminal justice outcomes. (A full list is provided in Appendix1).

Along with performance data the report highlights some of the work carried out during 2017/18 to deliver our strategic priorities, and put in practice the Integration Planning and Delivery Principles (a full list is provided in Appendix 2).

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

The national outcome measures are based on survey feedback available every 2 years from a national survey of people taken from a random sample based on GP practice populations. These people have not necessarily used HSCP services. Since the survey was last carried out in 2015, both the questions and the weightings used to calculate the percentages have been reviewed and updated. This has changed some of the reporting of results. For example, analysis has shown that older people are more likely to report a positive experience and we know that older people are also more likely to respond to the survey, the new weightings adjust for this.

The HSCP collects local data from people who have used our services and supports. This is included in the report as it is collected throughout the year and can be tracked over a longer time period. We believe better reflects outcomes achieved by the Health and Social Care Partnership.

The national organisational measures are taken from data that is collected across the health and care system for other reasons. It is the most up-to-date as released by ISD in June 2017, but may not represent the full end year position as some of the data completion rates are not yet 100%.

We have also included in the report information about our performance on the key local indicators and targets we have agreed with East Renfrewshire Council (ERC) and NHS Greater Glasgow and Clyde (NHS GGC).

This report contains the most up to date information available. If the measure is shown in grey we do not yet have data for 2017/18 but will update his as soon as it is available to us.

Children and Young People's Outcomes (Early Years)

- Our children have the best start in life and are ready to succeed
- Parents provide a safe, healthy and nurturing environment

NHSGGC Indicator	ER HSCP 2017/18	Target	ER HSCP 2016/17
Percentage of children meeting developmental milestones at 27-30 month child health review	84%	85%	82%
Local East Renfrewshire Council Indicator	**2017/18**	**Local Target**	**2016/17**
Children in kinship care remaining in their community	91%	75%	100%

Our performance on giving children the best start is very good, but we are committed to supporting the wellbeing and success of all our children. Our East *Early Years Strategy* focuses on the youngest members of our population and their families in order to address inequalities at the earliest stage of life. This chapter gives some examples of the ways we are developing positive ways of engaging with communities, families and individuals that build on their strengths; and how we and our partners are providing targeted interventions to those families most in need of support.

New Sir Harry Burns Centre in Auchenback

This year we opened a new centre which is both a replacement for Arthurlie Family Centre, but more importantly a "community hub", where parents and local people are able to access multiple services supporting children, families and communities to secure better outcomes for themselves. The centre was co-designed with the community of Auchenback and complements existing community facilities and activities whilst providing opportunities for front line staff from all agencies and partners to come together and work in new ways with the people of Auchenback.

The centre is named in honour of Sir Harry Burns, his work nationally and internationally, his leadership of the approaches which we continue to develop in East Renfrewshire and his support for our work on a local level.

Extending our Family First Worker Initiative

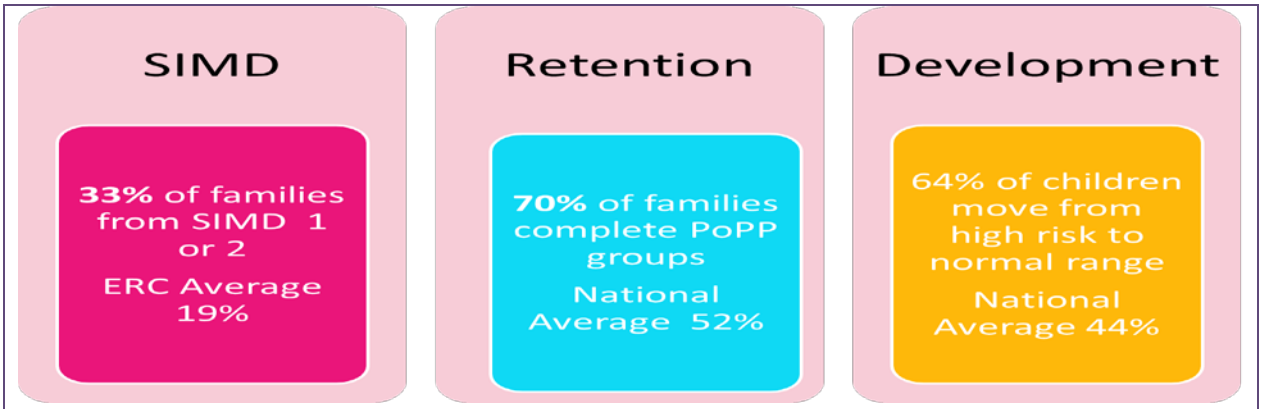
Family First is a service that was introduced as part of or Early Years Strategy to support families who need a little bit of help. Families have received support to deal with a range of parental stressors before they escalate into more complex issues. By intervening early we aim to prevent the need for statutory help in the future.

Family First workers have benefitted from intensive training with East Renfrewshire Council's educational psychological service. This has increased their skills in motivational interviewing, solution focused approaches, and building resilience.

Each year Family First reach more families across our communities with a focus on– Auchenback, Dunterlie, Neilston, Thornliebank, Busby and Newton Mearns.

Delivering effective parenting programmes

We continue our commitment to the Psychology of Parenting Project (PoPP). The project offers two high quality, evidence-based programmes - Triple P and Incredible Years. 22 trained practitioners from the HSCP and Education delivered PoPP programmes to 85 families. 86% of children improved developmental milestone scores, compared to 79% last year.



Reflecting upon these findings, the National Director of PoPP commended several factors considered to be significant contributors to these outcomes:

- ***Strong PoPP Implementation Team, and the management support of this team***
- ***PoPP Coordinator – Early Years Prevention Officer***
- ***Communication across the many layers within the CPP involved in this work***
- ***Fidelity with which the two programmes are delivered***
- ***Local commitment to the PoPP implementation plan***
- ***Strong organisational support across East Renfrewshire for this work***

Children and Young People's Outcomes (Health and Wellbeing)

- Our young people are successful learners, confident individuals, effective contributors and responsible citizens
- Children and young people are healthy, active and included

National Indicator	ER HSCP 2017/18	Scottish Average 2017/18	ER HSCP 2016/17
Rates of stillbirths per 1,000	-	4.3	4.6
Infant mortality rate per 1,000	-	3.3	1.2
Percentage of children exclusively breastfed at 6 - 8 weeks	38.3%	-	40.5%
Dental Registration 3-5 years	89.5%	-	90%
Percentage of obese children in Primary 1	-	-	4.2%
Local NHS GGC Indicator	**2017/18**	**Local Target**	**2016/17**
Percentage of children exclusively breastfed at 6 - 8 weeks in areas of greatest inequality	27.5%	29.3%	16.8%
MMR Uptake 24 months	95.4%	95.0%	96.9%
MMR uptake 5 years	95.9%	95%	98.6%
18 week referral to treatment for specialist Child and Adolescent Mental Health Services	88.8%	-	90%

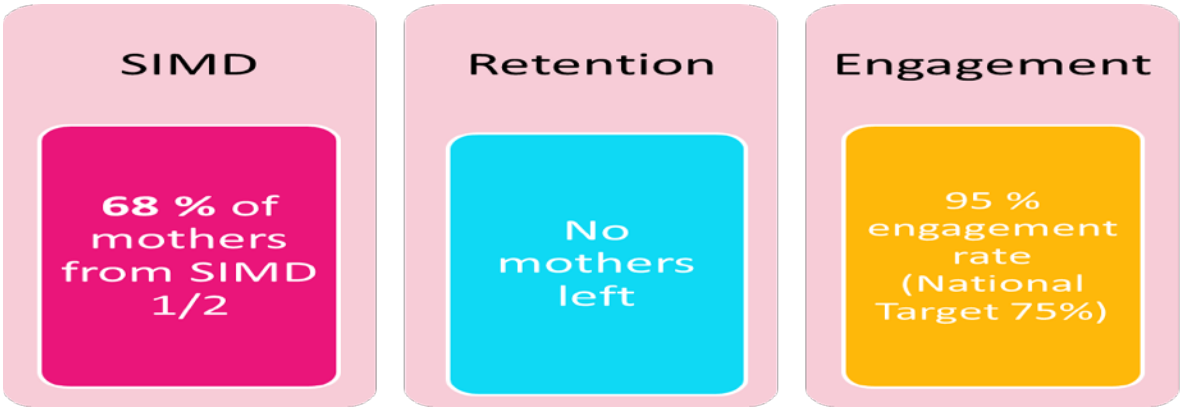
Overall children and young people in East Renfrewshire experience good health in comparison with the rest of Scotland. Uptake of immunisation and registration with local dental services is good.

Health in pregnancy, and the quality of the care giving babies receive during the first years of life, can have a long lasting impact on a child's future health, happiness, relationships and achievement of their aspirations. This chapter gives some examples of how we support new parents and also the work we have started with partners and families to try to improve the mental health and wellbeing of our young people.

Family Nurse Partnership

The Family Nurse Partnership (FNP) is a voluntary home visiting programme for first time young mums, aged 19 or under (and dads). A specially trained family nurse visits the young mum regularly, from early in pregnancy until the child is two. The Family Nurse Partnership is a preventive programme and has the potential to make a significant difference to all the families in the programme.

FNP recruited their first cohort of 19 young parents in East Renfrewshire between 1 August 2014 and 11 September 2015. This group of parents have now graduated from the scheme.



Supporting Breastfeeding

Accredited as Baby Friendly by unicef

Exclusive breastfeeding rates within East Renfrewshire have remained relatively stable over the last three to four years, but breastfeeding in our most deprived areas was considerably below the rest of East Renfrewshire.

Following the test of change reported last year, breastfeeding rates at 6-8 weeks in our 15% most deprived data zones have increased to 27.5%. This is close to target and shows that improvement activity is starting to have some impact.

Childhood Immunisation

In October 2017 the HSCP established a Community immunisation clinic was in Barrhead Health and Care Centre for pre 5's. Childhood immunisation data to date (ISD) indicates that the high local uptake rates have been maintained. We will continue to monitor this closely across all stages.

Improving Young People's Mental Health and Wellbeing

The Integration Joint Board recognised that many East Renfrewshire children and young people are presenting at GP services with requests for support around anxiety, depression, and distress. Parents expressing worry about the wellbeing of children and young people have been calling upon specialist and clinical services such as CAMHS, or Educational Psychology to respond. These services are becoming overwhelmed often inappropriately which in turn is resulting in long delays before help is offered.

The HSCP decided to test an alternative approach, a Family Wellbeing Service, to support these children and young people who present with a range of significant mental and emotional wellbeing concerns. Children 1st have been commissioned to deliver this Test of Change since September 2017.

The Family Wellbeing Service works with the with the HSCP to deliver a service based across 2 GP surgeries to;

- Improve the emotional wellbeing of children and young people aged 8 – 16
- Reduce the number of inappropriate referrals to CAMHS and other services
- Support appropriate and timely recognition of acute distress in children and young people accessing clinical help if required
- Improve family relationships and help build understanding of what has led to the distress and concerns
- Engage, restore and reconnect children and young people with school and their wider community

Evaluation mechanisms are in place to track and report on impact. Early indications suggest the service is having a positive impact and improving outcomes for the users. Feedback from stakeholders is hugely positive especially GPs and schools.

Post diagnostic support

The HSCP introduced a programme in October 2016 providing autism post diagnostic support for parents of children and young people aged 7-18yrs.

- 69 parents participated in 9 courses delivered in partnership with Barnardo's.
- On average parental rating improved by 1.5 points on a 5 point scale from 2.4 to 3.9 (2.0- some confidence and 4.0 – mostly confident)

"This has helped to reduce my daughter's distress/anxiety"

"*Walking out of a meeting where your child has been diagnosed feels a little like being set out to sea with no supplies or resources to navigate home. This course gave me insight, hope and above all a dedication to succeed with a newly gained understanding*"

Children and Young People's Outcomes (Life Chances)

- We have improved the life chances for children, young people and families at risk
- Children are protected

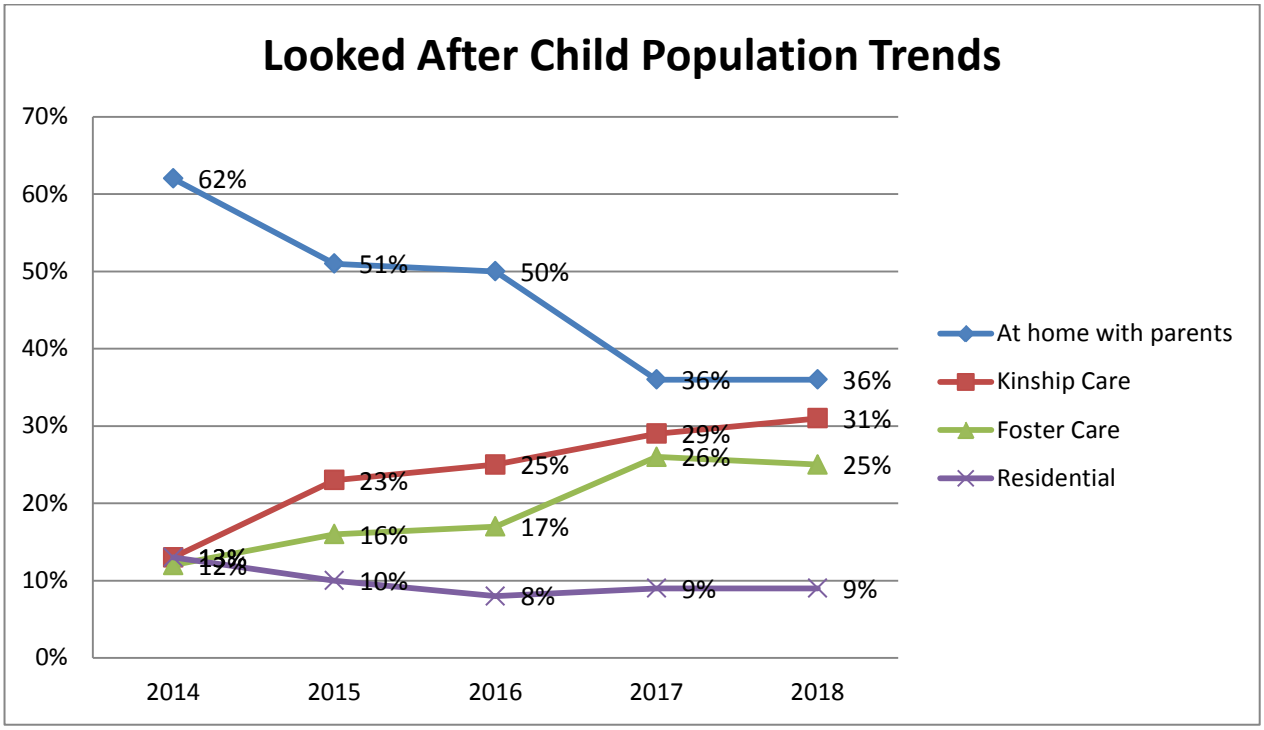
National Indicator		ER HSCP 2017/18	Scottish Average 2017/18	ER HSCP 2016/17
	Percentage of children being looked after in the community	92.7%	-	91.5%
Local East Renfrewshire Council Indicator		2016/17	Local Target	
	Percentage of children looked after away from home who experience 3 or more moves	1.2%	11.0%	7.1%
	Percentage of child protection re-registrations within 12 months of de-registration		17%	14.7%
	Percentage of positive Viewpoint review responses 'Do you feel safe at home?'	91%	90%	85%

We continue to perform well in keeping children safe in their local community wherever possible and acting quickly to make decisions. Thorough this work and work with our care experienced young people we aim to improve life chances.

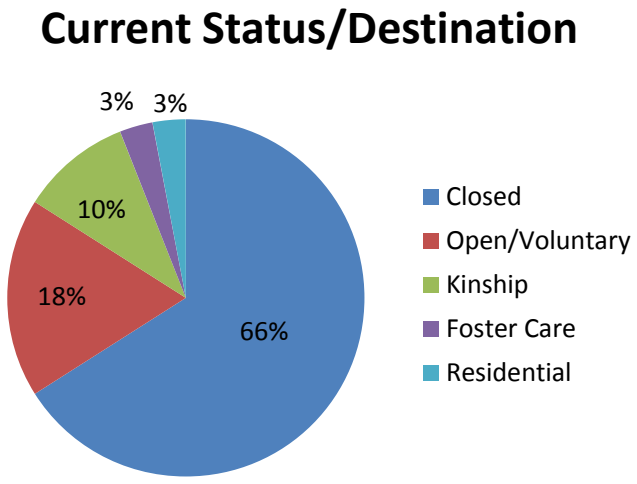
Through PACE (Permanence and Care Excellence) we have a positive joint working, commitment to change and a developing 'common understanding' of permanence across the whole system. We have streamlined our processes to ensure that children, young people and their families/carers are included throughout the process in decision making and care planning.

We have achieved 100% for each PACE aim to date

- ***By 31st October 2017 all children looked after and accommodated before 1st April 2017, will have a LAC review that makes a permanence decision.***
- ***From 1st April 2017, any child accommodated will wait no longer than 6 months for a LAC review to make a permanence decision.***



At the start of 2016 we had 146 looked after children, 80 of which were at home (55%). At March 2018, this has reduced to 115 looked after children, 40 of which are at home (35%). Although the overall data shows a 50% reduction of children looked after at home, in reality 102 children/young people came off orders at home over the 2 year period.



Of the 102 who came off orders over the 26 month period:

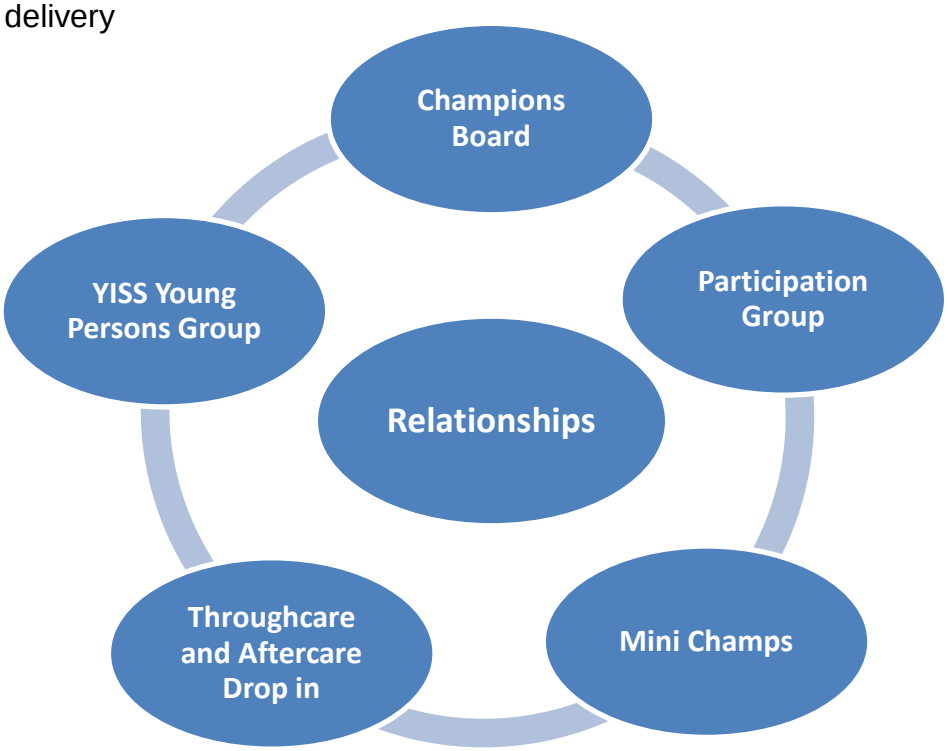
- 67 cases are now closed,
- 7 have moved to kinship carers
- 3 to foster care
- 3 to residential
- 22 open on a voluntary basis.

Of the 67 cases that were closed to social work only 44% had further contact with RFA, and all were signposted/given advice guidance, none were re-opened or re-allocated to social work.

50% of the children whose orders ended were on the order for a year or less, meaning that our interventions were effective and there were appropriate early reviews to end the order without it running for the full year.

Developing partnerships with care experienced young people through East Renfrewshire Champions Board

The overall aim of East Renfrewshire Champions Board is to improve the life chances of care experienced young people within the wider community. Our approach has been to involve as many of our looked after young people in activity based programmes and consultation exercises with their views directly filtered into shaping service delivery



36% of young people have participated in engagement activity over the last 12 months. According to Life Changes Trust research the average for engagement is 10% across Scotland

Our Corporate Parents are committed to listening and making a difference

Our Champions Board, which consists of our young care experienced champions and some older champions (the Corporate Management Team and elected members) and social workers from our Youth Intensive Support Service continues to go from strength to strength. The first theme around mental health has generated actions including recruitment of new staff and training across departments.

The Champions Board undertakes team building and regular planning together.

The trip wasn't all outdoor activities and had a much more serious side, as we all prepared for the formal champions meeting the next day. The canoeing helped with team building and we followed up with a session where we worked on the issues that the young people identified. Housing is a particularly big issue for young people coming out of care and we focused on that.

National Wellbeing Outcome 1 (Health Improvement)

- People are able to look after and improve their own health and wellbeing and live in good health for longer

National Indicator		ER HSCP 2017/18	Scottish Average 2017/18	ER HSCP 2016/17
1	Percentage of adults able to look after their health very well or quite well	94%	93%	96% (2015/16)
11	Premature mortality rate per 100,000 persons		441	297
Local East Renfrewshire Council Indicator			Local Target	
	Uptake of community and leisure health improvement programmes	460	440	460
	Citizens reporting taking part in physical activity	91%	80%	85%

Overall people in East Renfrewshire are healthier than the rest of Scotland, and are more physically active. This is reflected in the national survey result although it is lower than we might have expected. The HSCP Health Improvement Team in partnership with many council and community planning services actively promote health and wellbeing, increasing people's skills and access to healthy lifestyles.

Increasing people's awareness and skills to improve health and well being

The Health Improvement Team promote self-help and information campaigns throughout the year via face to face events, social media and information resources. Information about self-help and community support is provided via the 'Your Voice' Bulletin which sent directly to individuals on our database and also available in public places and online. Information materials and health campaign information are also available in Eastwood Health and Care Centre and in other local public and community facilities

During 2017/18 Health Improvement have delivered and co-ordinated a range of training and information sessions to build staff/partner capacity to address health behaviour and raise awareness of health related issues. Topics included sexual health, breastfeeding awareness, Childsmile training, mental health, breast health, bowel screening, cancer screening for people with additional needs, second hand smoke training, smokefree training for the Fire Service, health behaviour change training and physical activity

Working in partnership to tackle public health priorities

ER Tobacco Alliance have developed and implemented an action plan that addresses the key issues relating to the harm caused by tobacco. This includes supporting people to stop smoking through community and pharmacy cessation services, protecting children from second hand smoke through raising public awareness of the harm caused by second hand smoke and awareness of smoking in cars legislation. The plan also covers sales of illicit tobacco/underage and proxy purchasing, personal safety e.g. fires caused by cigarettes, education to prevent the uptake of tobacco by young people. Health Improvement have also worked with local community groups and partners to promote smoke free play areas and community events is commissioned by the Health and Social Care Partnership and NHS GCC to deliver the Live Active GP referral programme, which encourages people with a range of medical conditions to participate in exercise and healthy lifestyles. The HSCP funded a post with ERCLT to develop a range of activities with older people in mind.

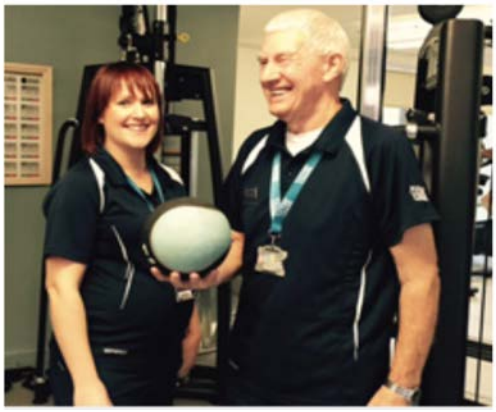
As you add years to your life, let us help you add life to your years.

Tai Chi
Tai Chi combines deep breathing and relaxation with slow and gentle movements. It's the perfect combination to help you exercise your body and mind.

Walking Group
A friendly, sociable walking group, suitable for all levels.

Art Classes
We offer a range of art classes, suitable for all abilities and interests. Develop your skills and creativity in a fun, friendly environment.

Vitality Classes
If you are living with a medical condition or have difficulties with mobility, our Vitality programme is just what you need. We offer gentle exercise for different ability levels.



Supervised fitness sessions
Our Live Active advisors are experts at guiding people from being inactive to active. You can do this, with our help, at supervised gym or fitness classes. Groups are small and very friendly.

Singing Group
Share a song sing-a-long, led by music loving library staff. Cuppa and chat are included and you don't even need to be able to sing well!

National Wellbeing Outcome 2 (Living Independently)

- 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.

National Indicator		ER HSCP 2017/18	Scottish Average	ER HSCP 2016/17
2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	74%	81%	83% (2015/16)
3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	64%	76%	78% (2015/16)
12	Emergency admission rate (per 100,000 population)	9,791	11,959	11,408
13	Emergency bed day rate (per 100,000 population)	104,990	115,518	117,592
14	Re-admission to hospital within 28 days (per 1,000 population)	72	97	82
15	Proportion of last 6 months of life spent at home or in a community setting	86%	88%	86%
18	Percentage of adults with intensive care needs receiving care at home	63% (2016/17)	61% (2016/17)	58% (2015/16)
Local East Renfrewshire Council Indicator		2017/18	Target	2016/17
	Self-Directed Support spend on adults as percentage of total social care spend on adults		-	6.63%
	Percentage of people reporting 'living where you want to live' needs fully met at review.	87%	81%	79%
	Percentage of people aged 65+ who live in housing rather than a care home or hospital	96.6%	97%	96.8%
Local NHS GGC Indicator		2017/18	Target	2016/17
	Delayed discharge: people waiting more than 72 hours to be discharged from hospital	5	0	5

Whilst the national survey information shows a poorer performance on living independently our local indicators and other national performance indicators have improved. This chapter contains many examples of the work we are doing to increase independence, choice and control and get people home from hospital.

Working with people early to help them stay independent

One of our strategic priorities has been the expansion of our telecare programme. Through active promotion of the service, new marketing materials implemented and refreshed web pages including online application, 1600 additional citizens have benefitted from Telecare over the course of the 3 year national T

Throughout 2017 we have been increasingly working in partnership with other teams and organisations.

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2017 has seen us introduce:

- New web pages where you can find information about our service www.eastrenfrewshire.gov.uk/tec
- The opportunity to make an online enquiry or referral to our team (accessible via the above webpage)
- A "Welcome Pack" to introduce new customers to our service

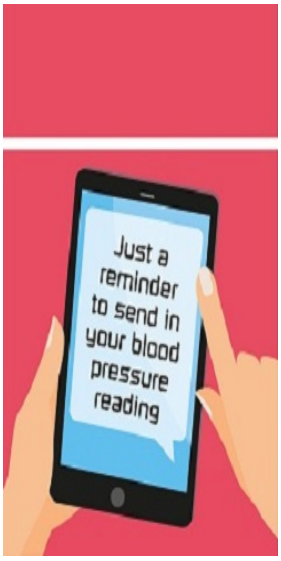
Prevention team
0141 577 3782
www.eastrenfrewshire.gov.uk/prevention

With East Renfrewshire Prevention Team who offer advice and practical assistance to beat doorstep crime and financial scams, in addition to providing call blockers to prevent nuisance calls.

SCOTTISH FIRE AND RESCUE SERVICE
Working together for a safer Scotland

With Scottish Fire & Rescue Service who offer home safety visits to provide fire and general safety advice. We provide smoke detectors linked to our telecare and Safety Net service.

Our Telehealth system is now established in 9 GP practices. 160 patients have benefitted from Home Health Monitoring with 90 face to face appointments saved. The system checks readings against a patient's personal profile and responds by sending advice based on this or alerting a health professional if appropriate.

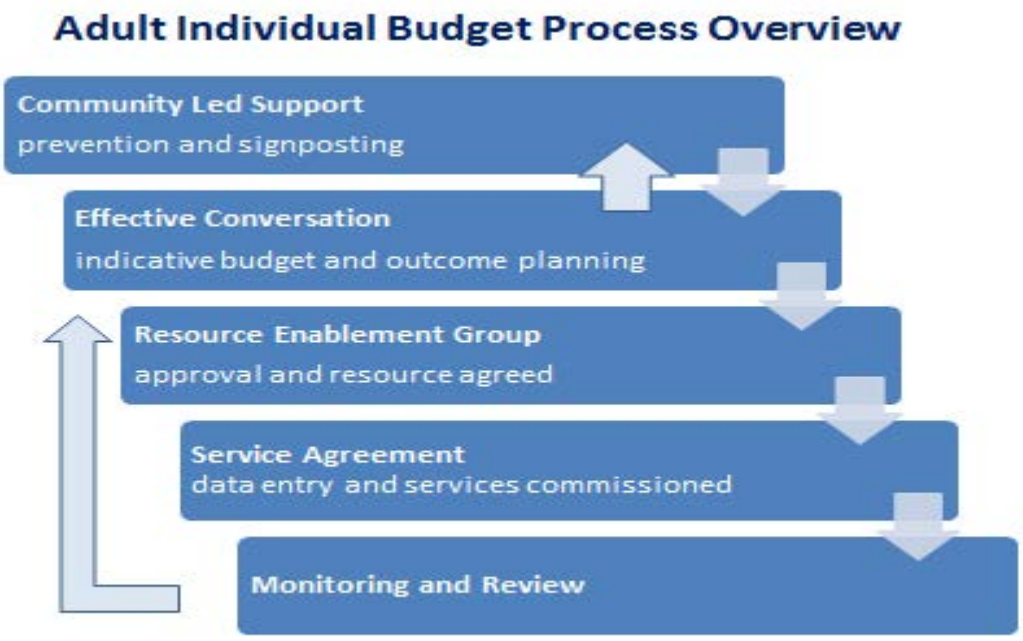


Changes planned for 2018:

- A new way of doing our initial and annual review visits
- A small increase in the cost of the service from £2.20 to £2.30 per week from April 2018
- Trialling of new everyday technology to see how this could be used to help people in their day to day lives.

Developing a new way of planning with people who need support so that they have choice and control over their lives

Our current (adult) method of resource allocation basis is on equivalency. The equivalency model uses an hourly value of care cost as the basis of calculation of the individual budget for a support package. Over 2017/18 we have been reviewing this approach and considering a new method for agreeing and individual budget that fits with our new ways of planning with people and allows more innovation and flexibility to meet their desired outcomes.



The 'just enough support' individual budget calculator wil be used for a modest one off intervention through to a complex care package. This removes the barriers and potential inequity of traditional eligibility criteria and recognises the importance of prevention. We are testing the individual budget calculator against desktop reviews of a number of existing care packages. This will allow us to ensure we have corect the weightings against each section before we roll out across adult care.

Using the just enough support budget as a guide the worker and the person can develop a costed plan of support and take this to the Resource Enablement Group for final approval.

The approved support agreement will then be entered to Care Finance. This takes the administration function away from operational services and with one point of data entry will mean consistent information is maintained.

Roles and Remits

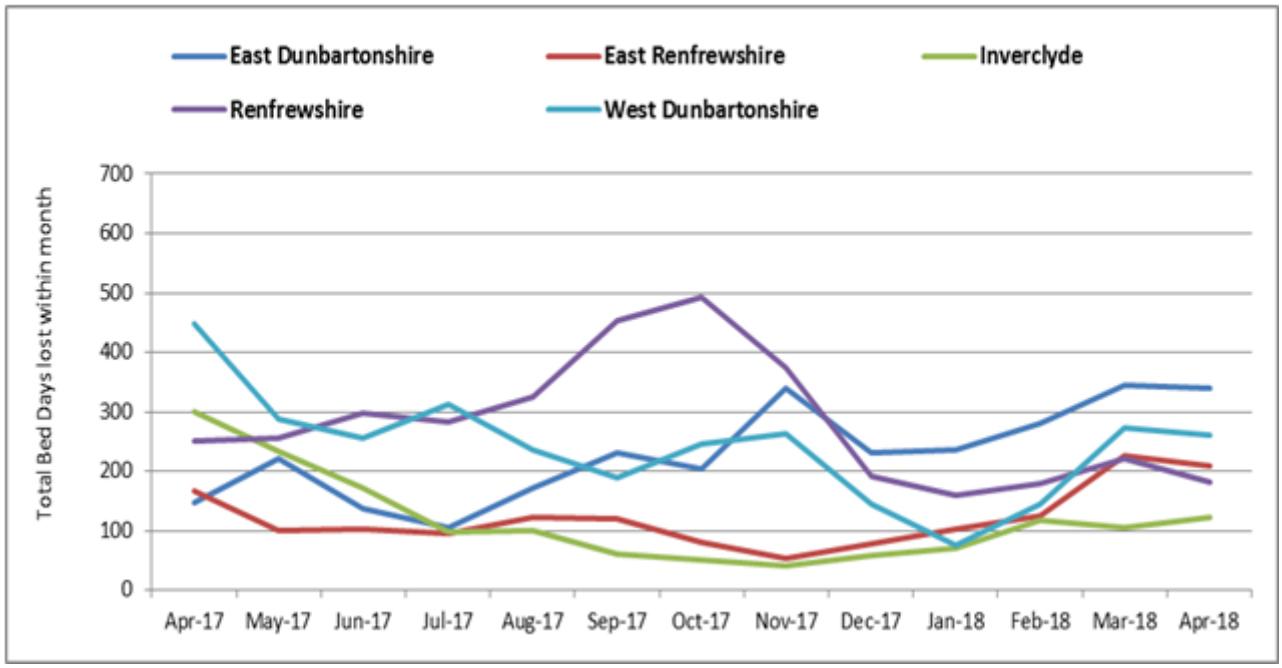
- Allow social work to focus on professional skills and individual outcomes
- Finance Support Office role to support and advise and undertake financial assessments
- Service agreement entry centralised and facilitated

Safe and Supported- improving pathways for people going into and coming home from hospital

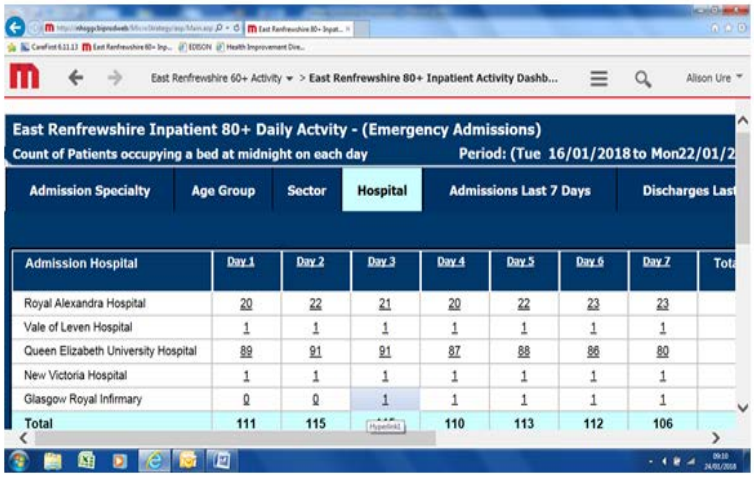
Our ‘Safe and Supported’ workstream, established last year, used improvement methodology to support groups of staff, clinicians, users , carers, third and independent sector representatives to consider what we could do differently at various points in people’s journey to and from hospital.

Through the Safe and Supported programme, various posts have been created to improve journeys from hospital to home. This includes a hospital connector role, medicines reconciliation and additional community resource to support discharge. We are seeing some of the results of this work, particularly in reaching into hospital and getting people back home.

Our performance benchmarked well locally on delayed discharge bed days

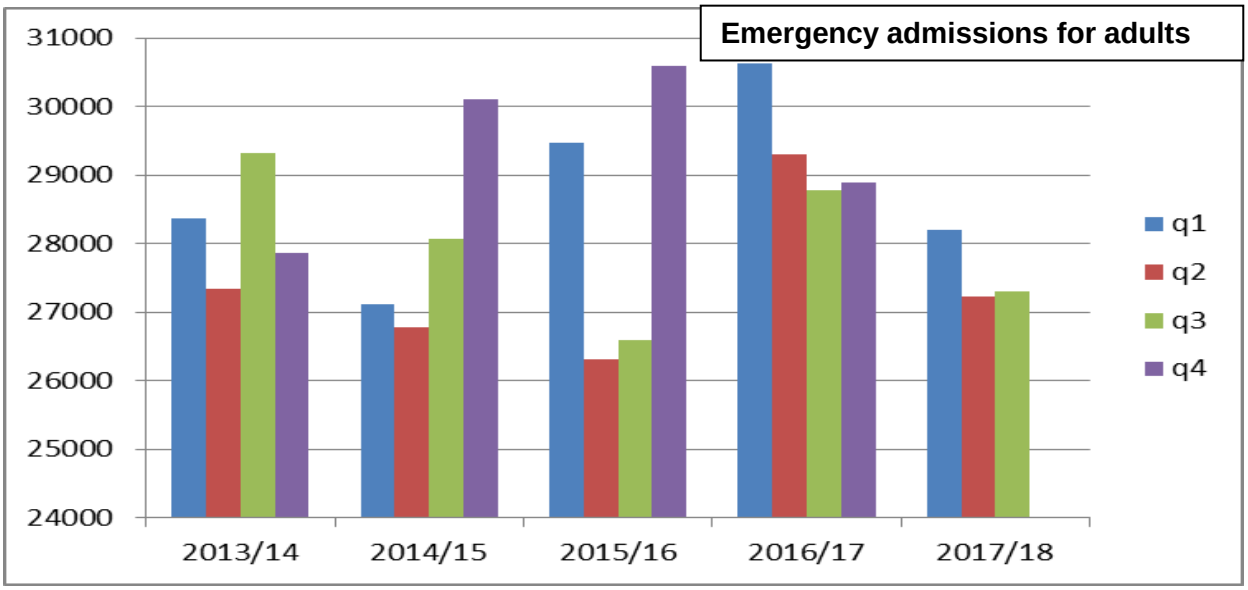


We use data to identify and intervene earlier



This year we worked with Information Services to develop a tool that provides information about local people admitted to hospital enabling staff to engage earlier to plan for discharge. This will be used to develop our new hospital to home arrangements in 2018/19.

East Renfrewshire is part of the complex NHS Greater Glasgow and Clyde acute hospital system. In August 2017 we agreed a new structure to ensure integrated working at a strategic and operational level between the Acute Division of the Board and HSCPs. This includes Sector Delivery groups working on a geographic basis as well as a GGC overview group. Through these groups we have been implementing and updating our unscheduled care plans, with a view to learning across the system and rolling out successful tests of change. We are seeing a slight decrease in emergency admissions as a result of our work with colleagues in local hospitals but there is still work to do to ensure people do not attend hospital unless they absolutely need to.



The National Falls Team, HSCP Falls Leads and Scottish Ambulance Leads have worked together to develop and implement pathways to be used by paramedic crews attending people who have fallen at home. This work aims to prevent conveyance to hospital (unless there is an identified medical need) by providing a clear process to directly refer a patient to community services.

The HSCP commissioned an independent report to understand the issues faced by our partners that lead to admissions and readmissions from care homes. The team talked to all 13 local care home managers, a number of local GPs and HSCP nursing staff. Care homes completed a detailed return about incidents and admissions over a two-week period to look for any trends and potential to avoid admissions.

The recommendations from this piece of work will be taken forward in 2017/18.

National Wellbeing Outcome 3 (Experience of Health and Care Services)

- People who use Health and Social Care services have positive experiences of those services, and have their dignity respected

National Indicator		ER HSCP 2017/18	Scottish Average	ER HSCP 2016/17
4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	60%	74%	69%
5	Total % of adults receiving any care or support who rated it as excellent or good	77%	80%	83%
6	Percentage of people with positive experience of the care provided by their GP practice	84%	83%	89%
17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections		85%	88%
Local East Renfrewshire Council Indicator		2017/18	Target	2016/17
	People reporting 'being respected' needs fully met at review	98%	96%	95.5%
	Citizen panel percentage of service users rating health and social care services as very good/good	76%	92%	77%

Whilst the national survey information shows a much lower performance on experience of health and care, our local indicators do not reflect such a change. This chapter contains many examples of the work we are doing to increase independence, choice and control and get people home from hospital and ensure that people have a positive contact with our Health and Social Care Partnership.

Over the course of this strategic plan we have been working with local people, community groups and organisations to design a different and easy way to access support and information. We call this our new 'front door'.

We have reviewed our first point of contact / request for assistance team.

Business support staff are being trained and supported to take on a greater signposting and information giving role. This will enable good conversations that focus on what matters to the caller to take place from the very first contact with us.

Ensuring dignity through valuing what matters to people

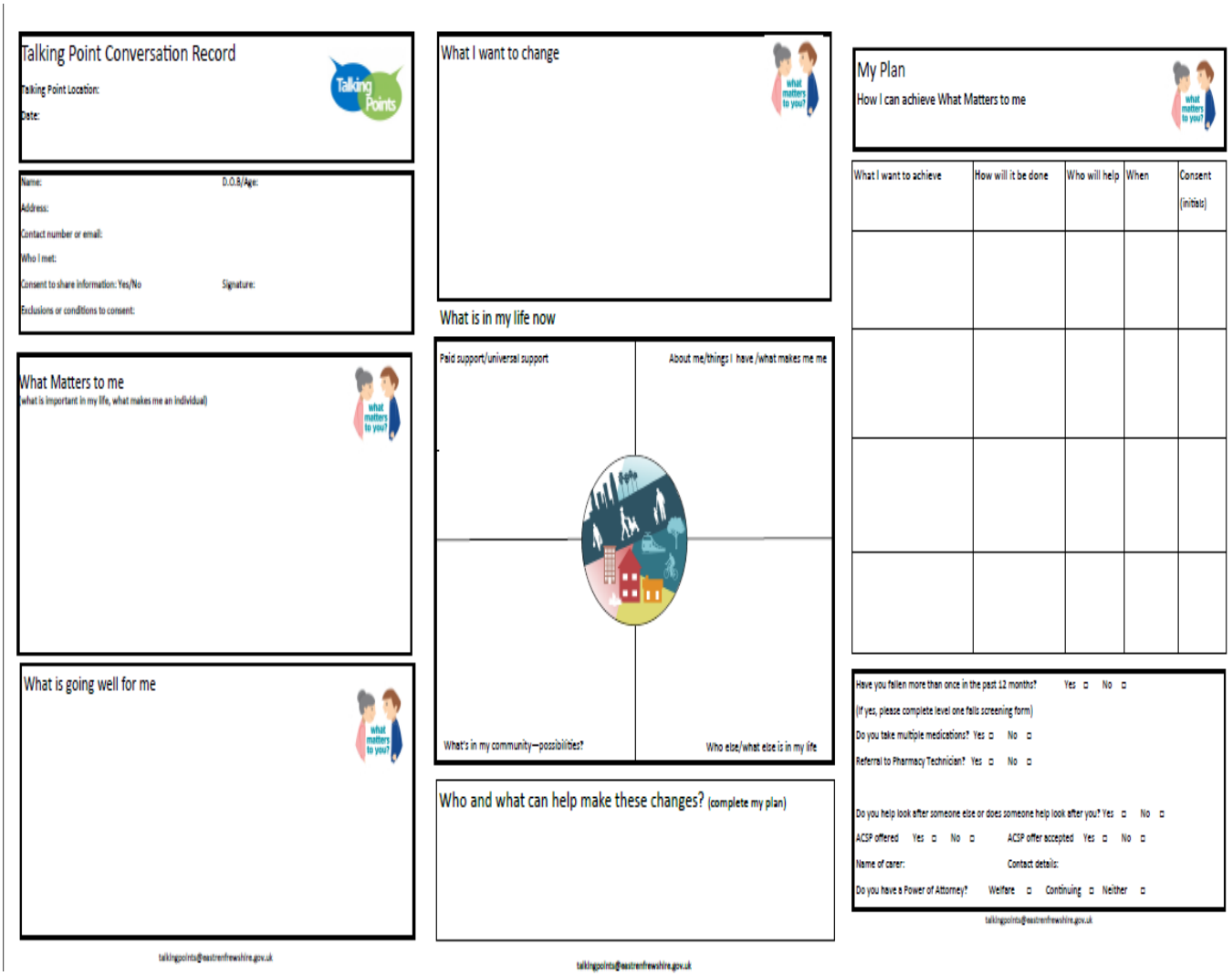
As part of the Community Led Support programme we have offered a series of good conversations training courses for anyone who will be, or would like to be, involved in helping local people understand and access community, health, social care or council support in the future.

Good Conversations

- Introduction to helping people explore what matters most to them about their current situation, think about how they want their life to be (their 'outcomes') and plan how to use all the resources available to them
- Training was delivered in partnership with HSCP & Voluntary Action between April and November 2017
- 19 courses with a total of 297 people attending from a variety of organisations and teams
- Further training is planned and will include a wider range of staff and community partners

In addition to training. Information materials and changes to the Eastwood Health and Care Centre Information Zone promote talking points and person centred conversations.

Person centred planning tools have been shared and staff supported in their use. We have updated our enquiry forms, records of conversations and planning documents


Talking Point Conversation Record

Talking Point Location:

Date:

Name: D.O.B/Age:

Address:

Contact number or email:

Who I met:

Consent to share information: Yes/No Signature:

Exclusions or conditions to consent:

What Matters to me
(what is important in my life, what makes me an individual)

What is going well for me

talkingpoints@eastrenfrewshire.gov.uk

What I want to change

What is in my life now

Paid support/universal support

About me/things I have /what makes me me

What's in my community—possibilities?

Who else/what else is in my life

Who and what can help make these changes? (complete my plan)

talkingpoints@eastrenfrewshire.gov.uk

My Plan
How I can achieve What Matters to me

What I want to achieve	How will it be done	Who will help	When	Consent (initials)

Have you fallen more than once in the past 12 months? Yes ☐ No ☐
(If yes, please complete level one falls screening form)
Do you take multiple medications? Yes ☐ No ☐
Referral to Pharmacy Technician? Yes ☐ No ☐

Do you help look after someone else or does someone help look after you? Yes ☐ No ☐
ACSP offered Yes ☐ No ☐ ACSP offer accepted Yes ☐ No ☐
Name of carer: Contact details:
Do you have a Power of Attorney? Welfare ☐ Continuing ☐ Neither ☐

talkingpoints@eastrenfrewshire.gov.uk

National Wellbeing Outcome 4 (Quality of Life)

- Health and Social Care services are centred on helping to maintain or improve the quality of life of people who use those services

National Indicator		ER HSCP 2017/18	Scottish Average	ER HSCP 2016/17
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	76%	80%	82% (2015/16)
16	Falls rate per 1,000 population aged 65+	21	22	21
19	Number of days people spend in hospital when they are ready to be discharged (per 1,000 population) (75+)	119	228	209
Local East Renfrewshire Council Indicator			Target	
	Percentage of those whose care need has reduced following reablement.	61.5%		64%
	Percentage of people reporting having things to do' needs fully met at review	85%		66%
	Percentage of people reporting 'seeing people' needs met	91%		76.4%
Local NHS GGC Indicator		2017/18	Target	2016/17
	18 week referral to treatment for psychological therapies	80%	95%	52%
	Clients will wait no more than 3 weeks for appropriate drug and alcohol treatment that supports their recovery	90.0%	95%	98.2%
	Primary care mental health team (% of patients referred to 1st appointment offered <4weeks)	35%	100%	Data unavailable
	Primary care mental health team waits (% of patients referred to 1st treatment appointment offered <9 weeks)	30%	100%	33%

Whilst the national outcome survey shows a lower percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life, this is not reflected in our local data from people using our services and supports.

This chapter contains an overview of some of the ward winning and innovative work being carried out in East Renfrewshire to support people with learning disability to have active and meaningful lives. We also report on our reablement work, which is working with more people supporting them to regain their skills and therefore requiring less care from formal services. Working to support people in their recovery is well advanced for people recovering from drug and alcohol addiction, and we have made a good start for people experiencing poor mental health. Our current model of primary care mental health is not working well but our test of change using GP link workers has been well received and indicates that we may need to change our model of support for people experiencing anxiety, stress or depression.

Extending access to reablement service for older adults and people with long term conditions

Transition to reablement by default model is now in final stages. We have worked with providers on our Care at Home Framework to develop and implement specific geographical zones for homecare, supporting providers to recruit and retain staff and improving the consistency of care delivered to service users. Discussions have commenced with in house reablement staff to discuss changes to work patterns, shift start times and finish times to meet new service requirements.

Together we will agree what goals we are working to achieve. We will then work with you to:

- Support you to achieve these goals
- Help you to manage tasks on your own

Improving your mobility

Being able to see friends and family

How long will it last?

The **reablement service** is a short term service that provides support for up to six weeks. During this time you will have regular reviews to see how well you are progressing.

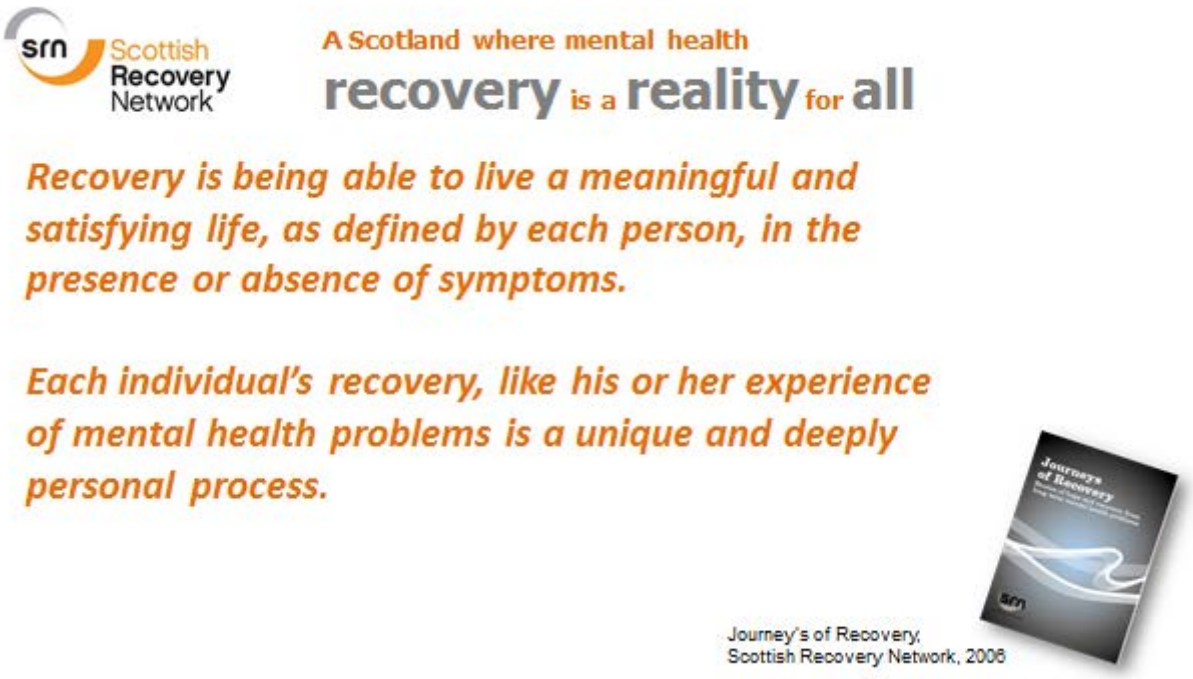
Feeling safe and in control

How does the Reablement Service differ from traditional homecare?

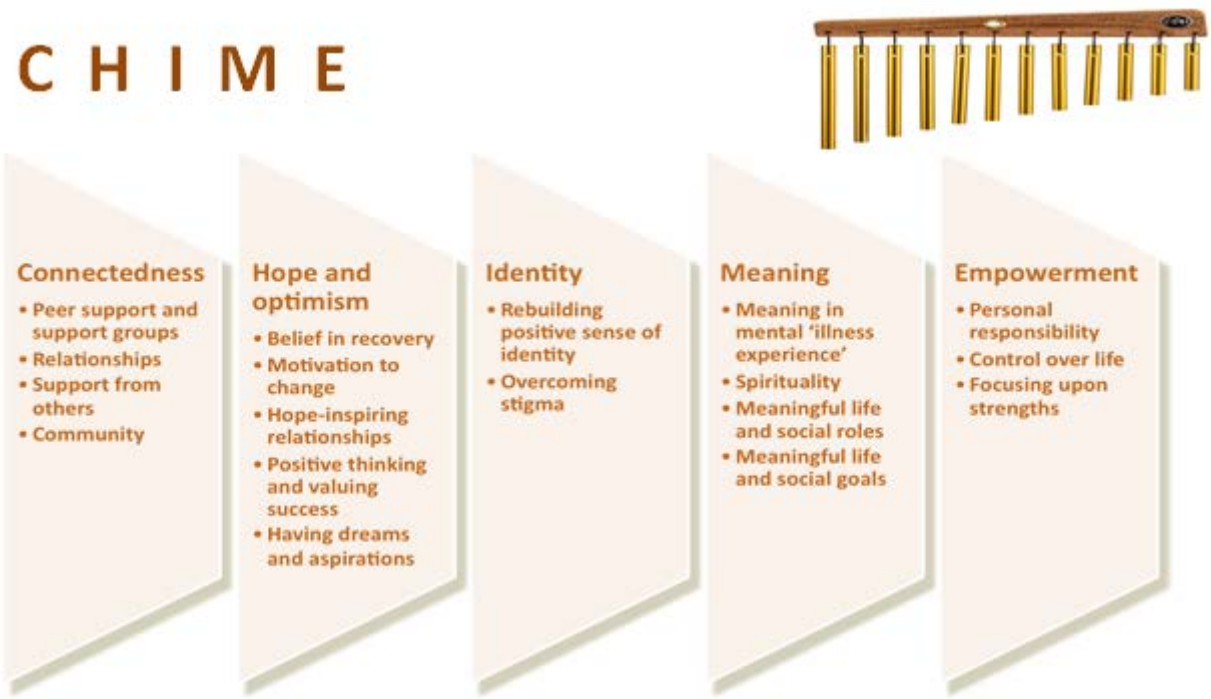
In traditional home care someone visits and does tasks for you. With the **Reablement Service** the team works with you, so that you learn (or re-learn tasks you need for everyday life. Many people find that after the **Reablement Service** they are able to manage on their own, without the need for continuing social care support.

Helping people plan for their mental health recovery

We have engaged with the Scottish Recovery Network and they have facilitated two events: Local Recovery Conversation and Keeping Mentally Healthy.



The next step is to ask practitioners to identify a group of individuals that they think may be most ready to "move on" given the right support and then doing some work with these people to help them identify what helps them maintain good mental health and what would support them in their recovery.



Recovery Focused Questions

- **Future Focused**
  What do you think needs to change in your life?
- **Goal Setting**
  What would make your life better/more enjoyable?
- **Relationship-focused**
  Who has helped you in the past?
- **Strengths Focused**
  When did you last have fun? What makes you happy?
- **Exception**
  What parts of your life just now are you happy with ?
- **Partitioning**
  What do you think is the first thing you need to do?

Ask more questions about what people did/enjoyed/were good at before they became unwell.

Find out what would make the most difference in the person's life.

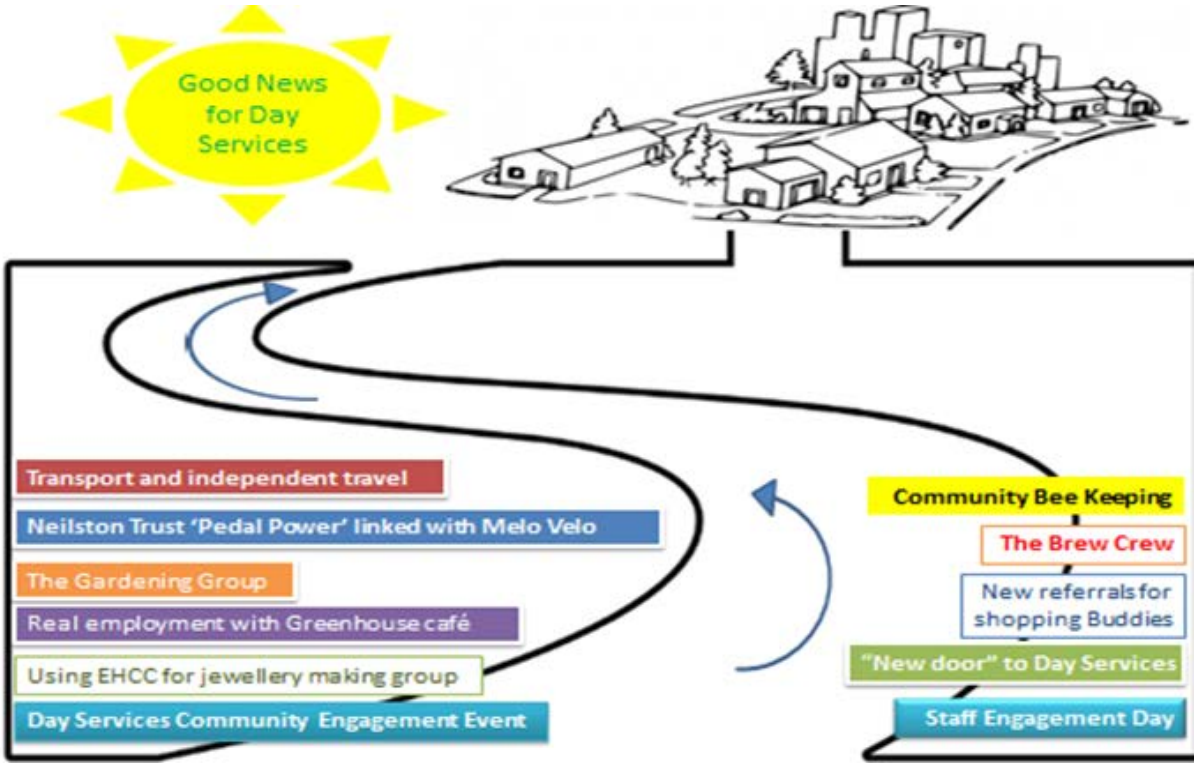
Acknowledge that it's OK to feel low but that does not mean that everything is bad and that things will never

Being prepared to take risks and recognise that people can recover even if they still experience symptoms.

Promoting recovery from drug and alcohol addiction

We continue to actively support and promote the development of recovery communities and peer support/mutual aid. PARTNER – People Achieving Recovery Together in East Renfrewshire' have established a new evening mutual aid group in Barrhead. They have been successful in a community funding bid to support the ongoing development of the group. They are working with Alcohol Focus Scotland on a new unique community engagement project called PHOTO Vox. Training on Photo vox is planned for May 2018.

Supporting people to engage in meaningful activities and make a positive contribution to their communities



What's been happening for people with learning disability …….

Real employment with Greenhouse café

The Green House is a Community Interest Company that runs the café in Eastwood Health and Care Centre. The Greenhouse offers employment training and opportunities for adults from our school sector and from other groups of individuals with additional support needs. These individuals are often underrepresented within conventional training/learning and employment sectors. The Greenhouse is now an SQA accredited training centre and the first cohort of individuals have received their SQA certificates.

The Brew Crew

The Brew Crew provides skills, training and experience to people who wish to move on to employment opportunities at the Greenhouse Café. The programme of learning is tailored to each person's ability and needs. The Brew Crew offers experience of what a working environment is like and also of the quality expected in catering environment. The training that is provided to volunteers is an essential step in their development to potentially progress to the Greenhouse café. We have provided over 30 short term placements for individuals since we have started the project. We also link to Isobel Mair School to provide work experience.

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The Gardening Group

The Gardening group have increase their garden maintenance service from 1 sheltered housing complex to 8 sheltered housing complexes across East Renfrewshire. This has increased to 4 days due to demand. The group provide regular maintenance to the staff area on the roof top of Eastwood Health and Social care building. They have started to take referrals from members of the public unable to undertake gardening maintenance themselves.

Using EHCC for jewellery making group

The jewellery group work in conjunction with the charity Poppy Scotland. They raised over £900 last year with the making of poppy brooches and sourced orders. They work in partnership with voluntary action and other organisations to provide experiences for volunteers. They have recently, with their connections, been able to provide someone with a job opportunity within a Jewellery supply shop.

New referrals for shopping Buddies

Shopping Buddies is a service offered to people in the community who are housebound and require some support with their weekly shopping. This initiative has been hugely successful in building natural networks and has recently won an award and featured on STV https://vimeo.com/album/5185408/video/271078790

Transport and independent travel

Day services continue to promote alternative to traditional transport. Initiatives include the use of electric cars for some routes and new independent travel programmes to support the use of public transport and active encouragement of use of personal vehicles through Motability. Of course we understand that for some people this is not an option and we remain committed to providing transport solutions for them when required. We have currently reduced the amount of large vehicles with a mixture of smaller vehicles, Caddy's, transporters, which mean that people and be being picked up and taken directly to their activity venue or meeting, rather than going to a day centre building.

And for older people more get together opportunities in local communities

As a result of which …….

- 70% said they felt less isolated.
- 90% said they felt happier.
- 80% said they felt more positive.
- 74% said they were doing more things

"He has enjoyed coming very much, I have enjoyed getting that little bit of time to myself, many thanks"

National Wellbeing Outcome 5 (Health Inequalities)

- Health and social care services contribute to reducing health inequalities

Local Indicator	Most Deprived in East Renfrewshire 2013- 2015		Total East Renfrewshire
Male life expectancy at birth in 15 per cent most deprived communities (age)	71.9		79.3
Female life expectancy at birth in 15 per cent most deprived communities (age)	78.8		83.4
Local NHS GGC Indicator	**2014/15**		**East Renfrewshire**
Bowel Cancer Screening take up in most deprived communities	43.8%		65.2%
Bowel Cancer Screening take up in most deprived communities by males	39.3%		61.4%
Bowel Cancer Screening take up in most deprived communities by females	48.0%		68.7%
Cervical Cancer Screening take up	69.5%		81.8%
Local NHS GGC Indicator	**2016/17**		**Target**
The number of smokers in our most deprived areas (SIMD1) supported to successfully stop smoking at 12 weeks post quit date'	16		28

Many of the indicators for this work are long term and not updated on an annual basis. This chapter gives some examples of the work we are doing with partners and communities to tackle health issues and some of the ways we target our activity to reach those most likely to experience ill health.

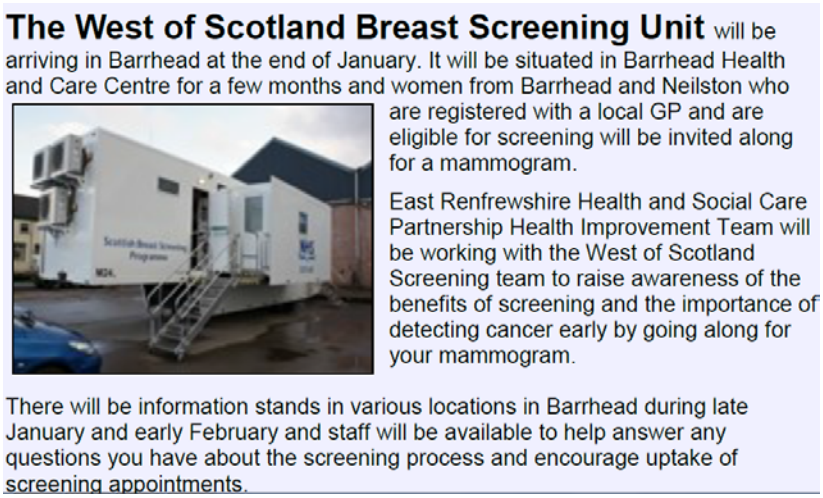
A total of 16 people who accessed Smokefree Services support from our most deprived areas were recorded as still quit at 3 months after quit date in quarter 3 (target 7 per quarter). Q4 data will not be available until July/Aug 2018. The target for first 3 quarters is 21 and is 28 for full year, but we often find that the final data reflects a more positive picture.

Providing targeted health improvement information

Targeted information campaigns have been delivered during 2017/18.

These include awareness sessions regarding breast health in Barrhead in January and March 18.

This was to coincide with the screening unit being in Barrhead.



The West of Scotland Breast Screening Unit will be arriving in Barrhead at the end of January. It will be situated in Barrhead Health and Care Centre for a few months and women from Barrhead and Neilston who are registered with a local GP and are eligible for screening will be invited along for a mammogram.

East Renfrewshire Health and Social Care Partnership Health Improvement Team will be working with the West of Scotland Screening team to raise awareness of the benefits of screening and the importance of detecting cancer early by going along for your mammogram.

There will be information stands in various locations in Barrhead during late January and early February and staff will be available to help answer any questions you have about the screening process and encourage uptake of screening appointments.

An awareness raising session on breast screening specifically to support women with additional needs was held in Thornliebank Resource Centre 18th Jan 18.

Providing targeted health interventions

Healthy Working Lives

The Healthy Working Lives Award successfully maintained in October 2017. A range of activities, training and information has been provided for staff and policies regarding health and wellbeing have been reviewed and updated. Our Healthy Working Lives Action plan has a focus on supporting staff who are most likely to experience health inequalities for example part time and manual staff.

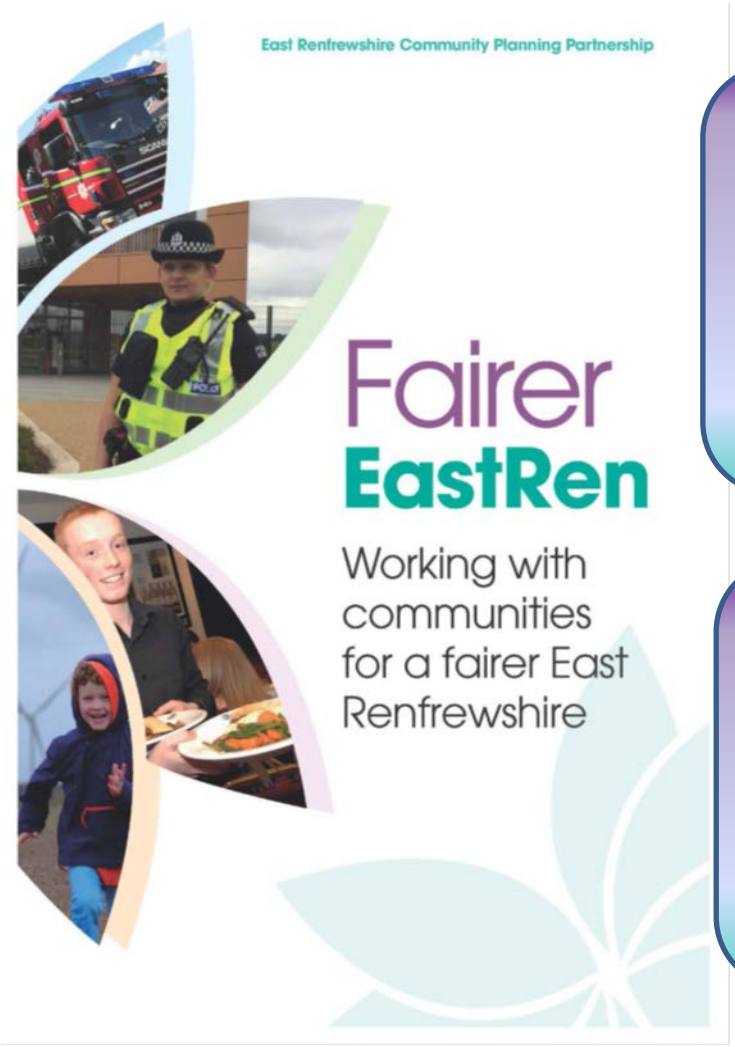
A further round of heath checks for staff in manual occupations completed during Jan - March 2018. Staff groups were from homecare service, manual workers and catering and janitorial staff from across HSCP and ERC. Appropriate advice was provided by Occupational Health nurse and appropriate referral where necessary. Information on issues relevant to staff was also provided including money advice, self-help information on health conditions and healthier lifestyle advice.

85 health checks up from 35 last year

Checks identified a significant number of individuals with risk factors such as high cholesterol levels and high blood pressure

Working with communities to tackle health inequalities

Community Planning Partners worked together to support communities to lead the development of Locality Plans for their area. The HSCP contribution to this work was from our health improvement team. The team also work with primary care and pharmacy service to ensure clients from areas who are likely to be affected by socio economic deprivation are referred to more specialist community based local support.



Proposed Auchenback community outcomes

Health and Wellbeing
Residents of Auchenback live healthy lives
Families of Auchenback have access to spaces and facilities to stay active and encourage play
Residents of Auchenback have a healthy diet based on locally grown produce.

Vision of ADD2Barrhead

Add2Barrhead will work with partners and services to achieve a better quality of life creating a thriving place, and will strive to tackle issues that affect our community.

The HSCP supports programmes of work to promote social inclusion and access to health improvement activities for people who are experience greater inequalities such as older adults with dementia and people with additional needs.

We recently achieved Dementia Friendly Accreditation for East Renfrewshire's walking programme in recognition of our work to make walking more accessible to people with dementia. Through supporting volunteers so that they are confident and able to sustain walking groups, we have seen the development of new walking groups across the authority and an increase in the number of people being more active more often. We support and encourage the social aspect of the walking programme which reduces social isolation for participants, many of whom live alone and have experienced bereavement or other life transitions.

National Wellbeing Outcome 6 (Carers)

- People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing.

National Indicator		ER HSCP 2017/18	Scottish Average	ER HSCP 2016/17
8	Total combined percentage of carers who feel supported to continue in their caring role	37%	37%	42%
Local East Renfrewshire Council Indicator		2017/18	Target	2016/17
	Percentage of people reporting 'quality of life for carers' needs fully met at review	80%	72.0%	69.8%

In East Renfrewshire the national performance indicator for carers support is similar to the rest of Scotland and is not where we want it to be. In partnership with the Care Collective (East Renfrewshire Carers and Voluntary Action East Renfrewshire), the Health and Social Care Partnership has undertaken a range of activities to prepare for the implementation of the Carers Act and development of a local Carers strategy.

We believe through the activity we have carried out together that we have developed a sound continuum of support for improving outcomes for carers of all ages.

7 STRANDS OF ACTIVITY

1. Establishing a local leadership collaborative
2. An improved carers information service
3. Improved access to carer support in the community
4. Creative short breaks
5. Self assessment and personal planning
6. Support for young carers
7. Volunteer development and peer support

A CONTINUUM OF SUPPORT

Information	Planning	Community Support	Assessment	Statutory Support
Carers Information Service	Peer Supported Planning	Integrated Provision of community services	Trusted Assessor	Statutory Support

CARERS INFORMATION SERVICE

An on-line platform with web-chat capability. Well designed wth attention to the user experience and providing comprehensive information on local and national resources to support carers in their caring role and to maintain their own wellbeing.

VOLUNTEER AND PEER SUPPORT

Trained volunteers and peer supporters providing support with early stage Carer Support Planning and sign-posting to community provision

COMMUNITY BASED INTEGRATED SUPPORT

Shop front access to advice, support, planning and community based services and activities. An accessible stigma free environment that offers carers the opportunity to participate in the design and delivery of activity that supports their own health and wellbeing, while raising awareness amongst the wider community of the challenges of caring.

ASSESSMENT AND PLANNING

Development of a carer-owned self assessment and planning tool. Trusted Assessor compliant assessments delivered to social work for decision making under an SLA agreement. Supported by fit-for-purpose case management and information management systems

SHORT BREAKS AND RESPITE

A comprehensive 'market comparison' of short break opportunities including cost and eligibility as appropriate. Market marking to develop provision of short breaks and respite.

YOUNG CARERS SERVICE

Out-reach supporting young people, schools and youth workforce to improve support for young carers. Working with young carers to provide planned, scheduled support, especially focusing on transition. Working with schools to implement Young Cares Statement and Young Carers manifesto. Supporting networks of youth workers to build capacity to support young carers.

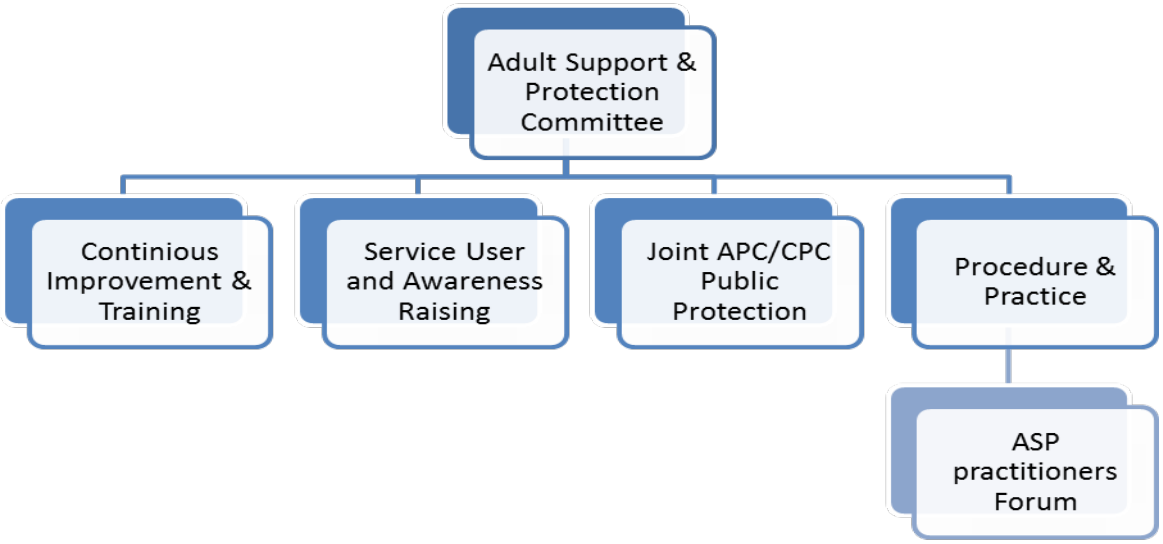
National Wellbeing Outcome 7 (Safe from Harm)

- People using health and social care services are safe from harm

National Indicator		ER HSCP 2017/18	Scottish Average	ER HSCP 2016/17
9	Percentage of adults supported at home who agreed they felt safe	82%	83%	84%
Local East Renfrewshire Council Indicator		2017/18	Target	2016/17
	Percentage average change in women's life outcomes domestic abuse- risk reduced	77%	Baseline only	62%
	Percentage of people reporting 'feeling safe' needs fully met at review	91%	84%	85%

Ensuring people are safe is a vital part of our work. Performance measures for this outcome are good. National outcome survey measures show an slight decrease in people feeling safe but local indicators have shown a rise. This chapter gives some examples of the work we do improve safety and our governance arrangements.

Following a period of reflection and self-evaluation of Adult Support and Protection practice within East Renfrewshire HSCP an action plan to address areas identified for improvement has been developed. This work will be supported by a newly developed subcommittee structure with oversight by the Adult Support and Protection Committee and Chief Officers Public Protection Group.



East Renfrewshire Women's Aid service reported a significant change and improvement for women across all reported outcomes. Reduction in risk is reflected in the significant increases in the areas of safety.

- Safety 65% improvement (4% increase on 2016/17)
- Health and wellbeing 77% (24% improvement on 2016/17)
- Empowerment and self-esteem 74% (4% improvement on 2016/17).

The service is open to all women, children and young people affected by domestic abuse in the East Renfrewshire area. Support workers travel throughout the area providing practical and emotional support in schools, homes, refuges and other suitable safe and confidential settings.

There has been a 7% increase in service users supported this year, demonstrating positive partnership working and good local awareness of services available locally This means that 249 women, children and young people have been supported with over 750 contacts made to the helpline or drop in service in 2017/2018

The HSCP with creative support from East Renfrewshire Council's Communication Team developed and launched a new poster campaign in partnership with Women's Aid. The campaign highlight's that coercive control a deliberate pattern of emotional and psychological abuse such as threats, intimidation, humiliation, isolation and stalking – can be as damaging as physical abuse. There has been considerable interest in the campaign nationally with other areas wanting to adopt it.

Ensuring robust clinical and care governance arrangements are in place

The role of our Clinical and Care Governance Group is to consider matters relating to Strategic Plan development, governance, risk management, service user feedback and complaints, standards, education, professional registration and validation, learning, continuous improvement and inspection activity.

The group meets a minimum of three times a year and the agenda is structured to cover the areas of:

- Professional Leadership/Standards including registration and practice assurance
- Improvement Activity including self-evaluation and clinical governance actions
- Service Care Group Activity
- Patient/Service User Views including complaints, surveys and feedback
- Quality and Safety of Care including public protection, Inspections and Contract Monitoring
- Review of Significant and Adverse Events

Delivering quality and safe services

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 31 March 2018.

We have seen a reduction in grades for our care at home and Bonnyton House Service following inspections from a new local Care Inspectorate Team. We are disappointed with the results but have started work on improvement plans.

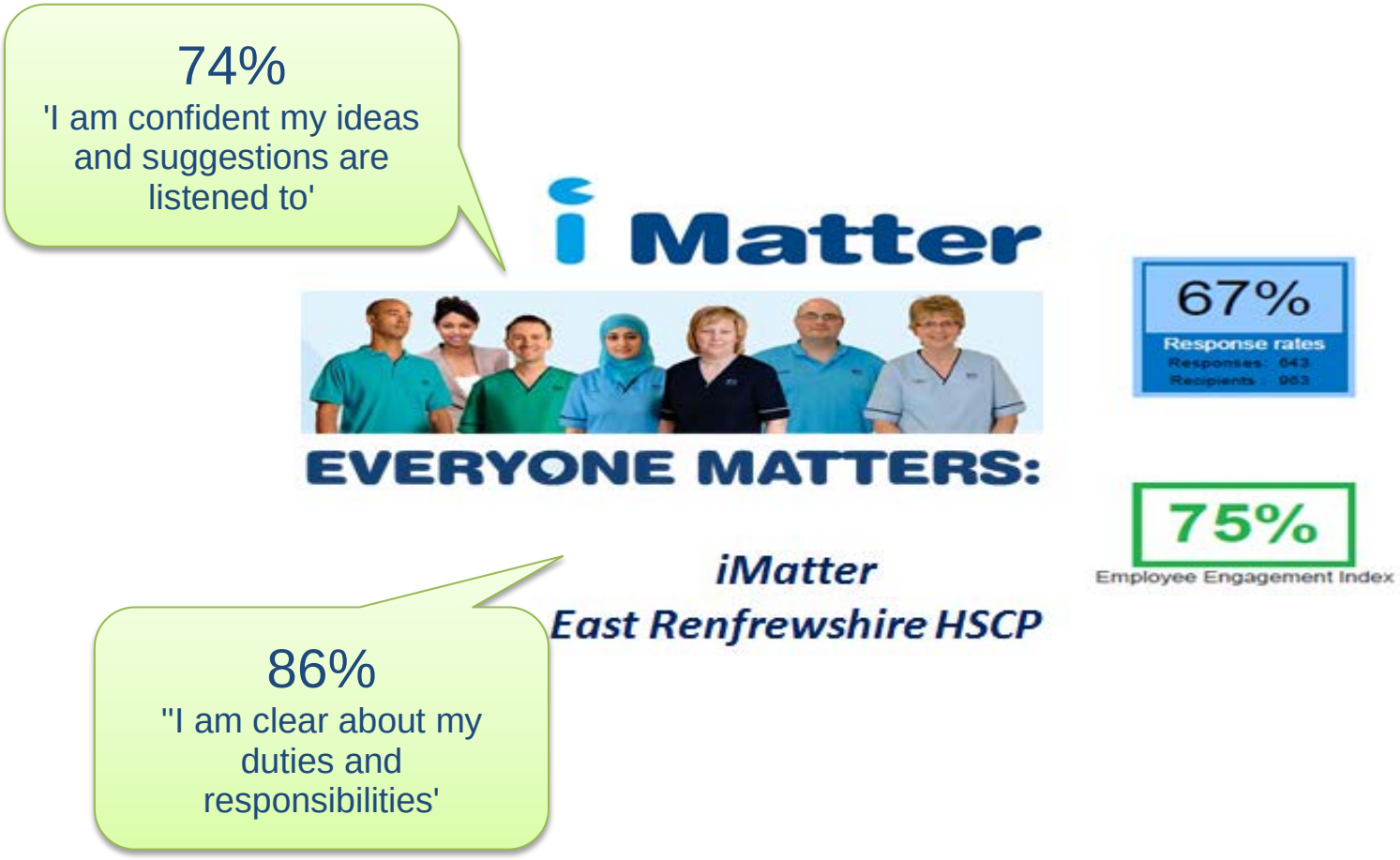
Service	Date of Last Inspection	Quality of Care and Support	Quality of Environment	Quality of Staffing	Quality of Management & Leadership
Adoption Service	02/11/2016	5 Very Good	no grade available	no grade available	5 Very Good
Barrhead Centre	23/02/2018	6 Excellent	Not Assessed	Not Assessed	6 Excellent
Bonnyton House	30/01/2018	3 Adequate	3 Adequate	3 Adequate	3 Adequate
Bonnyton Resource Centre	21/06/2016	4 Good	no grade available	no grade available	4 Good
Fostering Service	08/11/2016	5 Very Good	no grade available	no grade available	5 Very Good
Care at Home and Housing Support	16/03/2018	3 Adequate	no grade available	3 Adequate	3 Adequate
HSCP Holiday Programme	21/07/2017	6 Excellent	Not Assessed	Not Assessed	5 Very Good
Kirkton Service	24/10/2014	4 Good	5 Very Good	5 Very Good	4 Good
Thornliebank Resource Centre	07/04/2016	4 Good	no grade available	no grade available	4 Good
HSPC Adult Placement Centre	not inspected yet				

National Wellbeing Outcome 8 (Staff)

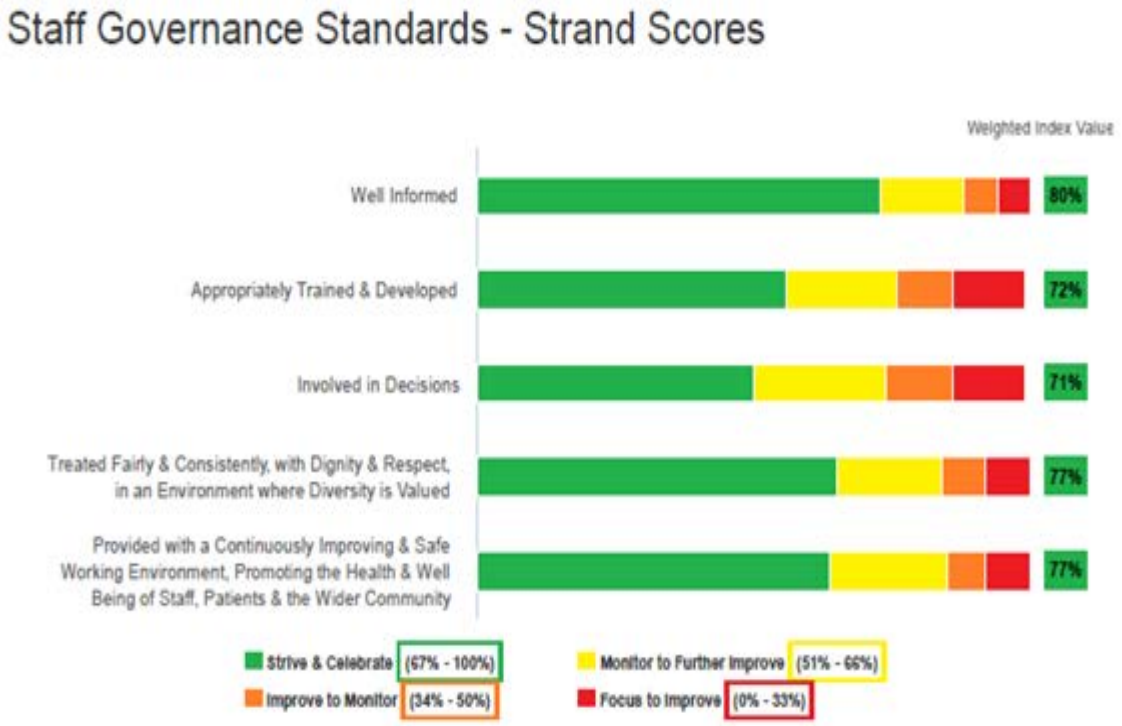
- People who work in Health and Social Care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide

National Indicator		ER HSCP 2017/18	Scottish Average	ER HSCP 2016/17
10	Percentage of staff who say they would recommend their workplace as a good place to work	Indicator under development (ISD)		
Local Proxy Indicator		2017/18	2016/17	2015/16
	% of staff who report feeling engaged in staff survey	75%	57% (data not comparable)	55%

National information is not available and we do not have comparative information for our local measures as 2017 was the first year that the HSCP participated in the iMatter survey and team planning. This is a staff experience continuous improvement tool designed with staff in NHS Scotland to help individuals, teams and Boards understand and improve staff experience. There was a generally positive response from HSCP staff.



Scores were positive in most of the strands of staff governance with a particularly high score for well informed .



Staff involvement in the wider Fit for the Future review

As we reviewed our services staff have reflected on what is working , what we can do better , the top pressures they are facing and how we can use IT and digital to improve how we work.

What Works Well?
- Integrated Duty Teams
- Business Support Processes
- Office Space
- Team Commitment
- Highly skilled staff
- Motivated
- Learning Disability – Keeping people at Home
- Learning Disability – Prevention of Admissions

What could work better?
- More integration with District Nurses
- Business Support Arrangements
- Communication with Finance Team
- Duty System
- Business Support staff being able to deal with basic queries
- Anticipatory approach/early intervention
- Quick access to services to prevent admission

Top Pressures
- Hospital Discharges
- High Volume of Referrals
- Duty
- Duty impacting on clinical time
- Access to Homecare

IT Improvements?
- Access to appropriate health information
- Remove the paper for Rehab teams
- Tablets for working with people in their home
- Integrated teams working from different case recording systems

National Wellbeing Outcome 9 (Resources)

- Resources are used effectively and efficiently in the provision of health and social care services

National Indicator		ER HSCP 2017/18	Scottish Average	ER HSCP 2016/17
20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	23%	23%	17%

We benchmark well on the national measure for this outcome. Locally we have not set other performance measures but are committed to achieving best value in all our work.

The HSCP embarked on a comprehensive review of Health and Care Services last year. A Fit for the Future team was created to complete a suite of end to end operational service reviews in conjunction with a review of the HSCP structure.

Our Fit for the Future change programme was intended to deliver £1.74m of the HSCP savings target for 2017/18. In recognition that this was a significance piece of redesign that would take time to plan and implement, the Integration Joint Board agreed to use reserves as bridging finance.

Shifting Demand through Community Led Supports
Through small tests of change using Talking Points we have seen reduction in waiting lists

Workforce planning

We have commenced a structural review using the principles below:

- It supports our focus on strategic priorities
- It delivers the required savings
- It enables stronger integration
- It is consistent in approach re span of control and layers of management
- It embeds planning and analytic capacity in operational services
- General management will be supported by strong professional

Systems and processes

Output from the service reviews, week in the life of and data analysis has enabled the following opportunities to be identified:

- Opportunity to improve consistency across across Rehabilitation & Enablement service teams which could improve customer experience
- Opportunity to reduce time spend on administration (including professional administration)
- Opportunity to further improve and streamline processes – including removing paper forms

Testing lean and digital approaches

Digital dictation pilot – staff can dictate documents, letters, supervision notes using software which will reduce the time spent on professional administration. This is being tested across a number of disciplines and teams at present.

Tablets – testing tablets with a small group of Occupational Therapy assistants and Rehab staff to understand if providing different kit enables work traditionally done in the office to be completed in the community and people's homes

Safe and Effective Practice

- Recognising the need for lead professionals and senior practitioners to provide leadership and supervision within integrated teams
- Building in audit and self-evaluation capacity
- Improving data quality and management information

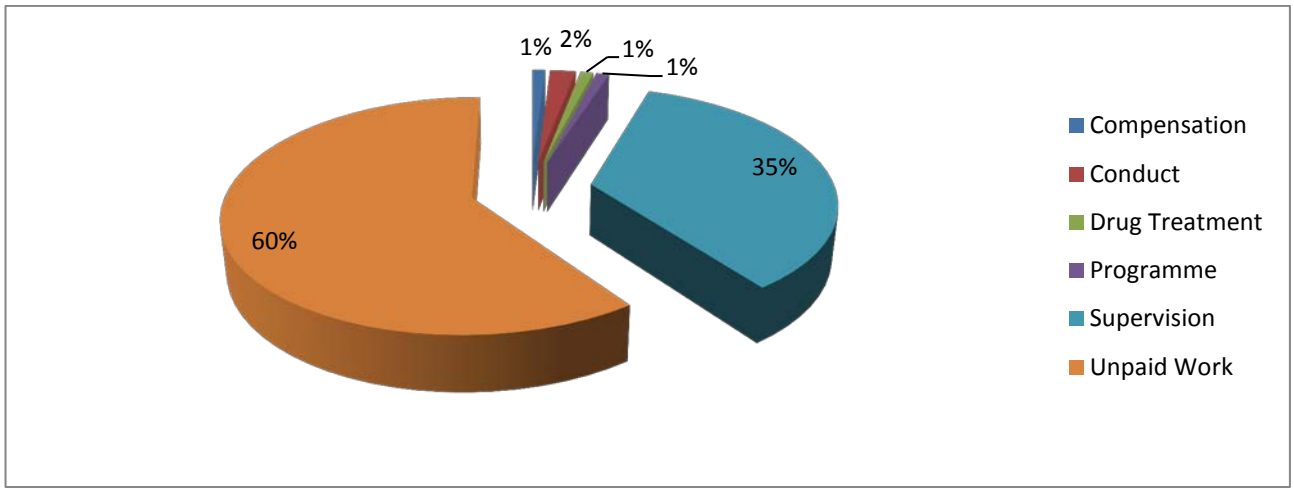
Criminal Justice Outcomes

- Community safety and public protection is safeguarded

Local Indicator	ER HSCP 2017/18	Target	ER HSCP 2016/17
Percentage of offenders successfully completing community based sentences whose risk has reduced	17%	21%	Data unavailable – new indicator

In 2017/18 a total of 265 Criminal Justice Social Work Reports (CJSWR) and progress reports were requested from Scottish courts. This represented a 10.4% increase from the previous year.

The most used disposal by courts was Community Payback Orders (CPOs). A total of 127 CPO's were imposed representing an increase of 4% from the previous year. The full use of all requirements by sentences was as follows:



During 2017/18, a total of 12,134 hours of unpaid work were completed across a range of projects and activities seven days **per week.**

The Unpaid Work service's strong links with Voluntary and Third sector agencies led to the development of several new projects including the painting and decorating of flats for disadvantaged and vulnerable people and gardening for adults with additional support needs. The service also supported several charities on a daily basis.

VAER
Support Development Collaboration

The service continued to respond to requests from community groups to undertake tasks which were of benefit to the local community. In particular, the service responded to requests from members of the public to clear a significant amount of fly tipping within the Barrhead area.

Where appropriate, service users can be credited for attendance at an activity which is beneficial to them and seen as a constructive use of time. Examples include engagement with the Community Addiction, Employability, Adult Learning, Money Advice and Voluntary Action. During 2017/18 referrals to Work East Ren, East Renfrewshire Council's Employability Service, increased by 50% with 23 people being referred to the service.

Links with Adult Learning continue to be strong. During 2017/18, we developed The No Barriers Barrhead service to provide access to education services for people undertaking CPO's. Individuals can be referred and receive support from Adult Learning staff.

Developing East Renfrewshire's Community Justice Partnership

The HSCP has supported considerable work on the development and implementation of the new plan for Community Justice which is led by the Council's Deputy Chief Executive. We work with our partners to lead, develop, support and promote Smart Justice measures that work for those who have offended, those wo have been harmed and for our community at large.

- Working in partnership with adult learning, employability and criminal justice services to support people with pre-employment needs and literacy to support and reduce reoffending.
- Engagement with the Crown Office Procurator Fiscal Service (COPFS) to increase and develop the use of Diversion.
- Undertaking trauma needs assessment and review to develop awareness of trauma informed practice across addictions, homelessness and justice services.
- Working closely with our partners in Victim Support to ensure that victims' rights and needs are supported within the justice system.

Locality Planning

Community led support

In 2016 we held a series of conversations around East Renfrewshire about creating new ways of working in communities. Local people contributed information and suggestions and got involved in planning for community led support

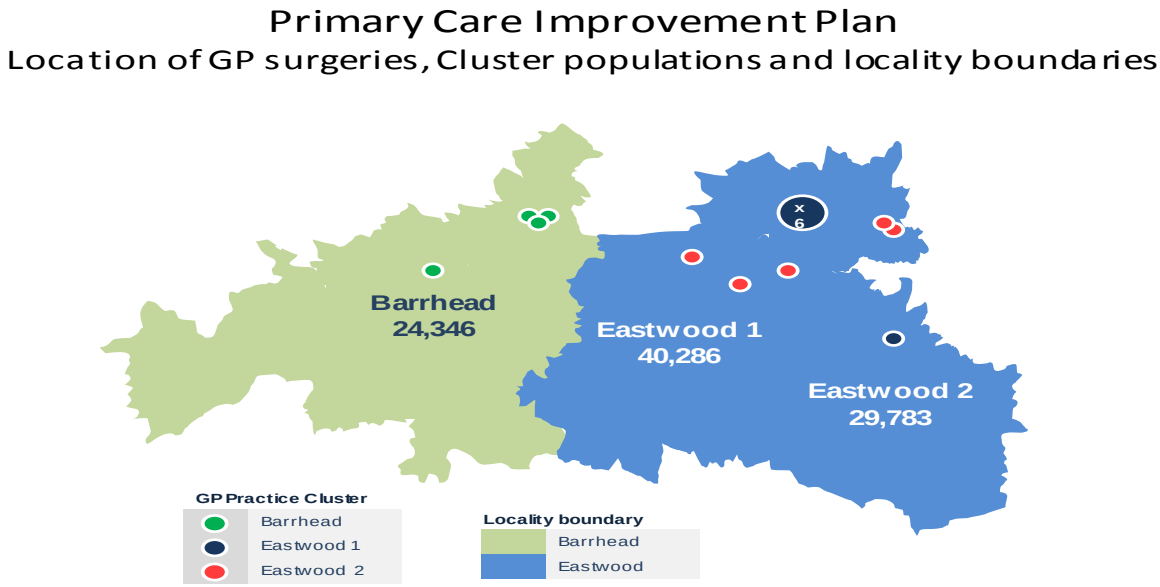
Over 2017/18 we have been developing a Community Led Support approach, which is based on involving local people in the planning and delivery of a series of Talking Points; places where they can come and find out about all aspects of what is available locally. This includes community activities and voluntary organisations, local amenities and transport, council and HSCP help and support.

Talking Points

We believe that that everyone we have contact with has the capacity to help themselves and to make a contribution to their community – the role of the Talking Point is to help them do this.

Working with our GP Clusters

East Renfrewshire HSCP has three GP clusters, Levern Valley, Eastwood 1 and Eastwood 2. Our clusters were quick to establish, with each successfully appointing a Cluster Quality Lead (CQL), and every practice in the HSCP being represented by sending a Practice Quality Lead (PQL) to Cluster meetings



The practices are listed below by cluster with the list size as at January 2018.

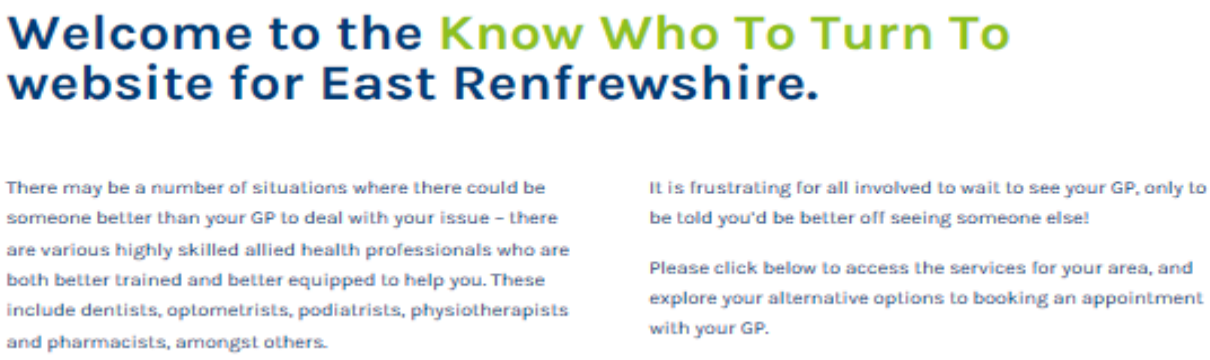
Eastwood 1 Practices	Eastwood 2 Practices	Barrhead Practices
Drs Morrice, Masson, Geddes & Andrews (7119)	Sheddens Medical Practice (2022)	Levern Medical Group (8739)
Drs Boardman, King, Earl & Boyd (6601)	Mearns Medical Centre (12476)	Glennifer Medical Group (8376)
Eastwoodmains Medical Practice (4895)	Broomburn Medical Centre (2822)	Oaks Medical Practice (3631)
Elmwood Medical Practice (3112)	Greenlaw Medical Practice (4427)	Neilston Medical Practice (3606)
MacLean Medical Practice (8742)	Carolside Medical Centre (8178)	
Williamwood Practice (9895)		

Across the HSCP there is on-going improvement activity. Our Quality Clusters are developing well with really positive engagement with GP, Practice Managers and the HSCP evidenced across the 3 clusters. East Renfrewshire HSCP provides support to the clusters including administration support, LIST analysts and Improvement & Performance Management support. Sharing of best practice around managing patient demand and practice capacity, flu vaccination uptake rates and safe prescribing are some examples of quality improvement topics to date. As a result of a presentation from our LIST analyst focussing on High Health Gain Individuals a test of change was developed and is underway in one of our clusters.

Signposting

To reduce this wasted time for both GP and patient, all clusters have been working on signposting activities. Know Who to Turn to materials are displayed as A1 posters and 6-foot high banner formats in both localities and have been made available to patients in the form of A6 leaflets (Eastwood) and business cards (Barrhead).

A simple, user-friendly website at www.knowwhototurnto-eastren.co.uk has been created, for all GPs to add to their own practice websites and for patients to access directly.



These resources tap into the already existent NHS Inform and NHSGG&C Know Who To Turn To websites.

Practice staff members from our local GP practices are receiving signposting training, so that they know what to say to patients and how to direct them to the appropriate destination and/or information.

Developing our Locality Planning and Service Delivery

As part of our Fit for the Future work we have been considering how we can strengthen our locality planning and service delivery. As a longstanding partnership we already had integrated teams of health and social work staff based around the three GP clusters.

The HSCP is moving to strengthen these arrangements by moving to two localities (Barrhead and Eastwood). A locality manager will be appointed for each area with responsibility for strategic leadership, operational and budget management for Adult Health and Social Care Services in the locality. Supported by planning, improvement and commissioning staff they will lead locality planning and market facilitation for their area. They will manage a number of locality teams made up of rehabilitation, nursing and social work staff. There will be some teams for example learning disability that due to size cannot be split into two but these will be hosted in one locality on behalf of the other and services will be delivered across both localities.

Our Hosted Service – Specialist Learning Disability Services

In 2017/18 we have successfully taken forward the redesign of both the Learning Disability Liaison team and the Specialist Epilepsy Nursing Service. Specialist Epilepsy Nurses in Learning Disability are now part of the wider Neurology team based the Queen Elizabeth University Hospital covering all of NHS GGC. This means people with a learning disability now receive their epilepsy care from one consistent service no matter where they live in NHS GGC.

A resettlement and retraction process is underway for our long stay services. In partnership with three other HSCPs people are now being discharged to local community based services. Waterloo Close closed in August 2017 and we are working towards resettling the remaining people who reside in Netherton this year and into next year.

A positive partnership with the National Development Team for inclusion was established in 2017 to take forward redesign of assessment and treatment bed based services. We have been looking locally and further afield to identify where progressive practice has enabled less people to come into hospital, spend less time in hospital when it has been unavoidable and return home quickly. We are developing a redesign programme in partnership with an extensive range of stakeholders.

Work to become accredited with the Royal College of Psychiatrists, Accreditation for In patient Mental Health Services (AIMS) is well underway and is making good progress.

Learning Disability Week ‘Our Generation’ celebrated the talents of young people with learning disability. We also took the opportunity to celebrate 70 years of the NHS with a number of events and activities. A firm favourite was the main event of forum theatre held in Blythswood House.

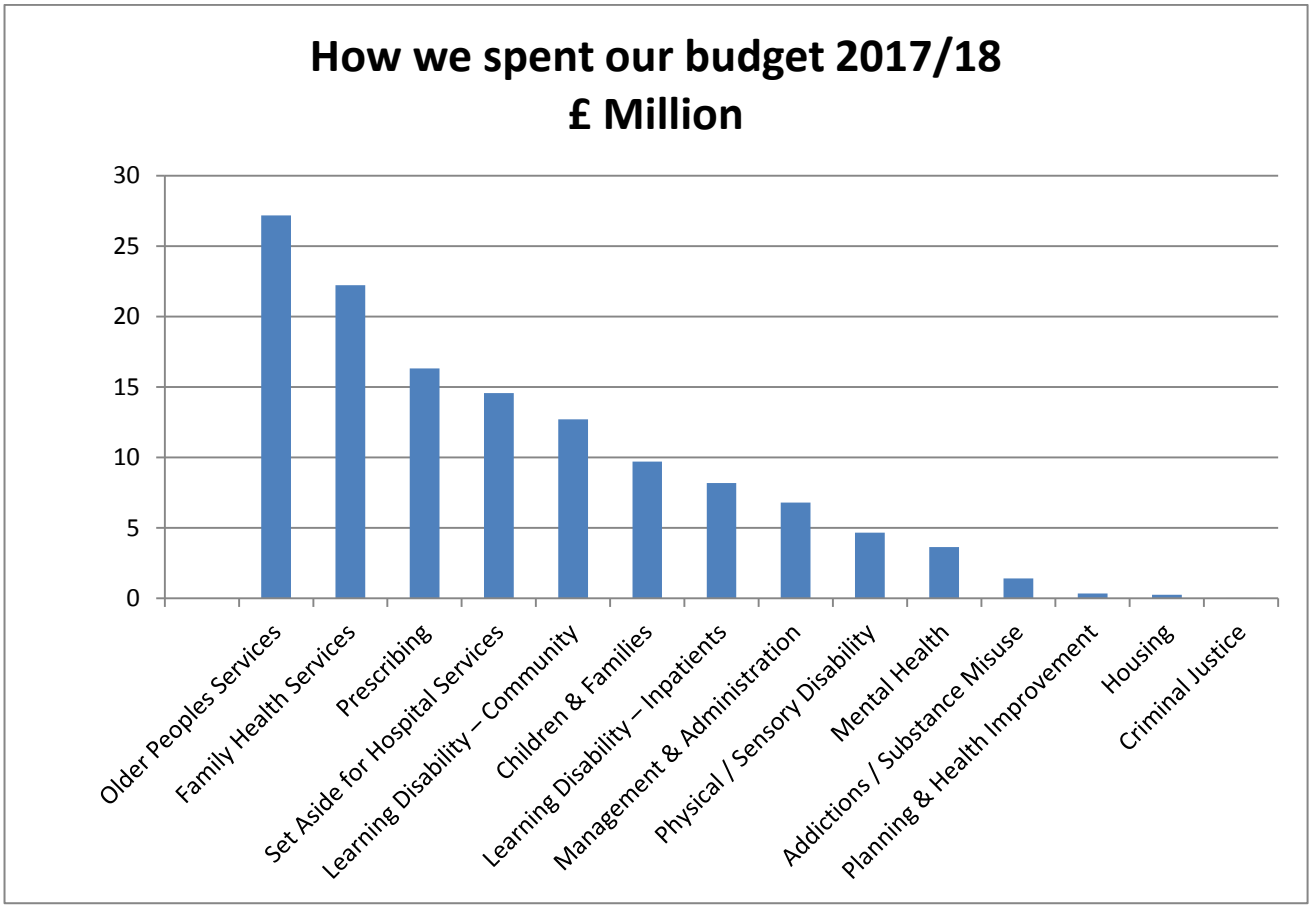
People with learning disabilities continue to clearly tell us about their aspirations to live healthy lives as equal citizens, our approaches to redesign and service quality will aim to ensure aspirations are reflected in the transformation work we are taking forward.

Finance

This section of the report gives an overview of how the Integration Joint Board used its resources in 2017/18. Greater detail is available East Renfrewshire IJB Annual Report and Accounts 2017/18.

The overall financial position for the IJB for 2017/18 can be summarised as follows:

Total 2016/17 £000	1st April 2017 to 31st March 2018	NHS Greater Glasgow and Clyde £000	East Renfrewshire Council £000	Total 2017/18 £000
147,410	Funds Received from Partners	87,581	61,863	149,444
144,191	Funds Spent with Partners	87,581	61,414	148,995
(3,219)	Underspend In Year	-	(449)	(449)
3,219	Earmarked Reserve Contributions	-	449	449
-	General Reserve Contributions	-	-	-



At the end of the year we used £0.177million from the budget saving reserve to balance the year. This was £0.777 million less than the maximum we had planned to use as we made a number of operational underspends in year. We also gained from the costs of support services and added to our reserves for new funding received.

A number of services are hosted by other IJBs across Greater Glasgow and Clyde. Our use of hosted services is as follows:

Services provided to East Renfrewshire IJB by other IJB areas	2017/18 £000
Physiotherapy	348
Retinal Screening	57
Podiatry	430
Primary Care Support	283
Continence	287
Sexual Health	616
Mental Health	1,014
Oral Health	891
Addictions	347
Prison Health Care	191
Health Care in Police Custody	159
Psychiatry	4,000
Total	8,623

Review of Strategic Plan 2015- 18

With our Strategic Planning Group we have reviewed our first strategic plan, considering the progress we have made towards the outcomes and strategic priorities we set for ourselves. We came to the following conclusions.

Children and young people

- Good progress has been made in prevention and early intervention through Early Years and Parenting strategic work and should continue.
- There has been a good start in learning from our Care Experienced young people and the IJB will continue to support the Corporate Parenting Plan
- The shift in the balance of care for children and young people, timely decision making and move to permanent destinations should be maintained to make sure that we get it right for every child.
- **There is an emerging strategic priority of mental wellbeing for children and young people that should be reflected in the new strategic plan**

Community Justice

- Performance under the current Strategic Plan has focused on effective interventions to manage risk
- East Renfrewshire has a new Community Justice Outcome Improvement Plan with a new focus on preventing and reducing offending and supporting people who have committed offences to reintegrate into the community and realise their full potential
- **Our revised strategic priority should reflect the Community Justice focus and performance measures need to be amended to reflect the HSCP service contribution**

Health Improvement and Inequalities

- Overall East Renfrewshire performs well for healthy life expectancy and on a number of population health targets
- However over the course to the plan we have not seen the same improvement in reducing health inequalities
- **The strategic priority for the next plan must reflect our commitment as a community planning partner to locality planning with our communities that experience shorter life expectancy and poorer health**

Keeping people at home

- HSCP activity to reduce delayed discharges and reduce lengths of stay by reaching into hospitals and getting people back to East Renfrewshire has been very successful
- Whilst the HSCP started from a positive baseline, we have not reduced unplanned care in the way that we predicted

- For us unplanned use of hospital care is a sign that as a health and care system we are not supporting people as well as we could and that we may be missing opportunities to intervene and plan earlier. A strategic priority moving forward must be working with **our colleagues in primary and acute care to reduce unplanned admissions to hospital, including at end of life.**

Living good lives independently

- The Strategic Planning Group has noted evidence of an increase in older people moving into care homes (although this should be seen alongside a reduction in use of NHS continuing care and in use of palliative care beds.)
- Good progress has been made in learning disability redesign to support people to live as independently as possible this needs to continue and inform our work with older people
- A strategic priority moving forward should be **working together with older people to maintain their independence at home and in their local community - this should include a focus on self-directed support and alternatives to residential care.**

Carers

- Over the course of the current Strategic Plan the focus has been developing plans to implement the new Carers legislation and the new detailed national carers performance framework
- The Care Collective has taken a wider reaching and inclusive approach to developing a Carers strategy and service redesign
- Whilst understanding the need to support cares health and wellbeing, the Care Collective work has identified **choice and control as the key strategic priority for carers**

Mental Health and Recovery

- Mental health and recovery is not a specific priority in the current plan, although there are number of actions in the plan that relate to recovery
- Performance information for mental health reported to the is limited and focuses primarily on waiting times
- In light of the national strategy and NHSGGC work it is suggested that **mental health and recovery** becomes a strategic priority in the new plan

Appendix 1: National Outcomes

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.

For East Renfrewshire our contribution to these outcomes is

- Parents provide a safe, healthy and nurturing environment
- Children are healthy, active and included
- Children are protected

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 and Standards for Social Work Services in the Criminal Justice System that we set out in our Strategic Plan are:

- Community safety and public protection
- The reduction of re-offending
- Social inclusion to support desistance from offending

Appendix 2: Integration Planning and Delivery Principles

The integration planning and delivery principles are set out in the Public Bodies (Joint Working) (Scotland) Act 2014. They are intended to be the lens through which all integration activity should be focused to achieve the national health and wellbeing outcomes. They set the ethos for delivering a radically reformed way of working and inform how services should be planned and delivered in the future.

The main purpose of the integration planning and delivery principles is to improve the wellbeing of service-users and to ensure that those services are provided in a way which:

- Are integrated from the point of view of service-users.
- Take account of the particular needs of different service-users.
- Takes account of the particular needs of service-users in different parts of the area in which the service is being provided.
- Take account of the particular characteristics and circumstances of different service-users.
- Respects the rights of service-users.
- Take account of the dignity of service-users.
- Take account of the participation by service-users in the community in which service-users live.
- Protects and improves the safety of service-users.
- Improves the quality of the service.
- Are planned and led locally in a way which is engaged with the community (including in particular service-users, those who look after service-users and those who are involved in the provision of health or social care).
- Best anticipates needs and prevents them arising.
- Makes the best use of the available facilities, people and other resources.