AGENDA ITEM No.7

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 23 September 2019
Agenda Item	7
Title	East Renfrewshire HSCP Annual Performance Report 2019/20

Summary

This report provides members of the Integration Joint Board with the Annual Performance Report for the Health and Social Care Partnership for 2019-20.

This is our fourth Annual Performance Report and outlines performance for the second year of our Strategic Plan 2018-21. The Annual Performance Report is a high level, public facing report. It focuses on the performance of the HSCP prior to the Covid-19 pandemic.

Presented by	Steven Reid Policy, Planning and Performance Manager

Action Required

The Integration Joint Board is asked to:

- Approve the report and its submission to the Scottish Government by the revised deadline of 30 September 2020.
- Agree that the Policy, Planning and Performance Team will work with the Communications Team to consider a range of media to engage with the public, illustrate performance and publish the Performance Report on our website and through social media.

Directions

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

Implications

☐ Finance	☐ Risk
☒ Policy	☒ Legal
☐ Workforce	☐ Infrastructure
☒ Equalities	☐ Fairer Scotland Duty

EAST RENFREWSHIRE INTEGRATION JOINT BOARD

23 SEPTEMBER 2020

Report by Chief Officer

EAST RENFREWSHIRE HSCP ANNUAL PERFORMANCE REPORT 2019/20

PURPOSE OF REPORT

1. This report advises the members of the Annual Performance Report for the Health and Social Care Partnership for 2019-20.

RECOMMENDATIONS

2. The Integration Joint Board is asked to:
   - Approve the report and its submission to the Scottish Government by the revised deadline of 30 September 2020.
   - Agree that the Policy, Planning and Performance Team will work with the Communications Team to consider a range of media to engage with the public, illustrate performance and publish the Performance Report on our website and through social media.

BACKGROUND

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

4. In recognition of the exceptional requirements being place on public bodies as they responded to the Covid-19 outbreak, the Coronavirus (Scotland) Act 2020 made a number of temporary changes to statutory reporting and publication requirements (as well as Freedom of Information requests). This gave public authorities the temporary power to postpone publishing reports if they are of the view that continuing with report preparation would impede their ability to take effective action in response to the coronavirus pandemic.

5. The Chief Officer agreed to delay the publication date for the Annual Performance Report until 30 September in exercise of the power granted to public authorities under the Coronavirus (Scotland) Act 2020 to do so. The staff who would have been involved in the preparation of the report have been heavily engaged in supporting the Covid-19 pandemic response.

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

7. 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.

8. Subject to approval of the report by the Integration Joint Board, the report will be published on our website by 30 September and promoted through appropriate media channels.

REPORT

9. The Annual Performance Report sets out how we delivered on our vision and commitments over 2019-20. This year is the second year of the HSCP Strategic Plan 2018-21 and this is our fourth Annual Performance Report. We review our performance against agreed local and national performance indicators and against the commitments set out in our second Strategic Plan, which covers the period 2018-21. The report is principally structured around the priorities set out in our strategic plan, linked to the National Health and Wellbeing Outcomes as well as those for Criminal Justice and Children and Families.

10. The main elements of the report set out: the current strategic approach of the East Renfrewshire Health and Social Care Partnership; how we have been working to deliver our strategic priorities over the past 12 months; our financial performance; and detailed performance information illustrating data trends against key performance indicators.

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

12. The national outcome measures are based on survey feedback available every two years from a national survey of people taken from a random sample based on GP practice populations. These people have not necessarily used HSCP services. The survey was last carried out in 2017 and as such no current data is available for these measures. 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.

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

14. The remaining performance information in the report relates to the key local indicators and targets developed to monitor progress against our Strategic Implementation Plan 2018-21. Our performance indicators illustrate progress against each of our seven strategic priorities. Chapter 4 of the report gives trend data from 2016-17 and uses a Red, Amber, Green status key to show whether we are meeting our targets.

15. In addition to activity and performance in relation to the seven strategic priorities the report includes sections on:
    - Public protection;
    - Our hosted Specialist Learning Disability Service;
    - How we support our staff.

16. Performance indicators that have seen the greatest improvement in 2018-19 are summarised in Chapter 4. These demonstrate significant progress across a number of areas, including:
    - Outcomes for children following support from our parenting programmes.
    - Improving the balance of Care for looked after children (% of children being looked after in the community).
    - Outcomes for women who have experienced domestic abuse.
    - Helping older people and people with long-term condition maintain independence at home.
    - Reducing waiting times for people accessing psychological therapies.
    - Reducing delayed discharges from hospital and reducing unplanned hospital bed days.
    - The proportion of people spending the last 6 months of life in a community setting.
    - Supporting the needs of unpaid carers.

17. The report also highlights indicators where we feel we could be doing better and will focus on improving. These include:
    - Children and young people accessing support through Child and Adolescent Mental Health Services (CAMHS).
    - Completion of unpaid work placement (Community Payback Orders) within Court timescales.
    - The number of people self-directing their care through receiving direct payments and other forms of self-directed support.
    - Reducing the number of A&E attendances and admissions.

18. Following any comments from either the Performance and Audit Committee or the Integration Joint Board on 23 September 2020, we will use the remaining weeks until the publication date to enhance any content and make presentational changes.

CONSULTATION AND PARTNERSHIP WORKING

19. The Annual Performance Report reflects the work of the Health and Social Care Partnership throughout 2019-20. 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.

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

IMPLICATIONS OF THE PROPOSALS

Finance

21. The Annual Performance Report incorporates relevant financial end of year performance information in Chapter 3. A separate Annual Accounts Report has also been produced and is on the IJB agenda.

Staffing

22. 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

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

Equalities

24. 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.

25. There are examples of this throughout the report.

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

DIRECTIONS

No directions are being issued as a result of this paper

CONCLUSIONS

27. The Annual Performance Report is the fourth 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.

28. The reports demonstrates continued progress in the delivery of the priority outcomes set out in our Strategic Plan 2018-21.

RECOMMENDATIONS

29. The Integration Joint Board is asked to:-
    - Approve the report and its submission to the Scottish Government by the revised deadline of 30 September 2020.
    - Agree that the Policy, Planning and Performance Team will work with the Communications Team to consider a range of media to engage with the public, illustrate performance and publish the Performance Report on our website and through social media.

REPORT AUTHOR AND PERSON TO CONTACT

Steven Reid, Policy, Planning and Performance Manager
steven.reid@eastrenfrewshire.gov.uk
0141 451 0749

September 2020

Chief Officer, IJB: Julie Murray

BACKGROUND PAPERS

East Renfrewshire HSCP Annual Performance Report 2018/19

East Renfrewshire HSCP Annual Performance Report 2017/18

EAST RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

East Renfrewshire Council

NHS Greater Glasgow and Clyde

East Renfrewshire Health and Social Care Partnership

Annual Performance Report

2019/20

Contents

1. Introduction

1.1 Purpose of Report

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

This is the fourth report for the East Renfrewshire Integration Joint Board. It sets out how we delivered on our vision and commitments over 2019-20. We review our performance against agreed local and national performance indicators and against the commitments set out in our second Strategic Plan, which covers the period 2018-21. The report looks at performance for the 12 months prior to the Covid-19 pandemic and does not focus significantly on the impacts of the crisis and our response following the introduction of lockdown on 23 March 2020.

The main elements of the report set out:

- the current strategic approach of the East Renfrewshire Health and Social Care Partnership (HSCP);
- how we have been working to deliver our strategic priorities over the past 12 months;
- our financial performance; and,
- key work areas we will be focusing on as we move forward.

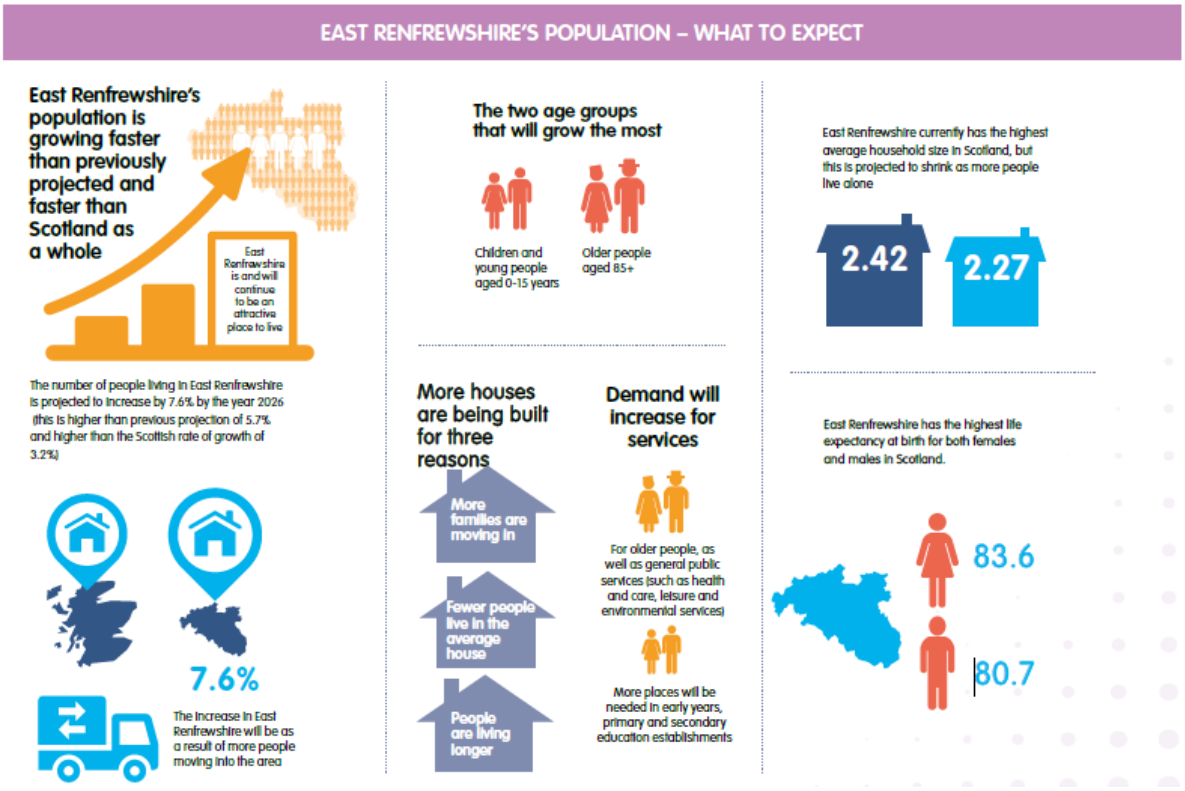
Detailed performance information illustrating data trends against key performance indicators is included in the Chapter 4 of the report.

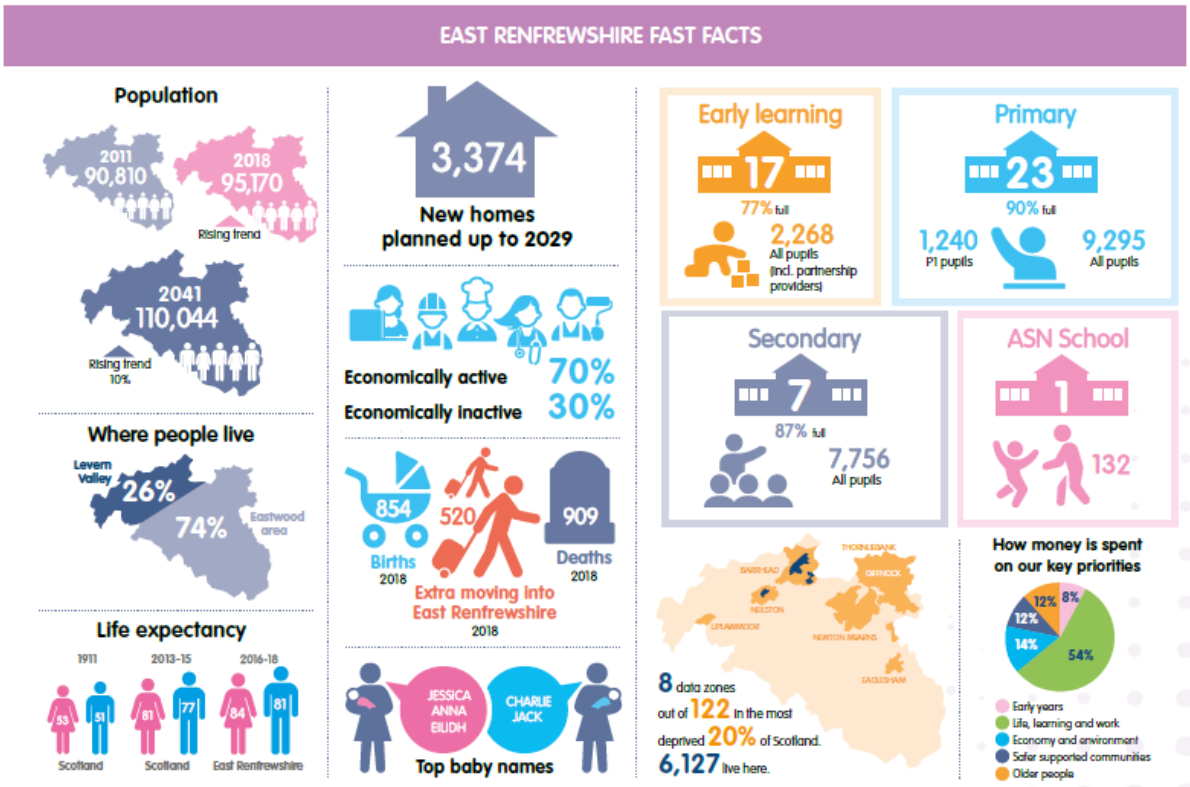
1.2 Local context

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

Our population is growing and reached 95,530 in 2019. 74% of the population live in the Eastwood area (Busby, Clarkston and Williamwood, Eaglesham and Waterfoot, Giffnock, Netherlee and Stamperland, Newton Mearns and Thornliebank) and 26% live in the Barrhead area (Barrhead, Neilston and Uplawmoor).

East Renfrewshire has an ageing population with a 44% increase in the number of residents aged 85 years and over during the last decade.





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

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

During the last 14 years our integrated health and social care management and staff teams have developed strong relationships with many different partner organisations. Our scale and continuity of approach have enabled these relationships to flourish. We have a history of co-production with our third sector partners and we are willing to test new and innovative approaches.

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

1.3 Our Approach

1.3.1 Our Strategic Vision and Priorities

In East Renfrewshire we have been leading the way in integrating health and care services. From the outset of the CHCP we have focused firmly on outcomes for the people of East Renfrewshire, improving health and wellbeing and reducing inequalities. Under the direction of East Renfrewshire's IJB, our new HSCP builds on this secure foundation. Throughout our integration journey during the last 14 years, we have developed strong relationships with many different partner organisations. Our longevity as an integrated partnership provides a strong foundation to continue to improve health and social care services.

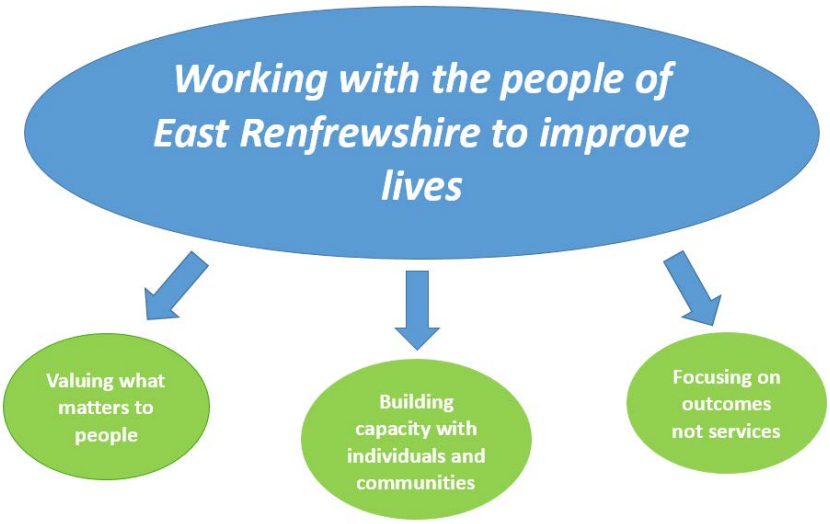
Our Vision

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

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

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

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



Our Strategic Plan

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

In 2017-18 we reviewed our current Strategic Plan in collaboration with our partners and local communities and began developing the priorities for our second plan. We considered our current performance using the national outcomes and indicators over the period of the first plan and sought feedback from our communities through national and local surveys. Our engagement activity was led by the third sector interface in partnership with Thrive, a commissioned external agency. We also looked at changes in the community planning, regional planning and the NHS Greater Glasgow and Clyde wider partnership landscape.

Through a series of workshops with our Strategic Planning Group, we recognised the need to reduce our strategic priorities in order to give more focus to areas of improvement. Much of our work from our previous strategic plan has continued. However, it was recognised that to meet the range of challenges presented by pressures on our finances and our growing and ageing population, we must fundamentally change the way we work together.

The plan recognises that the partnership must extend beyond traditional health and care services to a real partnership with local people and carers, volunteers and community organisations, providers and community planning partners. We must place a greater emphasis on addressing the wider factors that impact on people's health and wellbeing, including activity, housing, and work; supporting people to be well, independent and connected to their communities.

The plan also identifies that emergency admissions, out of hours pressures and carer stress are signs that our systems must continue to improve. We are committed to increasing the opportunities for people to talk with us earlier, exploring what matters to them and supporting them to plan and take action to anticipate and prevent problems and crises. By putting in place the right support at the right time we believe that we can improve lives and reduce demands on the health and care system.

Moving forward, hospitals will provide highly specialist treatment for people who are acutely unwell, with more locally provided rehabilitation and recuperation services. We have strong relationships with GPs in East Renfrewshire and over the course of the current strategic plan will be investing in primary care services to support people to better manage health conditions. We know that people staying in hospital longer than necessary makes them deteriorate and lose their independence and by reaching out to hospitals and providing a range of local supports we will get people back to East Renfrewshire sooner.

The strategic plan for 2018-21 sets out seven strategic priorities where we need to make significant change or investment during the course of the plan. These are:

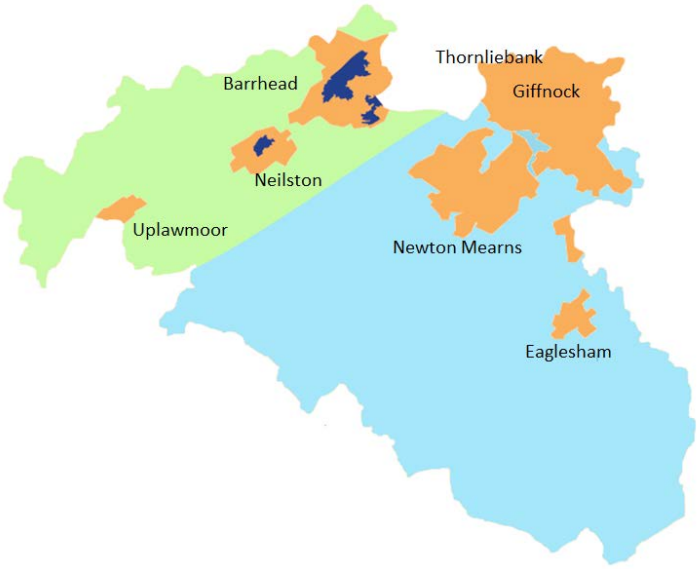
- Working together with **children, young people and their families** to improve mental wellbeing
- Working together with our community planning partners on new **community justice** pathways that support people to prevent and reduce offending and rebuild lives
- Working together with our communities that experience shorter life expectancy and **poorer health** to improve their wellbeing
- Working together with people to maintain their **independence at home** and in their local community
- Working together with people who experience **mental ill-health** to support them on their journey to recovery
- Working together with our colleagues in primary and acute care to care for people to reduce **unplanned admissions** to hospital
- Working together with **people who care for someone** ensuring they are able to exercise choice and control in relation to their caring activities

1.3.2 Locality planning in East Renfrewshire

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

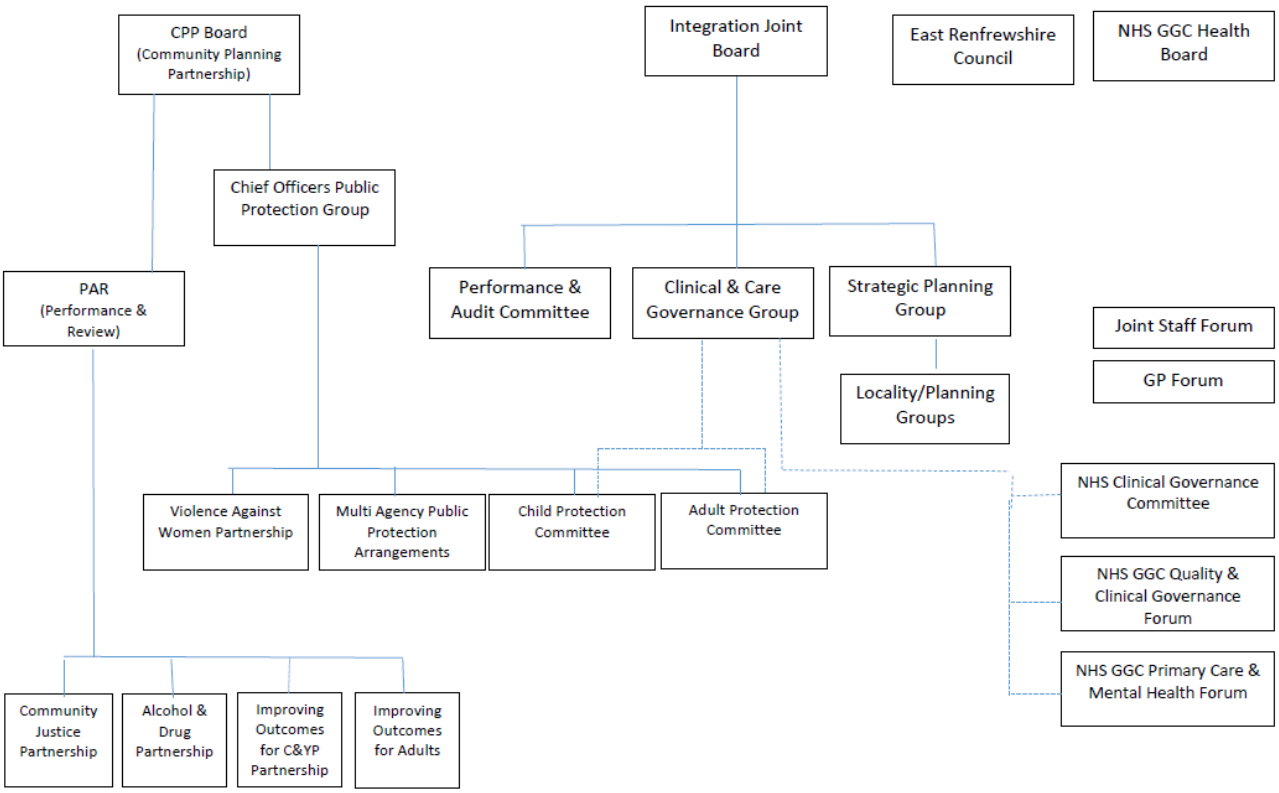
Our new localities also reflect our hospital flows, with the Eastwood Locality linking to South Glasgow hospitals and the Barrhead Locality to the Royal Alexandra Hospital in Paisley. The Barrhead Locality and Eastwood Locality Managers came into post in 2018. They have responsibility for both locality-based teams and services hosted on behalf of the entire HSCP.

Our management and service structure is designed around our localities. Our locality planning arrangements continue to develop and will be supported by new planning and market facilitation posts and financial reporting at a locality level.

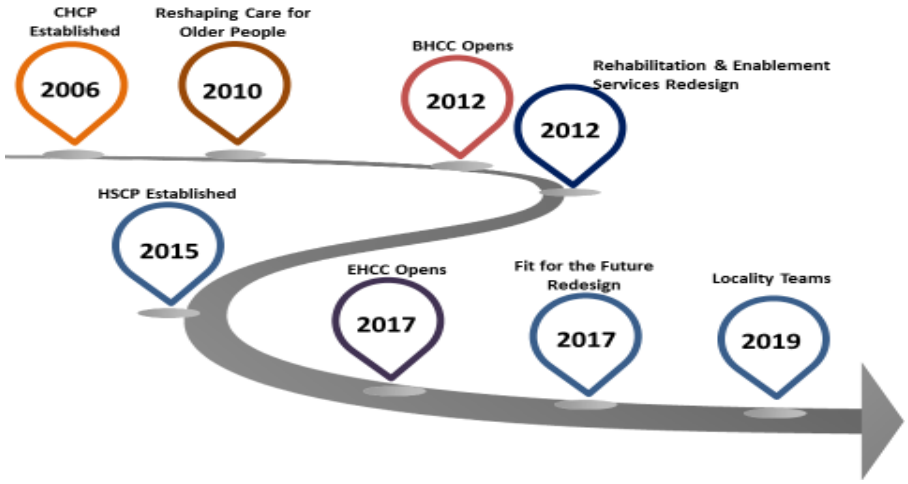


The IJB continues to build on the long standing delivery of integrated health and care services within East Renfrewshire and the continued and valued partnership working with our community, the third, voluntary and independent sectors, facilitating the successful operation of the Health and Social Care Partnership, hereafter known as the HSCP.

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



1.3.3 Realising the strategy through operational delivery

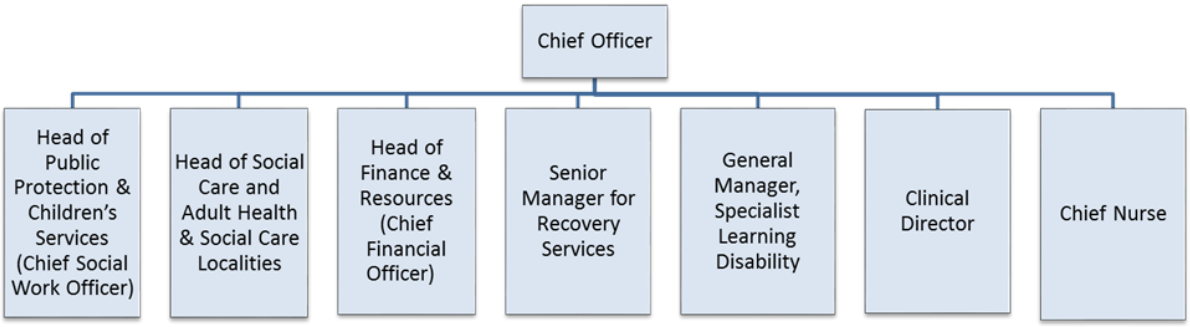


Developing our integrated Health and Care Centres at Barrhead and Eastwood has provided us with an ideal opportunity to facilitate a fundamental change in the operational delivery of health and social care for people in East Renfrewshire. Eastwood Health and Care Centre was designed to support the further integration of health and care, along with wider Council and third sector services, in a setting that promotes wellbeing.

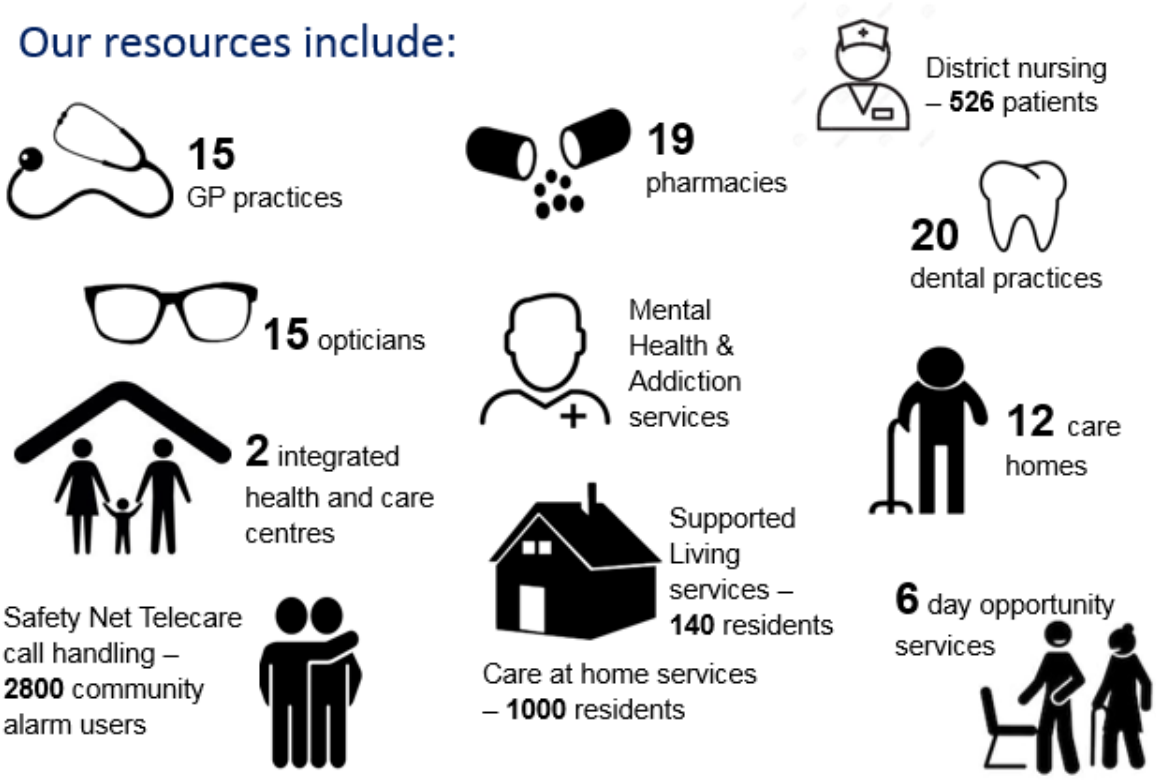
In order to prepare for the move to the Eastwood facility (opened 2017), a significant transformation programme was undertaken. We worked with staff groups to design zones that collocated workers and teams, in environments that supported their ways of working and fostered collaboration. Before finalising the physical design in Eastwood, we tested our new working environment in Barrhead Health and Care Centre. The building design and functionality of the Eastwood Health and Care Centre remains a reference design for future centres and a key asset for the HSCP.

More recently our Fit for the Future change programme (FFTF) has included end to end operational service reviews in conjunction with a review of our organisation structure and in line with our vision. The Chief Financial Officer (CFO) is responsible for ensuring that all project work and service designs are properly supported and that sound financial and risk governance is in place. This includes modelling and monitoring the FFTF programme.

This structure modelled through FFTF recognised the need to strengthen the link between strategy and operations, and to develop a stronger locality focus. Strategic planning, market facilitation and improvement capacity are being embedded in the locality structure. Our new teams have undertaken self-evaluation and planning activity to support the strategic direction. The structure of our leadership team is shown below.



During 2019-20 our partnership provided a wide range of health and social care service for local people including the examples given below.



The IJB continues to build on the long standing delivery of integrated health and care services within East Renfrewshire and the continued and valued partnership working with our community, the third, voluntary and independent sectors, facilitating the successful operation of the Health and Social Care Partnership, hereafter known as the HSCP.

1.3.4 Joint Strategic Inspection of East Renfrewshire HSCP

The Care Inspectorate and Health Improvement Scotland carried out a Joint Strategic Inspection of Adult Services in East Renfrewshire Health and Social Care Partnership between April and June 2019. The inspection was one of a series on the effectiveness of strategic planning requested by Scottish Ministers. The key elements during the inspection were how well the partnership had:

- Improved performance in both health and social care;

- Developed and implemented operational and strategic planning arrangements;
- Established the vision, values and aims across the partnership and the leadership of strategy and direction.

The inspection included analysis of the evaluative statements and evidence submitted by the partnership, followed by fieldwork in East Renfrewshire, which included focus groups, interviews and observation of activities. The final report of the inspection was published on 9 October 2019.

The inspection concluded that there was clear evidence that the partnership was improving its health and social services for adults. They found a culture of collaborative leadership, sound governance and a strong commitment to integration. Collaborative working with third sector partners to develop innovative person-centred services and community assets were recognised.

The inspectors considered the issues for the in-house care at home service to be a considerable risk for the partnership. They found no evidence of systemic problems with the partnership's governance and performance management systems. The partnership needs to make progress implementing its improvement plan for its care at home service. This will depend on the effectiveness of the operational management of this service.

The finding of the inspection was that partnership showed capacity for continuous improvement with its record of sound progress with the integration of health and social care services, supported by an integrated management structure and co-located teams of health and social care staff.

1.3.5 Our integrated performance management framework

Since the establishment of the Community Health and Care Partnership in 2006, there has been a commitment to integrated performance management.

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

An Implementation Plan and a supporting performance framework accompany our 3-year Strategic Plan. Working with key stakeholders, we developed these through outcome-focused planning. The plan is presented as a series of 'driver diagrams'. These diagrams show how we will achieve our strategic outcomes through 'critical activities' measured by a suite of performance indicators. This is the basis for strategic performance reporting to the Integration Joint Board (IJB) and it also feeds into East Renfrewshire Council's Outcome Delivery Plan and NHS Greater Glasgow and Clyde's Operational Plan. Our Strategic Performance Reports are presented to the IJB Performance and Audit Committee every six months (at mid and end year). We also provide quarterly updates (at Q1 and Q3) when data updates are available.

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

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

We gather service user feedback from a variety of sources. These include patient/service user surveys through for example, our Primary Care Mental Health Team; day centres and community groups; and users of our integrated health and social care centres. We also gather local feedback from East Renfrewshire Council's Citizens' Panel, Talking Points data and the National Health and Wellbeing Survey. We support a Mental Health Carers Group, where carers are able to raise issues about their needs and the support they receive.

1.3.6 Our Covid-19 response and remobilisation

East Renfrewshire HSCP has been at the forefront of the local response to the Covid-19 pandemic. Over the course of the Covid-19 crisis we have seen incredible resilience, commitment and creativity from staff in all services across East Renfrewshire HSCP. Within a very short space of time teams established and adapted to new ways of working and continued to maintain and deliver safe and effective services to our residents. There has been innovation and collaborative working across the health and care system including with external stakeholders and our communities.

Our response to the pandemic has necessarily been tailored within client groups to meet the specific needs of communities and respond to specific challenges posed within these services.

As we moved through the initial emergency phase of the pandemic, services developed (and continue to review) their own recovery plans setting out local milestones and these were collated into an HSCP-wide Operational Recovery Plan. The implementation of the Operational Recovery plan is being closely monitored and priorities are updated by service leads on a weekly basis.

Our strategic plan is due to be updated for 2021-24. We will review our strategic needs assessment in light of the COVID-19 outbreak and develop our strategic priorities taking into account the lessons learned and changing needs and expectations of local residents. The recovery work programme we have implemented will help inform our planning in the medium and longer term.

2. Delivering our key priorities

2.1 Introduction

This section looks at the progress we made over 2019/20 to deliver the key priorities set out in our Strategic Plan. We also set out performance for cross-cutting areas that support our strategic priorities including public protection and staff engagement. For each area we present headline performance data showing progress against our key local and national performance indicators. In addition to an analysis of the data we provide qualitative evidence including case studies and feedback from local people engaging with our services. We also illustrate which of the National Health and Wellbeing Outcomes we are contributing to through each area of activity.

A full performance assessment covering the period 2016/17 to 2019/20 is given in Chapter 4 of the report.

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

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

2.2.1 Our strategic aim

We provide ongoing support to children who are described as vulnerable due to being looked after and in our care, or on the edges of care, who need targeted interventions to safeguard their wellbeing.[1] Our Strategic Plan established a targeted priority of improving mental wellbeing of children and young people. We have been aware for some time of the pressures on our Child and Adolescent Mental Health Services (CAMHS), our disproportionate use of mental health inpatient beds and the number of GP consultations for mental wellbeing. Local community consultation also confirmed this as an area of concern for local residents.

Research suggests that half of adult mental health problems have begun by the age of 15, and once acquired they tend to persist. Mental ill health in children, young people and adults is strongly correlated with exposure to childhood adversity and trauma of various kinds. Adverse Childhood Experiences (ACEs) are an established indicator of exposure to such trauma. ACEs range from verbal, mental and physical abuse, to being exposed to alcoholism, drug use and domestic violence at home.

[1] Our main activities to support children and young people in East Renfrewshire are set out in "Getting it right with you" East Renfrewshire's Children's Services Plan 2017-2020.

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

- Providing the appropriate and proportionate mental health responses for children and young people;
- Increasing confidence among parents most in need of support as a result of targeted interventions;
- Improving maternal health and wellbeing;
- Strengthened family capacity through prevention and early intervention.

2.2.2 The progress we've been making

- 96% increase in improved outcomes for children after parent/carer completion of our Psychology of Parenting Project (PoPP)
- 98% positive response to Viewpoint question "Do you feel safe at home?"
- 96% of children/young people attending our Family Wellbeing Service with improved emotional health at end of programme in 2018/19
- Balance of Care for looked after children - 98% of children being looked after in the Community (the best in Scotland)
- 90% of supported mothers confirming they received information about close and loving relationships from staff

2.2.3 How we've been delivering

The Integration Joint Board are aware 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.

We are aware that these traditional service have been experiencing high demand resulting in longer waiting times. And in many cases this is not the most appropriate support for the young person and their family.

As an alternative approach we have established our **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 service since September 2017. The Family Wellbeing Service works with the HSCP to deliver holistic support based in 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.

As a consequence of a significant new funding stream from Robertson Trust and East Renfrewshire HSCP the newly enhanced Family Wellbeing Service began on 1 June 2019, expanding its reach to include all GP Practices. This has been very successful with almost all practices beginning to refer children and young people.

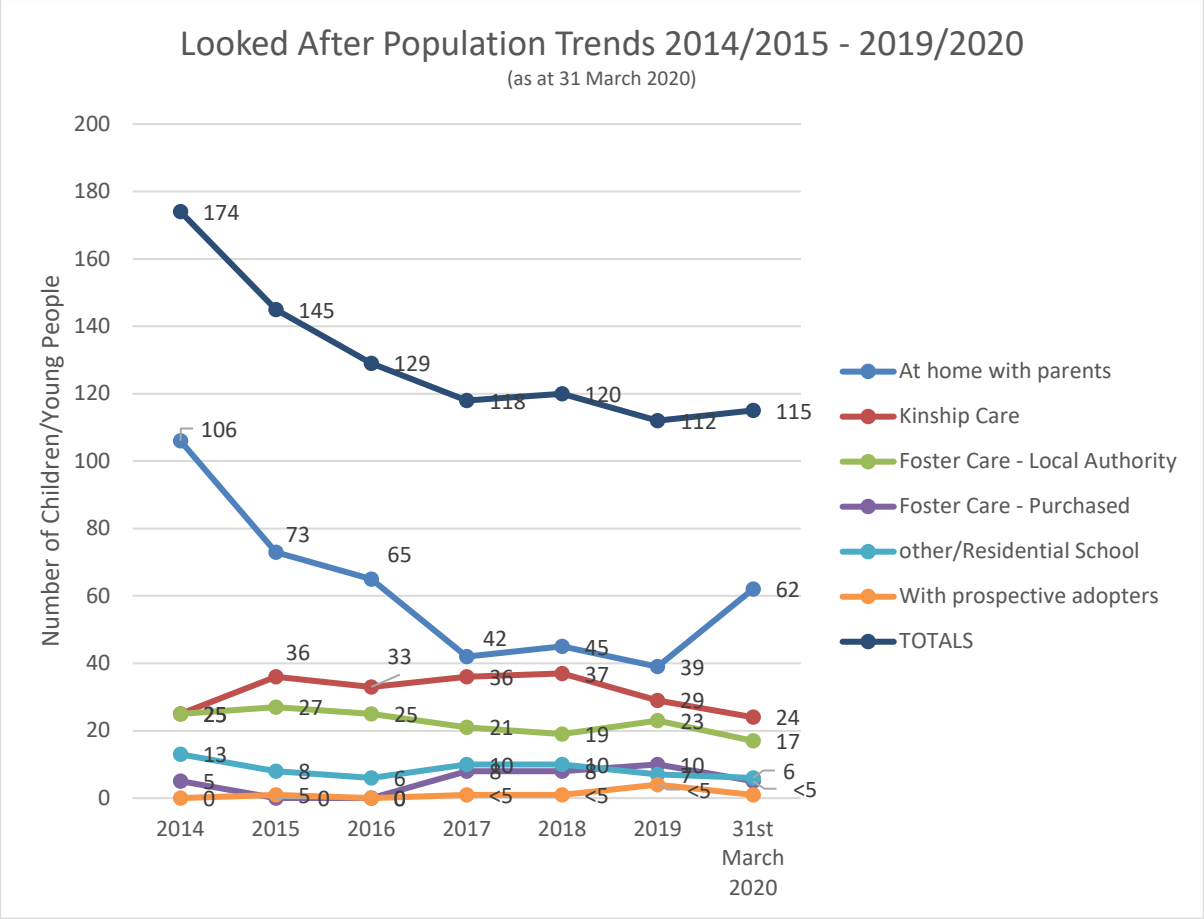
The service is funded to accept a minimum of one hundred and seventy-eight referrals per year but has exceeded this figure significantly already. Promotion of the service with GPs and strengthening the links with partner agencies is ongoing. Early evaluation of the programme is indicating a significant improvement in the emotional wellbeing of the children and young people referred with fewer repeat presentations to GPs with distress. The service has been delivering positive outcomes for those accessing support.

As part of our preventative approach, we are committed to strengthening family capacity and building confidence among parents where this is required. We continue to invest in and develop our **Psychology of Parenting Project (PoPP)** which offers support to families experiencing difficulties with behaviour. Families can access one-off interventions (discussion groups) focusing on a specific topic. There are also two high quality, evidence-based programmes - Triple P and Incredible Years – offering more intensive support for parents due to challenging developmental behaviours and distress. In 2019/20, 96% of the children participating demonstrated improved outcomes as measured by SDQ (Strengths and Difficulties Questionnaire) – up from 89% in 2018/19.

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

Through **PACE (Permanence and Care Excellence)** we have seen positive joint working, a strong 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.

To support the wellbeing of our looked after children we work to ensure they access the most appropriate destinations possible. We are proud that 98% of our looked after children are supported in the community rather than institutional settings (up from 94% for the previous available year).



On 31 March 2020, one hundred and fifteen children and young people in East Renfrewshire were looked after in a range of settings. This constitutes approximately 0.5% of the total children's population of the area and remains one of the smallest proportions in Scotland. Sixty-six of the children were boys (57%) and forty-nine were girls (43%). We have continued to consolidate the PACE Programme, working to improve outcomes for children by securing permanent destinations for them. The numbers of children who are looked after has remained consistent over the past four years.

Although this year has seen an increase in the number of children looked after at home there has been a consistent reduction in the length of time children are looked after for, particularly for children who are twelve and under. At March 2016 the average period a child was looked after for was nineteen months and this has reduced to fifteen months at March 2020.

Further analysis of our reduction in children who are looked after at home has shown that during the 2019/20, 23% of Compulsory Supervision Orders for children and young people at home with parents were terminated. A further 23% remain open on a voluntary basis to the Youth Intensive Support Service and 54% to Children and Families, again on a voluntary basis.

Key successes in supporting our looked after children over the course of 2019/20 include:

- The length of time children and young people are looked after at home has decreased.
- The number of children looked after away from home has decreased.
- Implementation of Signs of Safety approach has strengthened the voice of the family network in looked after reviews and permanence planning.

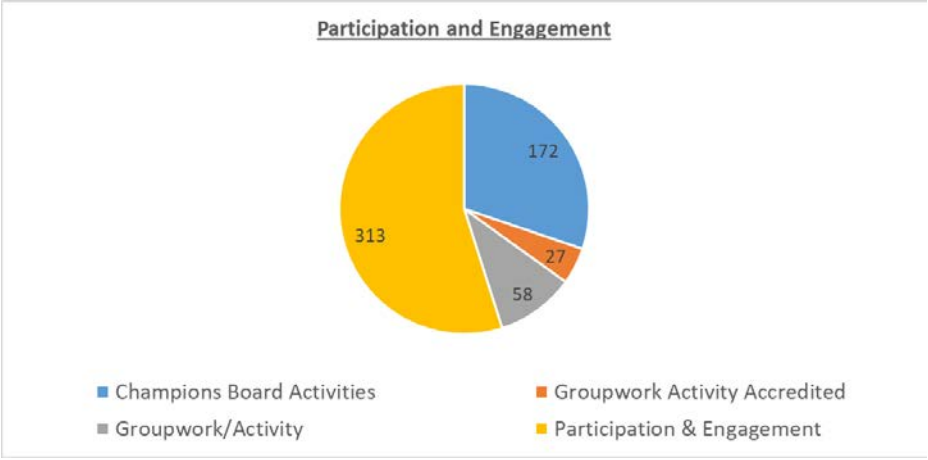
- Improvement work in multi-agency contribution to Scottish Children's Reporter Administration to support effective decision making.

Signs of Safety
Over 2019/20 we have continued the implementation of the Signs of Safety multi-agency model, led by the Chief Social Work Officer and the Head of Education Services (Equality and Equity). The model supports practice improvement, with a particular focus on developing relational interventions with children, young people, their families and carers in order to reduce risk and improve children's wellbeing.

Our key achievements for the second year of our five year implementation plan are:

- Continued commitment from Multi Agency Implementation Team.
- The development of a multi-agency practice lead network, which meets quarterly with a clear focus of direct practice improvements.
- Continued workforce training provided at different levels, advanced and generic for all staff groups including education, health, police and adult services.
- The implementation and application of revised processes and documentation which complement the model - for Child Protection, Looked After Children, Scottish Children's Reporter Administration (SCRA) and Children with Additional Needs.
- The application of the model in our Child Protection Case Conferences to ensure they are solution orientated, strength based and risk focused.

Throughout 2019/20, we have continued to engage with our children, young people, families and communities through the **East Renfrewshire Champions Board**, group work and participation activities. Between April 2019 and March 2020 there were five hundred and twenty opportunities for children and young people to take part in participation and engagement, twenty-seven of these have led to an recognised accredited award. These opportunities were taken up by eighty seven children and young people from all age groups across the children and families teams.



The 14-19 age group are most likely to participate but we are seeing increased engagement by the 7-12 age group which demonstrates the continued efforts of the community team to encourage involvement of all ages.

The overall aim of **East Renfrewshire Champions Board** is to improve life chances of looked after young people both within our community planning partnership and in the

wider community. A central focus is on inclusion and participation allowing looked after young people a meaningful forum to directly influence and, through time, redesign services that affect them in a co-produced way by influencing their corporate parents.

Through our Champions Board we offer looked after young people leadership opportunities, develop relationship-based practice and the opportunity to change practice and policy. Our aim is to demystify and challenge misconceptions about looked after children and young people and strengthen awareness of the barriers that they face whilst offering opportunities to develop policy and practice to overcome these. Moreover we aim to reduce stigma and ensure that our looked after young people flourish and become all that they can be so that they move into adulthood and beyond, achieving their aspirations.

2.3 Working together with our community planning partners on new community justice pathways that support people to prevent and reduce offending

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

2.3.1 Our strategic aim

The East Renfrewshire Community Justice Outcome Improvement Plan sets out our core outcomes, what we will deliver as partners and how this will contribute to and improve the lives of people with lived experience of the community justice system from point of arrest through to returning from custody.

Over the course of our Strategic Plan the East Renfrewshire HSCP is strengthening links with other community services and programmes to provide greater access and support for people to prevent and reduce offending. Through this work we will ensure that people moving through the criminal justice system have better access to the services they require, including welfare, health and wellbeing, addiction services, housing and employability.

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

- Reducing the risk of offending is through high quality person centred interventions;
- Ensuring people have improved access to through-care and comprehensive range of recovery services;
- Ensuring effective interventions are in place to protect people from harm.

2.3.2 The progress we've been making

- 100% of people reported that their community payback order helped to reduce their offending.
- 71% of community payback work placements were completed within court timescale.
- 79% of women accessing domestic abuse support services demonstrated a positive improvement in their outcomes.
- 16% of people moved from drug/alcohol treatment into recovery services.

2.3.3 How we've been delivering

We work with our partners to lead, develop, support and promote **Smart Justice** measures that work for those who have offended, those who have been harmed and for our community at large.

In 2019/20, East Renfrewshire's **Community Payback Team** successfully completed 9057 hours of unpaid work. This is approximately a 15% reduction in the number of hours

completed in the previous year (10,779), although we note the significant disruption of COVID-19 in March 2020. The Community Payback Team have been involved in a range of new projects during the year bringing benefits to the environment, local community and service user groups including local people with learning and physical disabilities. We continue to receive regular feedback from the public on the positive impact that community payback has had on their local community.

Dunterlie Foodshare

The Community Payback Team work in partnership with Dunterlie Community Hub to deliver a new food share project. This sees team members processing and delivering food parcels to those in need.

During 2019/20 we enhanced our unpaid work service by ensuring that tasks are meaningful to communities and provide learning opportunities for service users, including improving the environment and supporting charitable and voluntary organisations. Workshop premises have also been secured to expand opportunities of unpaid work.

Over the course of 2019/20 we have continued to develop strong partnership working in the **early planning of support** for offenders being released from prison. Our criminal justice and housing services are working closely together to ensure short stay accommodation is identified for individuals prior to release and support then provided to access a permanent tenancy.

We continued to deliver a multi-agency programme of offender focussed **trauma training**. Led by the criminal justice service and delivered to a multi-agency group of professionals (including housing, alcohol and drug services, employability and adult learning), this has supported the multi-agency delivery of interventions with those who hold convictions and have experienced trauma.

Several people with convictions were part of an **employment training programme** called Strive during the summer of 2019. This resulted in a number of positive outcomes for people who accessed this course, including employment. We have continued in 2019/2020 with a strong focus on our “No Barriers” project, which provides support with literacy and numeracy.

We have made significant progress to ensure we have a suitably qualified workforce supported by a clear pathway for domestic abuse referrals. As part of our community planning work to protect people from harm we implemented a multi-agency risk assessment conference (MARAC) for high risk domestic abuse victims. The MARAC is now fully operational as of June 2019. We appointed a Domestic Abuse coordinator in June 2019. This post has a critical role in supporting MARAC operations, co-ordination, risk assessment training, audit and reporting. All high risk domestic abuse victims and children now have multi agency action plans in place to reduce the risks posed to them by perpetrators.

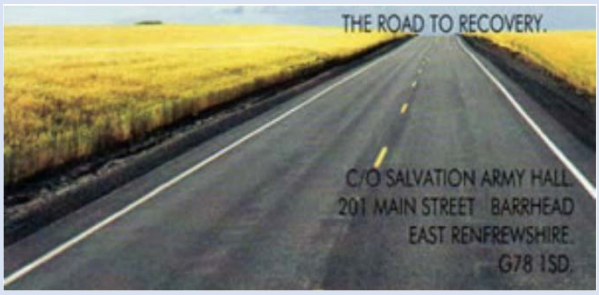
In 2019/2020, the criminal justice team began to facilitate the local delivery of the nationally accredited sex offender treatment programme, **Moving Forward Making Changes (MFMC)**. Three social workers are now trained to deliver the programme, with our Advanced Practitioner

being supported to undertake the treatment management role to ensure accredited standards can be met.

We provide a high level of support for women and children who have experienced **domestic abuse**. We work in partnership with East Renfrewshire Women's Aid Service to deliver a helpline, drop in and direct support services for women, children and young people accessed the. In the past year we saw 79% women experiencing domestic abuse reporting improving their personal outcomes with safety, health and wellbeing, and empowerment and self-esteem scoring highly. This was a significant improvement on performance for the previous year (64%).

We continued to deliver a comprehensive range of services to support people recovering from **drug and alcohol addiction**. During 2019/20 our local Community Addictions and Recovery Team provide tailored support including planning for recovery, one-to-one and group support, family support and links to other agencies and resources to help people in their recovery journey.

P.A.R.T.N.E.R. Group – supporting recovery



A key part of our local recovery community is the P.A.R.T.N.E.R. Group (People Achieving Recovery Together Now East Renfrewshire). The group provides mutual aid support and is run by people who are in recovery and have life experiences which they can pass on to any one struggling with addiction. P.A.R.T.N.E.R. runs weekly group meetings in Barrhead.

2.4 Working together with our communities that experience shorter life expectancy and poorer health to improve their wellbeing

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

2.4.1 Our strategic aim

East Renfrewshire's Community Planning Partnership has developed locality plans for the localities that have areas within the 20% most deprived areas in Scotland, with significantly poorer outcomes in health, education, housing and employment. The localities are: Arthurlie, Dunterlie and Dovecothall; Auchenback; and, Neilston. Plans have been developed using a community-led approach, which supported local residents to form steering groups to drive the process. Most of this work has been led by the Council's community planning team but health improvement staff have been involved in supporting the process.

Each plan has a set of priorities that reflect the unique needs of that locality. The plans form a basis for further work to which we are committed as a community planning partner. We will continue to support targeted health improvement interventions in our communities that experience the greatest health inequalities.

Our aim is to **improve wellbeing in our communities that experience shorter life expectancy and poorer health**, by:

- Reducing health inequalities by working with our communities;
- Mitigating health inequalities through targeted interventions.

2.4.2 The progress we've been making

- Our premature mortality rate remains significantly below the national average at 308 per 100,000 (Scotland 432)
- Male life expectancy at birth in our 15% most deprived communities is 74.7 compared to 72.1 for Scotland.
- Female life expectancy at birth in our 15% most deprived communities is 79.8 compared to 77.5 for Scotland.

2.4.3 How we've been delivering

Our **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 is 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 2019/20 Health Improvement supported 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, health behaviour change training and physical activity.

Strength and balance **exercise sessions** are being delivered in the Dunterlie area of Barrhead to encourage local people to access physical activity and walking groups have been set up in Barrhead and Neilston. Chair based exercise groups for older adults are also provided in Barrhead and other venues.

The Live Active programme funded by ERHSCP and NHSGGC is being actively promoted in Barrhead to increase referrals and we have strengthened links with East Renfrewshire Culture and Leisure Trust (ERCLT) and other exercise providers to develop smooth referral pathways between services.

East Renfrewshire HSCP continues to provide funding for an active health and wellbeing manager within ERCLT. This post has been developing the **Ageing Well** brand and has supported projects in Barrhead such as Dunterlie Tenancy Sustainability Project. Health Improvement staff have continued to provide information resources for community projects and events.

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

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

2.5.1 Our strategic aim

A key strategic aim for our partnership is to ensure that people with support needs continue to enjoy a good quality of life in their own home and local community. We do this through a wide range of community-led supports and interventions to ensure that individuals have choice and control in the decisions that affect their life.

We worked together with local people, community groups and organisations to redesign our 'front door' and establish new ways of engaging with people in their communities. We have established local 'Talking Points', where people can talk to different health and care staff and community volunteers about what matters to them. Through this approach we ensure that people have access to the right conversation at the right time and have the right support to maintain their independence.

Through our partnership with East Renfrewshire Culture and Leisure Trust we continue to deliver a key service for older people under the Ageing Well programme, with a range of activities that support and encourage older people to be physically and mentally active and maintain their independence. For those people who require support for their daily lives, we are moving to a model of "the right amount of support". In 2019/20 we implemented a new individual budget calculator for self-directed support. This is helping to minimise the barriers for people looking to take on more 'choice and control' and providing a more simple and transparent approach. We are also building the outcome focused support plans that move away from the task and time approach and allow more innovation and flexibility.

Our work in localities is building on our strong local partnerships and social enterprise approach, encouraging innovation that supports people to live independently in the community and offers alternatives to residential care.

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

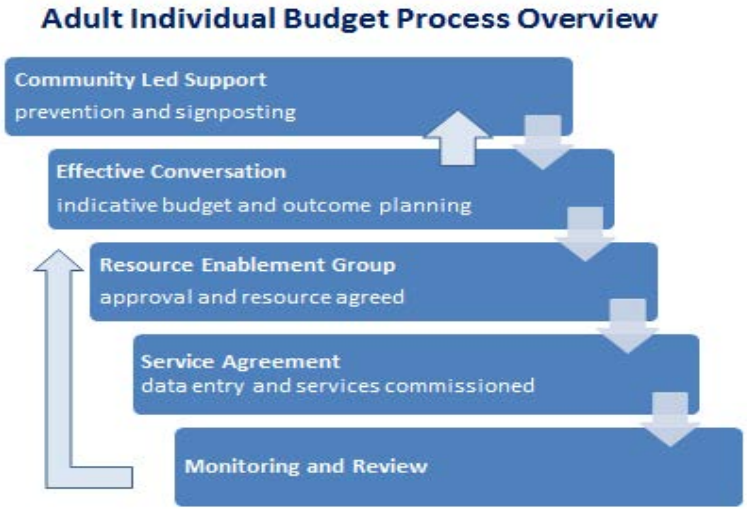
- Ensuring the people we work with have choice and control over their lives and the support they receive;
- Helping more people stay independent and avoid crisis though early intervention work;
- Ensuring people can maintain health and wellbeing through a range of appropriate activities.

2.5.2 The progress we've been making

- 88% of people reported that their 'living where you/as you want to live' needs were being met
- 8.2% of adult social work spend is spent through SDS Options 1 and 2 (4th best in Scotland)
- 58% of people aged 65+ with intensive needs are receiving care at home

2.5.3 How we've been delivering

During 2019/20 we implemented our new approach to planning with people who need support so that they have greater choice and control over their lives. Our individual budget calculated replaced our previous equivalency model for **resource allocation** for adults and was rolled out across our teams. The individual budget approach fits with our new ways of planning with people and allows more innovation and flexibility to meet their desired outcomes.



The 'right amount of support' individual budget calculator is now being used for all types of resource provision from modest one-off interventions through to a complex care package. This removes the barriers and potential inequity of traditional eligibility criteria and recognises the importance of prevention.

Our teams are working creatively with people to make the best use of their budget to meet their outcomes. From the launch of the guidance in December 2019 to the end of March 2020, the Resource Enablement Groups in Barrhead Locality considered fifty-five individual budgets and plans and Eastwood Locality considered seventy individual budgets and plans.

We have listened to the views of local people and have redesigned the way people can access support and information at the first point of contact – our "front door". Our **Initial Contact Team** came into place in May 2019 and has transformed the way people can engage with the HSCP.

Our team have been trained in good conversations that focus on what matters to each person and what assets and community supports could help them achieve this.

Occupational Therapy Rapid Access is also part of our new Initial Contact Team. This integrated approach has reduced waiting times for occupational therapy assessment and more efficient access to e-advice and equipment to support independence.

The HSCP is committed to promoting Community Led Support which sees a move from traditional day service provision for older people to enabling access to more local, personalised and flexible services.

As part of this approach, **Talking Points** hubs have been established across East Renfrewshire as places where people can go to have a good conversation about their health and wellbeing within their own community. Here they can be directed to services and support that best meet their needs. The Talking Point hubs are staffed by third sector organisations with support from social work services. A Talking Points Partnership was created to bring together the third sector across East Renfrewshire to support the development and coordination of Talking Point hubs.

The Talking Points Partnership consists of over 50 local organisations and representatives from the statutory sector. The Core Partners Group consists of 12 cross-sector partners; Voluntary Action East Renfrewshire, Carers Centre, Care and Repair, Recovery Across Mental Health, East Renfrewshire Disability Alliance, Enable Scotland, HSCP, ERC Communications Team, Self-Directed Support Forum, Neilston Development Trust, East Renfrewshire Culture and Leisure Trust/Libraries, and Community Volunteers. Talking Points are held in venues across East Renfrewshire

We delivered a total of 102 'Talking Points' engagement sessions during 2019/20. Over the course of the sessions we undertook 959 conversations with individuals resulting in 773 referrals or signposting. Of these less than a fifth (145 – 19%) resulted in referrals to the HSCP. Forty-four percent (336) were referrals/signposting to the 3rd sector, 20% (158) were the provision of general community information and 17% (134) were referrals to East Renfrewshire Council services.

Views on Talking Points

"My conversation with the Talking Points Team was First Class. I got all the information and help I needed and my Home adjustments are now in place. Everything's sorted."

- Attendee

"Thank you for your informative and courteous first contact with impressive list of care and recreational possibilities which will certainly help me acquire the necessary cultural and health info to enable my ongoing independence as I enter this new phase in my life"

- Attendee

"I am living on my own since my wife went into a home with dementia. It has been difficult for me as she has changed so much but coming to Talking Points and going to the club you told me about gives me a break from the stress and lets me meet other people and make friends. Thank You."

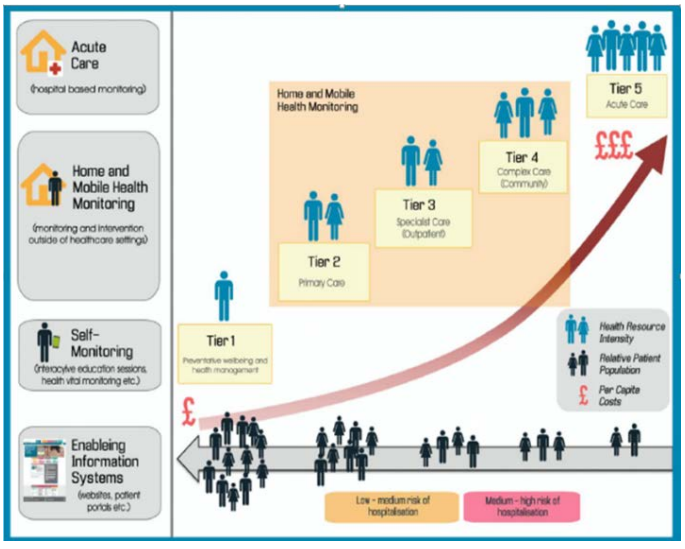
- Attendee

"If one of our clients phones and it's something we can't help with, through meeting all the other organisations, I know who to pass them on to. Now I know the services personally."

- Third sector organisation

"We have a much clearer understanding of who is offering what across East Renfrewshire."

- Third sector infrastructure organisation



We continue to develop and modernise our approaches to supporting people to live independently and well in the community. The vast majority of East Renfrewshire's GP practices use **Home and Mobile Health Monitoring (HMHM)** to support the management of hypertension and some practices also offer it for the management of COPD. During 2019/20 we have been undertaking innovative Tests of Change. This saw us scale up our work relating to blood pressure, rolling out access to the Florence telehealth service, and working in close partnership with the Heart Failure Nurse team. Our new protocol means that the team can monitor the blood pressure and heart rate of East Renfrewshire patients remotely. The benefits include:

- Patients can more effective self-manage their condition;
- It allows the specialist heart failure nurses to identify patients whose condition is deteriorating and require more input;
- It allows nurses to reduce visits to only those needing a visit.

We have been working closely with eHealth to install Attend Anywhere equipment in all GP surgeries allowing remote access to consultations. Due to the onset of Covid 19, this was fast tracked and all GP surgeries received equipment, equipment installation and training in use of the system which is now utilised as business as usual.

Over the course of 2019/20 we have continued to expand our **telecare** provision. Through active promotion of the service via marketing materials and web pages including online application, around 3,000 residents are benefitting from our Telecare service. The Telecare team continues to work in close partnership with other teams and organisations to support independence at home. The team were delighted with the outcome of the most recent Technology Enabled Care (TEC) Services Association audit which resulted in the service having no requirements or improvement areas identified.

Telecare performance highlights 2019-20

Performance targets:

- Alarm calls answered within 1 minute- 98.9% (target 97.5%)
- Response visits within 45 minutes – 90.82% (target 90%)
- Critical repairs completed within 48 hours-94.7% (target 90%)

Customer satisfaction survey shows:

- 100% were satisfied with installation process, with 85% rating it as excellent
- 99.4% were satisfied with call handling, with 96% rating it as excellent
- 97.4% were satisfied with our response visits, with 93% giving a rating of excellent
- 100% were satisfied with the quality and value for money of the service, with 95% giving a rating of excellent

We continue to support people with **learning disabilities** to live independently in our communities. We support a wide range of meaningful activities in the community for people with learning disabilities. This includes social enterprise groups delivering bike workshops, jewellery making, gardening groups and kitchen/café training. We also support a range of community groups, e.g. social/ leisure groups that allow people to follow their interests as well as health groups.

For **older people**, we support a range of health and leisure activities in the community under our Ageing Well programme to help people keep their bodies and minds as active as possible.

2.6 Working together with people who experience mental ill-health to support them on their journey to recovery

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

2.6.1 Our strategic aim

Health and Social Care Partnerships across Greater Glasgow and Clyde are committed to working together to develop a whole system five-year strategy for adult mental health. Delivering on our strategy will involve a whole series of actions and service changes.

Our local services in partnership with third sector organisations like Recovery Across Mental Health (RAMH) have shifted to recovery-oriented care, supporting people with the tools to manage their own health. A recovery-based approach has the potential to improve quality of care, reduce admissions to hospital, shorten lengths of stay and improve quality of life. While service users will always have access to the clinical and therapeutic services they need, a recovery approach will require services to embrace a new way of thinking about illness, and innovative ways of working. Those changes include:

- A change in the role of mental health professionals and professional expertise, moving from being ‘on top’ to being ‘on tap’: not defining problems and prescribing treatments, but rather making their expertise and understandings available to those who may find them useful.
- A recognition of the equal importance of both ‘professional expertise’ and ‘lived experience’ and a breaking down of the barriers that divide ‘them’ from ‘us’. This must be reflected in a different kind of workforce (one that includes peer workers), and different working practices founded on co-production and shared decision making at all levels.

We are working in partnership across Greater Glasgow and Clyde to improve responses to crisis and distress, and unscheduled care. The strategy signals a further shift in our balance of care moving away from hospital wards to community alternatives for people requiring longer term, 24/7 care with mental health rehabilitation hospital beds working to a consistent, recovery-focused model.

Our aim is to **support people experiencing mental ill-health on their journey to recovery**, by:

- Ensuring East Renfrewshire residents who experience mental ill-health can access appropriate support on their journey to recovery.

2.6.2 The progress we've been making

- 65% accessing psychological therapies within 18 weeks (improving).
- 16% of service users moving from drug treatment to recovery service

2.6.3 How we've been delivering

Our Primary Care Mental Health Team (PCMHT) have been working to reduce our waiting times for psychological therapies which we acknowledge are currently too high due to capacity issues in the service. The proportion of people accessing psychological therapies within the 18 week target has improved to 65%, up from 54% last year.

Our preventative and holistic approach continued to develop over 2019/20. To support appropriate responses to individuals with mild to moderate mental health issues we have put in place alternative pathways for people needing supports. This includes our Link Workers which are now established in all GP surgeries in East Renfrewshire. Delivered in partnership with RAMH, the **Link Workers** signpost people to a wide range of support providers offering physical, social and psychological interventions. The workers have provided support to approximately 2000 local people.

We continue to promote the use of computerised cognitive behavioural therapy (**cCBT**) through our GPs, with people referred to an online course of therapy. There continues to be a good uptake of this alternative model with 287 referrals from GPs to cCBT in 2019/20 although this does represent a drop from 2018-19 of 394.

We have been referring individuals who have a Borderline Personality Disorder to the Dialectic Behavioural Therapy (DBT) service in South Glasgow and have seen a reduction in the use of acute mental health days following the intervention compared to the average use in previous years.

2.7 Working together with our colleagues in primary and acute care to care for people to reduce unplanned admissions to hospital

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

2.7.1 Our strategic aim

We are committed to a programme of work with colleagues in acute services to ensure that only those people who require urgent or planned medical or surgical care go to hospital. Together we are looking at the most frequent preventable causes of admission and putting in place new services and pathways to support people in the community wherever possible, including at the end of life. Our aim will always be to return people home as quickly as possible and to support people at home wherever possible. However, sometimes people require additional supports. Over the lifetime of our plan we intend to develop Bonnyton House using six beds as an intensive rehabilitation resource to prevent hospital admission and to ensure a safe return home for people discharged from hospital. We will also create a further six beds so that people who need end of life care, who can't be supported to die at home, could also be supported at Bonnyton.

We want to work together with local care homes, the people who live there and their families to ensure that they get the best care for this final stage of their lives. Over the course of our strategy we have been redesigning our services to focus on this, ensuring that our most skilled nurses and staff are available to offer specialist advice and support.

We are working together with our colleagues in primary care to implement the new GP contract and Primary Care Improvement Plan. The new contract aims to support local GPs to spend more time in managing patients with complex care needs. Over the course of our strategy we will support primary care teams to grow to support more patients in the community, with additional pharmacy, community treatment (e.g. phlebotomy), other health professionals and link workers.

Our aim is to **reduce unplanned admissions to hospital (through working together with our colleagues in primary and acute care)**, by:

- Supporting people at greatest risk of admission to hospital;
- Working with local partners to reduce attendances and admissions;
- Ensuring our services support rehabilitation and end-of-life care.

2.7.2 The progress we've been making

- Average of 2 delayed discharges per month

- 1,788 hospital bed days lost to delayed discharges (adults) – down 21% from 2018/19
- 20,090 A&E attendances (adults) – slight reduction from 2018/19 (20,212)
- 7,504 emergency hospital admissions (adults) – slight increase from 2018/19 (7,320)
- 88% for % of last six months of life spent in community setting (up from 86% previous year)

2.7.3 How we've been delivering

Reducing **Accident and Emergency attendances** continues to be challenging area for us. Over the course of 2019/20 there were 20,090 attendances by adults, above our target of 18,332. Adult emergency **hospital admissions** were 7,504 a slight increase from 2018/19. We have been using local data to identify people making frequent emergency attendances and exploring lines of enquiry to determine what further action would provide better support to the patient and avoid unnecessary presentation at the Emergency Department. We continue to work closely with GPs at cluster level and individual practice level.

During 2019/20 we continued our collaborative work with local **care homes**, working to minimise emergency attendances and admissions. We have seen a reduction for both attendance and admissions from care homes compared with 2018/19 and are ahead of target for both measures. Annual emergency admissions from care homes have continued to fall steadily at 233 in 2019/20, down from 261 in 2018/19 and 338 in 2017/18. We have been looking closely at reasons for admissions and sharing learning on best practice between care homes. There has been several improvement interventions put in place to help reduce emergency attendance and admission:

- Red Bags - This has helped standardise the processes for the admission to hospital and return of care home residents. However, there still remains the challenge of raising awareness of the project with staff across all the services that come into contact with the red bag.
- Anticipatory Care Planning – Role out of pathway and processes at care homes has been shared. The test is in the number that is reported in the Key Information System (KIS).
- Care Home Improvement Forum – this has been set up to be used as an improvement forum with key stakeholders invited to provide advice and share relevant learning and expertise. Having the lead nurse, Care Home Liaison Manager, Prescribing lead and Falls lead joining the forum regularly has helped strengthen relationships with between the Care Home sector and the HSCP. The Care Home Improvement Forum has helped develop integrated working with key teams where gaps have been identified.

East Renfrewshire continues to develop a model to support safe and early discharge from hospital by increasing their resource and skill mix within the **Hospital to Home team**. A Delayed Discharge dashboard is being proactively used along with Improvement activity to support earlier in-reach and effective discharge planning with individuals and their families. Despite this proactive activity the HSCP is still challenged with delays resulting from Adults with Incapacity (AWI) and family choice/indecision. 2019/20 saw a range of development including 'Choices meetings' being fully utilised to support shared decision making and cross partnership working to look at AWI pathways.

Anticipatory Care Planning (ACP) is a person-centred, proactive approach, requiring services and professionals to work with individuals and their carers to set personal goals ensuring the right thing is done at the right time by the right person with the right outcome. ACP evolves reflecting the individual's situation and requires a supportive whole-system infrastructure to ensure delivery of positive outcomes.

East Renfrewshire aims to:

- Improve engagement with the ACP process to facilitate the sharing of key information to prevent hospital admission and facilitate safe, early discharge
- Reduce unnecessary attendances to Emergency Departments and Acute Assessment units
- Connect with the Frailty management process to deliver a more co-ordinated and integrated approach across Health and Social Care, Primary Care and Acute services

Prince and Princess of Wales Hospice Collaborative agreed to implement out multi-disciplinary team (MDT) huddle, initially based at Eastwood HSCP building with the aim of improving communication between HSCP staff to prevent unnecessary admissions and proactively manage ACP, promoting seamless joint care. The work responds to the challenge of providing care for an ageing population with increasing prevalence of long term conditions and multiple core morbidities.

We remain committed to strengthening **End of Life** provision in our communities. We continue to take a collaborative approach working with Prince and Princess of Wales and Accord Hospices. We have been using data and case file reviews to better understand the circumstances of East Renfrewshire residents dying within the hospital setting in last 6 months of life. Positive work in this area has seen an improvement in the percentage of time people are spending in the community in their last 6 months with the indicator rising to 88% from 86%.

During 2019/20, GP practices in East Renfrewshire were supported to deliver an NHSGGC-wide **prescribing initiative** which focussed on improving prescribing in four key areas: oral anticoagulant medicines, medications for pain, diabetes and respiratory medicines. As well as supporting residents in the community, these projects resulted in efficiency savings to the HSCP of approximately £65k.

The **Medication Support Service (MSS)** continued to support patients and their carers to achieve the desired outcomes from their medication, leading to better health and improved quality of life. The team of Clinical Pharmacy Technicians offered home visits to people following discharge from hospital or who were identified as needing help with their medicines at home. The number of referrals into the service has continued to increase with a 34% increase compared to the previous year.

Primary Care Improvement Plan

2019-20 was year two of the East Renfrewshire's Primary Care Improvement Plan. The plan is in place to enable the role of the GP moving forward to evolve into the expert medical generalist. This new GP role will be achieved by embedding multi-disciplinary primary care staff in practices to work alongside and support GPs and practice staff to reduce GP practice workload and improve patient care.

Key impacts of the plan in year two included:

- The Vaccination Transformation Programme (VTP)
  The delivery of routine childhood immunisations has fully transferred from all East Renfrewshire GP practices, with delivery now based in two community clinics within our Health Centres, these are delivered by a new NHS GGC Pre School Immunisation Team.

  The Heath Visiting team ran a pilot of children's flu clinics in Barrhead Health and Care Centre for 2-5yrs olds and the uptake had increased greatly based on previous years. The learning from this pilot will help inform the shift of this target group in year three.

			Historical uptake % of participating GP practices	
HSCP	**Pilot Clinic**	**Accumulative uptake % to date**	**2018/19**	**2016/17**
East Ren	Barrhead	73.3%	47.9%	52.9%

  Adult Immunisations (Flu, Pneumococcal, Shingles and Travel), the wider programme of adult vaccinations, continues to be scoped and planned through HSCP representation at the NHS Greater Glasgow and Clyde Adult Immunisation VTP group.

- Pharmacotherapy
  All 15 GP Practices have a minimum of 0.4WTE allocation of PCIP Pharmacotherapy. Prescribing Lead and Localities Improvement Manager were visited all GP Practices in January 2020 to review their Pharmacotherapy resource and gather views to inform the planning process for year three of PCIP.

  Work is currently underway to scope out the feasibility of testing a hub model, in which some level one activities would be carried out in a hub, possibly at GP cluster level, staffed by Pharmacy Technicians and Pharmacy Support Workers. Such a model would increase Pharmacist capacity, reduce demand for space in practices, and might provide a more efficient use of resource by minimising duplication of effort.

- Community Treatment and Care Services
  Our Band 3 Community Health Care Assistants 3.8WTE successfully completed the Community Health Care Assistant module at Glasgow Clyde College, improving their competencies to undertake a broader variety of tasks to support scheduled chronic disease management within a practice setting, treatment room setting or out in the community including suture removal, urinalysis, simple wound dressings, BMI, health and weight etc.

  In collaboration with GP practices data was gathered to understand the activity currently taking place in local practices by the nursing team, to allow us to understand the type and volumes of activity planning to shift from practices to Treatment Rooms. Staff have been recruited for the two Treatment Rooms and Eastwood and Barrhead Health and Care Centre. Two Short Life Working Groups are actively developing referral pathways/processes, appointment allocation, sharing of information between GP Practices and the Treatment Room and Standard Operating Procedures planning to go live in April 2020.

- Urgent care (advanced practitioners)
  In June 2019 following three rounds of recruitment our transitioning Advanced Nurse Practitioner (ANP) came in to post. In order to complete transition to ANP a portfolio had to be completed requiring GP support. PCIP funding was used to remunerate two practices who offered to support the competency sign off over a six month period. Competency sign off was completed to a fully-fledged ANP by January 2020. Data will

be reviewed in April 2020 to measure impact of the role in reducing GP House visits, reducing unscheduled hospital admissions, onward referrals and improved outcomes for individuals to help inform the model required for East Renfrewshire GP's.

- Additional Professional roles
  We now have 2WTE Advanced Practice Physiotherapists (MSK) in post providing support to four GP practices. A key success factor in utilising this resource appropriately is effective signposting by reception staff, which GGC have noted as a key enabler in East Renfrewshire's high percentage of referrals.

- Community Links Worker (CLW)
  We have 4 WTE allocated and embedded across all 15 GP Practices. We are looking to complete a full analysis of the service and impact review by the end of March 2020. To date this service has provided support to 2,000 patients.

- Partnership working
  The local PCIP Steering Group continues to progress well and demonstrates positive collaborative working between GP practices, Quality Clusters and the HSCP. Terms of Reference have been approved and several option appraisals and standard operating procedures have been developed in partnership prior to implementation of the MOU's.

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

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

2.8.1 Our strategic aim

Working together, stakeholders including HSCP staff, the Carers Centre, Voluntary Action East Renfrewshire (VAER), the Care Collective and people with experience as carers have considered information and guidance for the Carers (Scotland) Act 2016 as it emerged from Scottish Government along with our local context and implications for implementation of the Act, including local people's thoughts and experiences of caring and support for carers. They have identified the following conditions for success:

- Carers can participate in the decisions and the design of services that affect them;
- Stigma associated with the challenges of caring is reduced;
- Accurate information in relation to rights, eligibility criteria, statutory and non- statutory support is available and accessible.

In delivering our strategic plan we are working together to improve access to accurate, timely information that meets carers' needs and awareness of the range of supports for carers. We will continue to encourage collaboration between providers of supports to carers ensuring local provision best meets carers' needs. We will provide information and training to raise awareness of the impact of caring responsibilities and ensure we have trained advisers in a range of organisations who can develop plans with and for carers.

Through our work on self-directed support we will develop and implement a consistent and clear prioritisation framework and ensure that carers and support organisations are aware of the availability of suitable respite care and short-break provision. Working together with education we have been developing support systems that appreciate young carers and build resilience through opportunities for peer support. This includes implementing a process for a young carers statement that has been designed by young carers for young carers and is owned by the young carer.

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

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

2.8.2 The progress we've been making

- 92% of people reported 'quality of life for carers' needs fully met
- 37% of carers feel supported to continue in their caring role (2017/18 - in line with Scottish average)

2.8.3 How we've been delivering

Our local indicator shows 92% of carers reporting satisfaction with their quality of life, up 14% from 2018/19. This indicator has improved consistently year on year and by 22% since 2016/17. However, the 2017/18 Scottish Health and Care Experience Survey showed that just 37% of carers felt supported in their caring role. While this is in line with the Scottish average, we would like to see this indicator improve and remain focused on ensuring that local people who provide unpaid care are valued and supported.

Over 2019/20, support to carers has been delivered in collaboration with our local Carers Centre. Carers Centre staff have been trained in outcome-focussed, asset-based planning and Good Conversations and have completed 56 Adult Carer Support Plans (ACSP) with carers since January 2019. Of these, using our recently developed eligibility framework, 14 carers were identified as having a substantial or critical need for support and referred for further social work intervention.

Working in partnership with the Care Collective (East Renfrewshire Carers and Voluntary Action East Renfrewshire), the HSCP has undertaken a range of activities to support the implementation of the Carers Act and establish a holistic approach to supporting local carers. We believe we have developed a sound continuum of support for improving outcomes for carers of all ages. To support this the HSCP appointed a Carers Lead in 2019/20 to promote the understanding and uptake of the legislation within East Renfrewshire. The Carers Lead is taking forward the development and implementation of the new East Renfrewshire Carers Strategy.

We continue to deliver **community-based integrated support** for carers in East Renfrewshire including access to tailored advice, support, planning and community activities. We work closely with partners to ensure we develop the appropriate range of creative **short breaks and respite** options as support for families with their caring role. Our Short Breaks Statement forms the basis of how we develop short breaks for carers within East Renfrewshire. It provides useful links to sources of advice, information and support and will be reviewed annually as per the Act with partners from the carers centre.

Our Carers Strategy sets out the following key principles in our approach to supporting carers in East Renfrewshire:

Principles	Outcomes
Carers are identified. respected & involved	• Carers will be identified at an early stage as carers, valued as equal partners in planning and involved in decisions about any service that affects them
Carers experience is positive	• Carers will have a positive experience of support and solutions, their voice will be heard in support planning and assessment conversations and their own outcomes will be met as well as the person they care for
Carers lead full lives and support their own wellbeing	• Carers will be able to lead a full life, to maintain their own health and wellbeing, to plan and identify what matters to them and will know what resources are available to help them with this and where to find them
Carers have choice, control and balance in their life	• Carers will have choice and control in their caring role and balance in their life with the other things that matter to them

2.9 Public protection

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

2.9.1 Our strategic aim

Ensuring people are safe is a vital part of our work. We take a multi-agency approach to deliver our community planning outcomes:

- Residents are safe and supported in their communities;
- Children and adults at risk are safer as a result of our intervention.

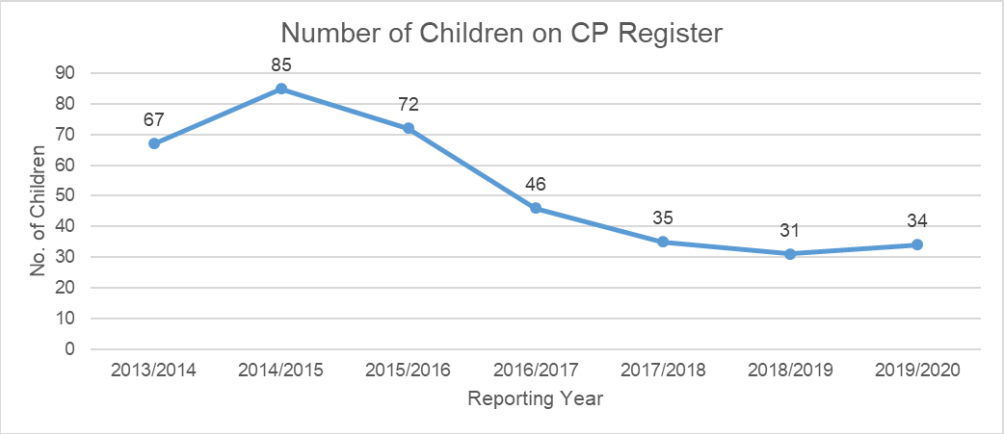
Our aim is to **ensure residents are safe and supported in their communities**, through:

- Prevention - People, communities and services actively promote public protection;
- Identification and Risk Assessment - Services know who is most at risk and understand their needs;
- Interventions - Communities and individuals are supported to manage and reduce risk;
- Monitoring and Reviewing Risk - Services effectively measure progress and identify further problems quickly.

2.9.2 How we've been delivering

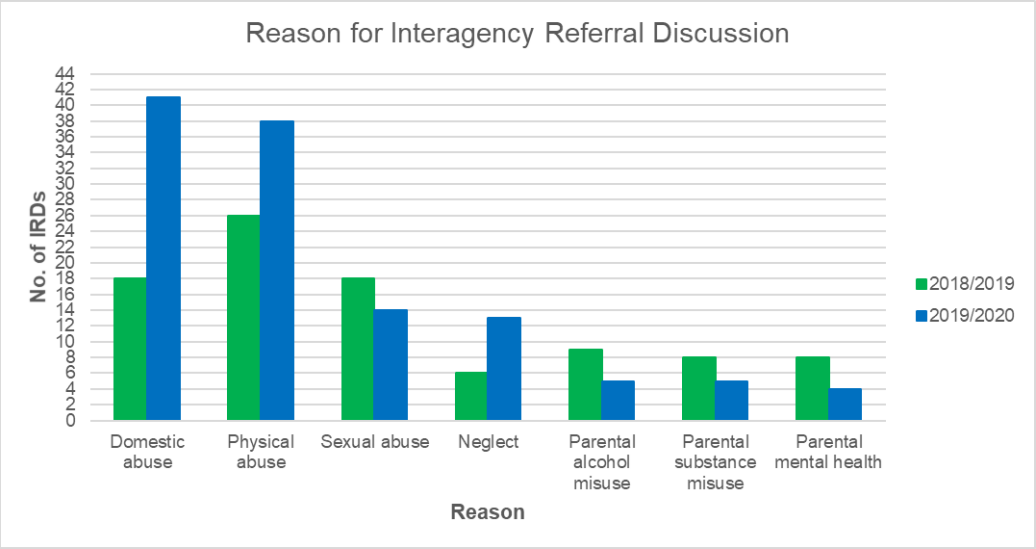
Supporting Children

The number of children on East Renfrewshire's **Child Protection** Register remained stable at 34 in 2019/20. In addition to robust management and audit activity, we continue to benchmark against comparator authorities to ensure that the rate of registration activity is proportionate and necessary.



During the period 2019/20, we undertook 126 **Interagency Referral Discussions (IRDs)** (between social work, police, health and where appropriate education services) in respect of 209 children. As shown in the chart below, there has been a significant increase in IRDs relating to domestic abuse which could be due to the increased awareness raising across the authority of the Multi Agency Risk Assessment Conference (MARAC) process. The associated Risk Assessment and Safe and Together training is also building confidence in the workforce in recognising and understanding the signs and impact of domestic abuse. There

was an increase in concerns of neglect and decrease in referrals relating to parental alcohol/substance misuse and mental health respectively.



During 2019/20 our programme of IRD audits reported significant strengths in our practice, including:

- 100% of the children subject to child protection investigation met the threshold for child protection.
- Initial Referral Discussion was assessed as good or above in identifying, analysing and making a decision for children about the risk of significant harm in over 90% of families.
- Planning to reduce risk to children was assessed as good or above in 97% of families.
- Early analysis suggests that changes to our discussion paperwork have improved the quality of recording around key decisions such as the requirement for medical examination.

In 2019/20 our audit programme also showed continuing improvement in our processes for Joint Investigative Interviews (JII) with children. East Renfrewshire is one of the first areas nationally to pilot and implement the learning from a new Joint Investigative Interviews training course, which aims to design a truly child-centred, trauma-responsive approach to Interviews with the best interests of children at the centre based on European Promise quality standards.

Supporting Adults

Following a period of self-evaluation of Adult Support and Protection (ASP) practice within East Renfrewshire HSCP we developed and have been delivering our ASP Improvement Plan. During 2019/20 this has seen significant progress in the development of more effective and efficient operational procedures as well as improvements in our management information and performance monitoring.

EAST RENFREWSHIRE
ADULT PROTECTION COMMITTEE
Adults need protecting too

Our Adult Support and Protection Committee is responsible for monitoring and advising on adult protection procedures and practice, for ensuring appropriate cooperation between agencies and for improving the skills and knowledge of those with responsibility for the protection of adults at risk. The Committee has links with a number of key agencies and is supported by a range of sub-committees working to continuously improve our approaches.

Over 2019/20 we have reviewed and implemented new professional governance arrangements for ASP and this has resulted in an improvement in the accuracy of our data in ASP. We have implemented enhanced senior management oversight and decision making within ASP. For example, all Initial and Review Case Conferences are now chaired by a Senior Social Work Manager with escalation processes built in to the Head of Service. This provides professional reassurance to the Chief Social Work Officer about the implementation of ASP within the HSCP.

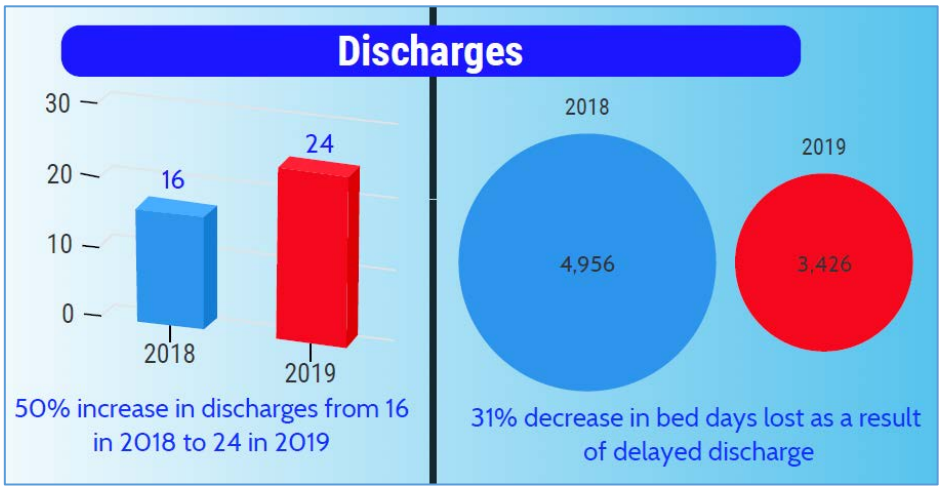
We continue to see improving timescales for the completion of **ASP inquiries** in 2019/20, 82.5% of all inquiries were completed within the five day standard timescale and we are seeing increased compliance with the timescale in comparison to the same period in 2018/19. There were 697 inquiries in 2019/20, up by 11% from 624 in 2018/19.

During 2019/20 there were 191 **ASP investigations** that involved 175 individuals. The conversion rate from inquiry to investigations is 27% and is lower than in previous years. (36% in 2018/19 and 34% in 2017-18). Over 2020/21 we will be quality assuring this process, to gain a greater understanding of the decrease in conversion from inquiry to investigation in the context of an increase in inquiries.

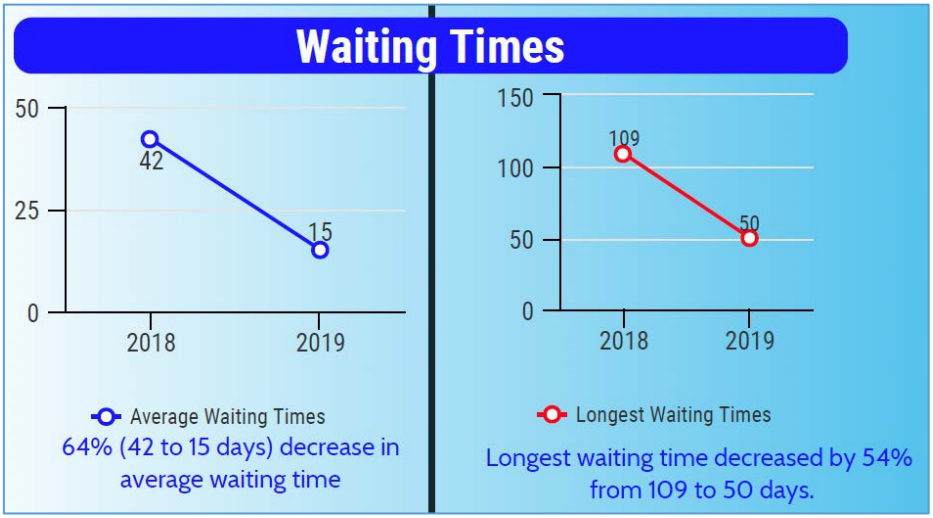
2.10 Hosted Services – Specialist Learning Disability Service

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

Over the course of 2019 we have seen an improvement in patient flow, including a significant reduction in patients being admitted inappropriately for challenging behaviour and an increase in appropriate mental ill-health admissions. In 2019 only 3 people (14% of new admissions) were admitted to the service for challenging behaviour alone. This compared with 7 people (54%) in the previous year. Discharges from the service increased by 50% between 2018 and 2019 (from 16 to 24) and there was a 31% reduction in bed days lost as a result of delayed discharges. At the end of 2019, 56% of people had a discharge plan, compared with 20% for the previous year.



There has been a significant improvement in waiting times for the service, with a 64% reduction in the average waiting time from 42 to 15 days. The longest wait to access the service also reduced from 109 days to 50 days (a 54% reduction).



2.11 Supporting our staff

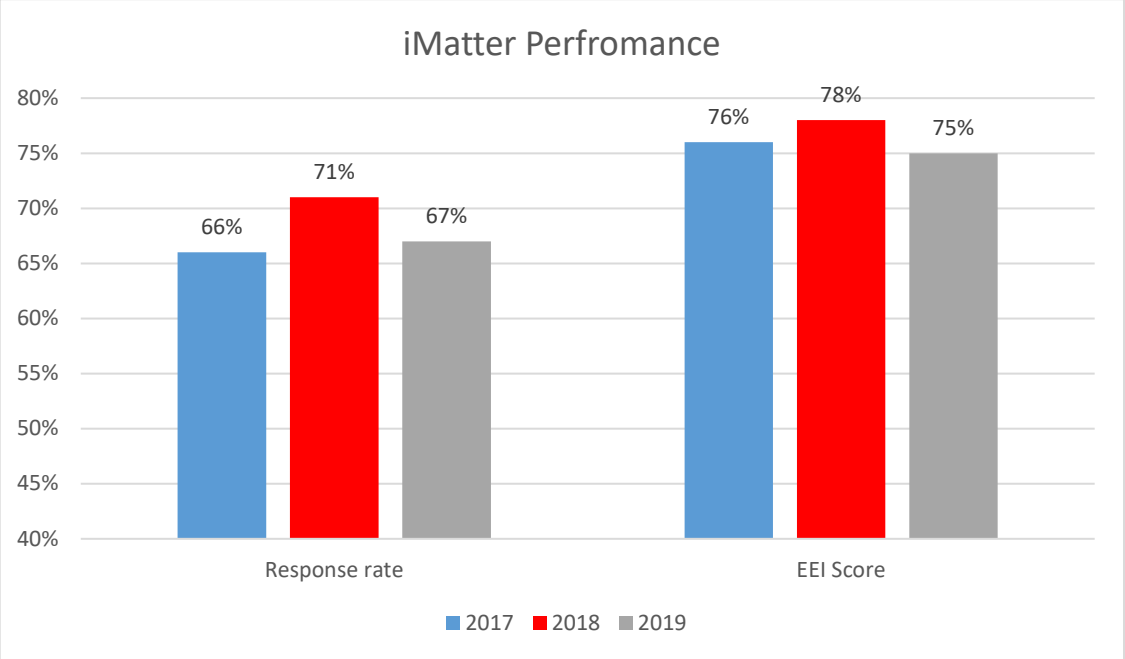
National Health and Wellbeing Outcomes contributed to:
NO8 – People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide

2.11.1 Our strategic aim

We are focused on developing and maintaining a workforce that is engaged and fully committed to delivering the outcomes and key objectives of the HSCP. 2019 was the third 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.

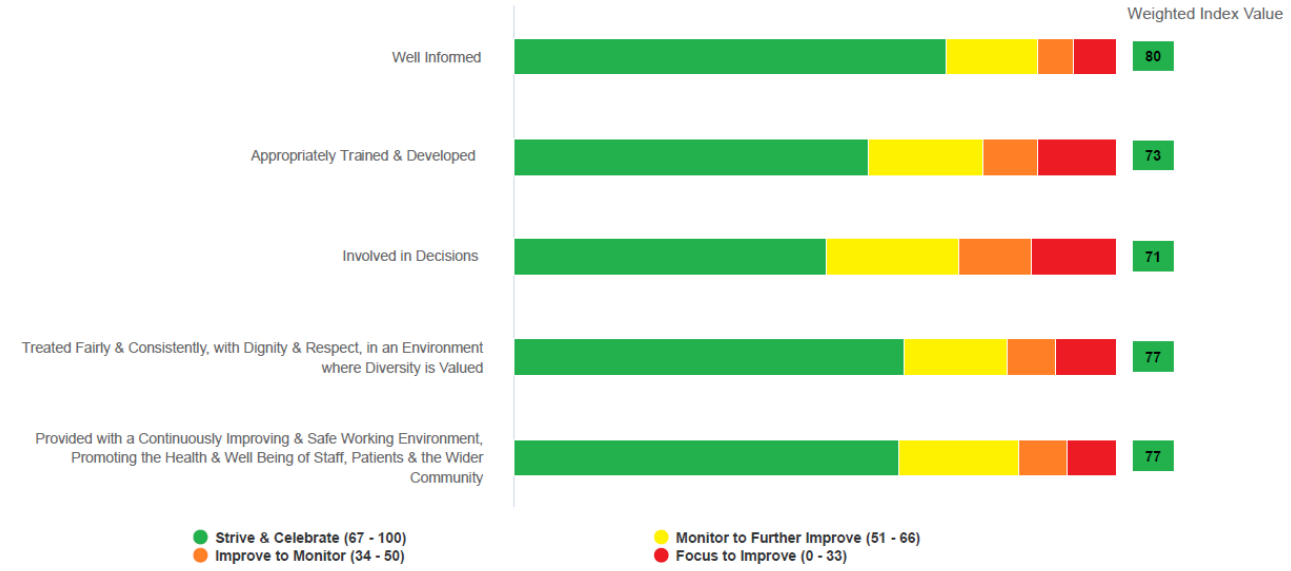
2.11.2 The progress we've been making

In 2019 we continued to see high participation in iMatter although there was a drop on the participation rate from the previous year. This was anticipated due to the expansion of the response group and inclusion of more staff requiring to give paper responses. The chart below shows that in the last year participation was at 67% and that our Employee Engagement Index (an aggregated score relating to key employee engagement measures) was 75%. iMatter is increasingly being used as a development tool with a high level of teams completing Action Plans in response to the survey results. Team action planning was at 96%, up from 93% for the previous year.



In 2019 the HSCP performed well across all of the 28 iMatter questions and we were in the highest scoring sector ('strive and celebrate') for 86% of the questions. The 'strand scores' given below show performance against the main employee engagement topics. 'Well informed' scored highest at 80% with high scores for 'Treated fairly and consistently' (77%) and a 'Continuously improving and safe working environment' (77%).

Staff Governance Standards - Strand Scores



84%

"I am clear about my duties and responsibilities"

82%

"I understand how my role contributes to the goals of my organisation"

82%

"I am treated with dignity and respect as an individual"

87%

"My direct line manager is sufficiently approachable"

85%

"My manager cares about my health and wellbeing"

3 Financial performance and Best Value

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

3.1 Introduction

Within this section of the report we aim to demonstrate our efficient and effective use of resources. Our Annual Report and Accounts 2019/20 is our statutory financial report for the year. We regularly report our financial position to the IJB throughout the year.

3.2 Financial Performance 2019/20

The annual report and accounts for the IJB covers the period 1st April 2019 to 31st March 2020 and provides a detailed financial overview of the year which ended with an operational overspend of £0.065 million.

Service	Budget	Spend	Variance (Over) / Under	Variance (Over) / Under
	£ Million	£ Million	£ Million	%
Children & Families	13.268	12.631	0.637	4.20%
Older Peoples Services	18.736	19.072	(0.336)	(1.06%)
Physical / Sensory Disability	5.498	5.468	0.030	0.37%
Learning Disability – Community	10.586	10.681	(0.095)	(0.90%)
Learning Disability – Inpatients	8.361	8.359	0.002	0.02%
Augmentative and Alternative Communication	0.220	0.220	-	-
Intensive Services	10.570	11.100	(0.530)	(6.03%)
Mental Health	4.130	3.941	0.189	4.58%
Addictions / Substance Misuse	1.111	1.098	0.013	1.14%
Family Health Services	23.805	23.805	-	-
Prescribing	15.779	16.090	(0.311)	1.97%
Criminal Justice	-	-	-	-
Planning & Health Improvement	0.230	0.132	0.098	42.81%
Finance and Resources	9.766	9.528	0.238	1.82%
Net Expenditure Health and Social Care	**122.060**	**122.125**	**(0.065)**	**(0.05%)**
Housing	0.276	0.276	-	-
Set Aside for Large Hospital Services	31.223	31.223	-	-
Total Integration Joint Board	**153.559**	**153.624**	**(0.065)**	**(0.05%)**

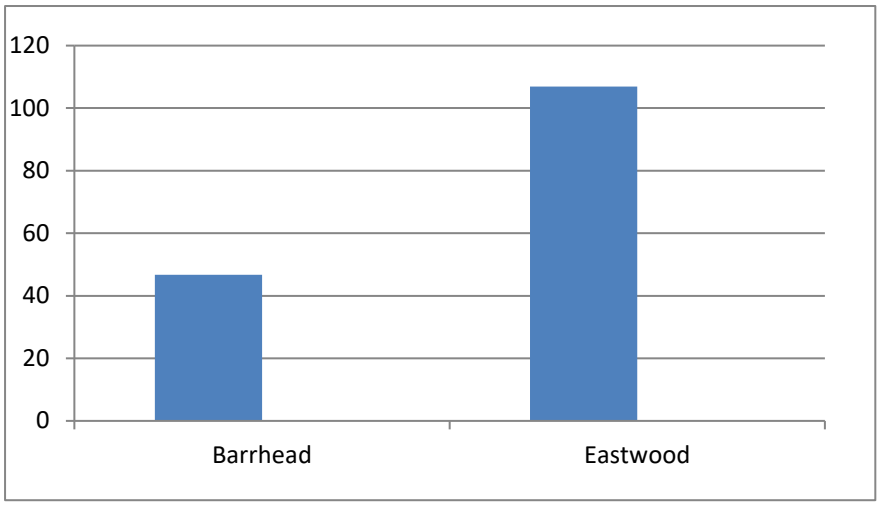
The £0.065 million overspend (0.05%) is broadly in line with the reporting taken to the IJB during the year and the overspend is funded, as planned, from our reserves. We expected to draw from reserves as we recognised we would not achieve all savings required during the year as our individual budget approach would take many months

to implement; we did not have capacity to work on our digital savings programme and we achieved part year savings from the second phase of our structure review.
The impact of COVID-19 in the closing weeks of 2019/20 will have resulted in some reduction in day to day costs. The main variances to the budget were:

- Underspends in a number of services are from staff turnover and vacant posts during the year, reflecting the general trends of recruitment and retention issues within health and social care.
- Children's services purchased care costs, including residential care, foster and adoption were lower than budget during the year.
- Older Peoples and Intensive Services ended the year with a collective overspend of £0.9 million from care package costs for residential and care at home costs, reflecting the continued impacts of population growth in older people and the demand for services. We are addressing our care at home costs as an element within the action plan and redesign of this service.
- The overspend in prescribing is a result of both cost and volume across a number of drugs and also allowed for an expected spike in demand in February and March 2020 as the implications of the COVID-19 pandemic began to emerge.

The IJB receives regular and detailed revenue budget monitoring throughout the year.

Expenditure of £153.624 million by Locality



The expenditure split by Locality is shown using a combination of direct costs and population to give an indication of the total cost split.

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

2018/19 £000	SERVICES PROVIDED TO EAST RENFREWSHIRE IJB BY OTHER IJBs WITHIN NHS GREATER GLASGOW AND CLYDE	2019/20 £000
434	Physiotherapy	460
53	Retinal Screening	48
452	Podiatry	464
295	Primary Care Support	303
293	Continence	297
613	Sexual Health	618
876	Mental Health	906
858	Oral Health	868
335	Addictions	348
184	Prison Health Care	194
163	Health Care in Police Custody	162
3,811	Psychiatry	4,211
8,367	**NET EXPENDITURE ON SERVICES PROVIDED**	8,879

3.3 Reserves

We used £1.643 million of reserves in year, of which £1.578 million was on a planned range of activities and £0.065 million to balance our budget. We also invested new monies into earmarked reserves. The year on year movement in reserves is summarised below.

	£ Million	£ Million
Reserves at 31 March 2019		5.337
Planned use of existing reserves during the year	(1.643)	
Funds added to reserves during the year	1.032	
Net decrease in reserves during the year		(0.611)
Reserves at 31 March 2020		4.726

3.4 Prior Year Financial Performance

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

	2019/20	2018/19	2017/18	2016/17	2015/16
	(Over) / Under £ Million	(Over) / Under £ Million	(Over) / Under £ Million	(Over) / Under £ Million	(Over) / Under £ Million
Children and Families	0.637	0.800	0.083	0.537	0.604
Older Peoples & Intensive Services	(0.866)	(0.228)	0.153	(0.046)	1.763
Physical / Sensory Disability	0.030	0.056	(0.167)	(0.280)	(0.345)
Learning Disability - Community	(0.095)	(0.047)	(0.214)	0.986	(1.801)
Learning Disability - Inpatients	0.002	0.123	-	-	-
Augmentative & Alternative Communication	0	N/A	N/A	N/A	N/A
Mental Health	0.189	0.419	0.409	0.393	0.354
Addictions / Substance Misuse	0.013	0.032	0.018	0.1229	0.085
Family Health Services	-	0.008	-	-	-
Prescribing	(0.311)	(0.428)	-	-	-
Criminal Justice	-	0.039	0.011	0.013	0.027
Planning and Health Improvement	0.098	0.074	0.001	0.039	0.029
Management and Admin / Finance & Resources	0.238	(0.190)	0.483	(0.144)	(0.335)
Planned Contribution to / from Reserves		(0.3976)	(0.9536)	**	-
Net Expenditure Health and Social Care	**(0.065)**	**0.260**	**(0.177)**	**1.622**	**0.381**

** In 2016/17 we agreed to carry forward our planned underspend to reserves to provide flexibility to allow us to phase in budget savings including our change programme.

3.5 Best Value

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

3.6 Future Challenges

The IJB continues to face a number of challenges, risks and uncertainties in the coming years and this is set out in our current Medium-Term Financial Plan for 2019/20 to 2023/24 which supports our strategic planning process and provides a financial context to support medium-term planning and decision making.

This plan sets out the potential cost pressures of circa £5.1 to £5.7 million per year for the five years 2019/20 to 2023/24. The resulting funding gap will be dependent on the funding settlement for each year.

The 2020/21 budget settlement fell within the poor settlement range of scenario planning assumptions with cost pressures of just over £6 million and subsequent required savings of £2.4 million after all funding uplifts.

The budget agreed on 18th March 2020 set out how we will achieve the £2.4 million savings to balance our budget. We identified £0.8 million from specific budget areas and we will need to prioritise care package costs to meet the remaining balance of £1.6 million savings, as we had previously signalled, this will mean an impact on our frontline services and care packages.

This budget was agreed as the COVID-19 pandemic was emerging in Scotland and the rest of the UK, and regular monitoring of the operational budget and the COVID-19 Mobilisation Plan are in place and implications and risk will continue to be addressed as costs become clearer. There is a significant financial risk to the HSCP if additional costs are not fully funded.

The work undertaken to date on our recovery programme has focussed on the short to medium term to allow us to emerge from the crisis phase and work towards the “new normal”. There will be significant work coming from this programme that will inform our longer term strategic and financial planning.

Demographic pressures remain a very specific challenge for East Renfrewshire as we have an increasing elderly population with a higher life expectancy than the Scottish average and a rise in the number of children with complex needs resulting in an increase in demand for services.

In addition to COVID-19 the consequence of Brexit may also impact on the future of the services we provide and our ability to meet the needs of the communities we serve.

We have successfully operated integrated services for a number of years and we have already faced a number of challenges and opportunities open to newer partnerships. However our funding and savings challenge take no account of this history. Whilst we have agreed a population based approach for future (NHS) financial frameworks and models this does not address the base budget.

Prescribing Costs; The cost of drugs prescribed to the population of East Renfrewshire by GPs and other community prescribers is delegated to the IJB. This is a complex and volatile cost base of around £16 million per year. The COVID-19 impact on prescribing in the medium to long term is unclear.

Delayed Discharge; In order to achieve the target time of 72 hours we continue to require more community based provision. The medium-term aspiration is that the costs of increased community services will be met by shifting the balance of care from hospital services. The work to agree a funding mechanism to achieve this remains ongoing with NHS Greater Glasgow and Clyde and its partner IJBs.

Care Providers: The impact on the sustainability of the care provider market following COVID-19 is unknown and we will continue to work closely with all our partners to work through issues, support where we can and look to develop the best way of working as we move forward. This will build on our work to date, including preparation to move to a new contractual framework.

We continue to develop our performance and financial reporting in more detail at a locality level to allow fuller reporting and understanding of future trends and service demands and include COVID-19 implications and scenarios.

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

- Our Recovery Plan will be implemented throughout 2020/21 and beyond and regular reports will be taken to the IJB.
- We will update our Medium-Term Financial Plan once COVID-19 impacts become clearer. This will allow us to continue to use scenario-based financial planning and modelling to assess and refine the impact of different levels of activity, funding, pressures, possible savings and associated impacts.
- We will continue to monitor in detail the impacts of COVID-19, Brexit and operational issues through our financial and performance monitoring to allow us to take swift action where needed, respond flexibly to immediate situations and to inform longer term planning.
- We will continue to work through our Care at Home action plan and service redesign, taking into account the changing COVID-19 landscape.
- We will continue to progress and report on our Strategic Improvement Plan until fully complete.
- We have identified savings proposals for 2020/21 and as we previously indicated will now need to move to a prioritisation and criteria-based model for care package support. Our individual

budget calculator will be revised. We will continue to use our reserve through 2020/21 to phase in budget savings. It is possible we will deplete this reserve in 2020/21 so there is a significant risk associated with:

  - Ensuring savings are achieved on a recurring basis by the end of the financial year
  - Impact of a similar level of budget settlement in 2021/22
  - Unknown impact of COVID-19

- We have realigned our adult services to reflect a change to our senior management structure which we have increased recognising, as supported in the Strategic Inspection, we had reduced capacity too far in previous savings delivery. We have appointed to our new post; Head of Recovery and Intensive Services.
- We routinely report our performance to the IJB with further scrutiny from our Performance and Audit Committee and our Clinical and Care Governance Group. The service user and carer representation on the IJB and its governance structures is drawn from Your Voice which includes representatives from community care groups, representatives from our localities and representatives from equality organisations including disability and faith groups.
- Governance Code; we have robust governance arrangements supported by a Governance Code.
- The IJB continues to operate in a challenging environment and our financial, risk and performance reporting continue to be a key focus of each IJB agenda.

We regularly review our strategic risk register for the IJB which identifies the key areas of risk that may impact the IJB and have implemented a range of mitigating actions to minimise any associated impact. A separate COVID-19 Risk Register is in place.

The future challenges detailed above and our associated response include the main areas of risk that the IJB is facing. The uncertainty of the impact of COVID-19 and the capacity for the HSCP and its partners to deliver services whist maintaining financial sustainability are significant risks.

4 Performance summary

4.1 Introduction

In the previous chapter of this report we outlined key areas of work carried out by the HSCP over the course of 2019/20. In this final chapter we draw on a number of different sources to give a more detailed picture of how the partnership is performing.

The sections below set out how we have been performing in relation to our suite of Key Performance Indicators structured around the strategic priorities in our Strategic Plan 2018-21. We also provide performance data in relation to the National Integration Indicators and Ministerial Steering Group (MSG) Indicators. Finally, we provide summary information on performance reporting during Inspections carried out in 2019/20.

4.2 Performance indicators

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

Direction of travel*	
	Performance is IMPROVING
	Performance is MAINTAINED
	Performance is WORSENING

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

Strategic Priority 1 - Working together with children, young people and their families to improve mental wellbeing						
Indicator	**2019/20**	**Current Target**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
Percentage of positive response to Viewpoint question "Do you feel safe at home?" *(INCREASE)*	**98%**	92%	93%	94%	85%	↑
Children and young people starting treatment for specialist Child and Adolescent Mental Health Services within 18 weeks of referral *(INCREASE)*	**78%**	90%	74%	89%	90%	↑
Child & Adolescent Mental Health - longest wait in weeks at month end *(DECREASE)*	**33**	18	34	35	31	↑
100% of parents of children who have received an autism diagnosis have opportunity to access Cygnet post diagnostic programme within 12 months of receiving diagnosis. *(INCREASE)*	**100%**	100%	100%	97%	n/a	–
% Mothers confirming they have received information about close and loving relationships from staff *(INCREASE)*	**90%***	80%	100%	n/a	n/a	–
Increase in improved outcomes for children after parent/carer completion of POPP *(INCREASE)*	**96%**	84%	89%	79%	78%	↑
Balance of Care for looked after children: % of children being looked after in the Community (LGBF) *(INCREASE)*	**n/a**	Data only	98.0%	93.6%	91.5%	↑
% Child Protection Re-Registrations within 18 months (LGBF) *(DECREASE)*	**n/a**	Data only	7.7%	0%	9%	↓

*Mid-yr 19/20 figure

Strategic Priority 2 - Working together with our community planning partners on new community justice pathways that support people to prevent and reduce offending and rebuild lives						
Indicator	**2019/20**	**Current Target**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
Community Payback Orders - Percentage of unpaid work placement completions within Court timescale. *(INCREASE)*	**71%**	80%	84%	92%	96%	↓
Criminal Justice Feedback Survey - Did your Order help you look at how to stop offending? *(INCREASE)*	**100%**	100%	100%	100%	100%	–
% Change in women's domestic abuse outcomes *(INCREASE)*	**79%**	70%	64%	65%	66%	↑
People agreed to be at risk of harm and requiring a protection plan have one in place. *(INCREASE)*	**100%**	100%	100%	n/a	n/a	–

Strategic Priority 3 - Working together with our communities that experience shorter life expectancy and poorer health to improve their wellbeing						
Indicator	**2019/20**	**Current Target**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
Increase the number of smokers supported to successfully stop smoking in the 40% most deprived SIMD areas. (This measure captures quits at three months and is reported 12 weeks in arrears.) *(INCREASE)*	**12***	6*	6	20	27	↑
Health and Social Care Integration - Core Suite of Indicators NI-11: Premature mortality rate per 100,000 persons aged under 75. (European age-standardised mortality rate) *(DECREASE)*	**n/a**	Data Only	308	301	297	–

*Mid-yr 19/20 figure

Strategic Priority 4 - Working together with people to maintain their independence at home and in their local community						
Indicator	**2019/20**	**Current Target**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
Number of people self directing their care through receiving direct payments and other forms of self-directed support. *(INCREASE)*	**518***	600	514	491	364	↑
Percentage of people aged 65+ who live in housing rather than a care home or hospital *(INCREASE)*	**96%**	97%	95.9%	96.6%	96.8%	–
People reporting 'living where you/as you want to live' needs met (%) *(INCREASE)*	**88%**	90%	92%	84%	79%	↓
SDS (Options 1 and 2) spend as a % of total social work spend on adults 18+ (LGBF) *(INCREASE)*	**n/a**	Data Only	8.15%	7.5%	6.6%	↑
Percentage of people aged 65+ with intensive needs receiving care at home. (LGBF) *(INCREASE)*	**n/a**	62.0%	57.5%	62.5%	61.1%	↓

*Mid-yr 19/20 figure

Strategic Priority 5 - Working together with people who experience mental ill-health to support them on their journey to recovery						
Indicator	**2019/20**	**Current Target**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
Percentage of people waiting no longer than 18 weeks for access to psychological therapies *(INCREASE)*	**65%**	90%	54%	80%	56%	↑
% of service users moving from drug treatment to recovery service *(INCREASE)*	**16%**	10%	22%	12%	9%	↓
Primary Care Mental Health Team (Bridges) wait for referral to 1st appointment within 4 weeks (%) *(INCREASE)*	**27%**	100%	14%	21%	n/a	↑

Strategic Priority 5 - Working together with people who experience mental ill-health to support them on their journey to recovery						
Indicator	**2019/20**	**Current Target**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
Primary Care Mental Health Team (Bridges) wait for referral to treatment appointment within 9 weeks (%) *(INCREASE)*	**11%**	100%	8%	30%	33%	↑

Strategic Priority 6 - Working together with our colleagues in primary and acute care to care for people to reduce unplanned admissions to hospital						
Indicator	**2019/20**	**Current Target**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
People (18+) waiting more than 3 days to be discharged from hospital into a more appropriate care setting including AWI *(DECREASE)* (NHSGGC data)	**2**	0	4	4	4	↑
Acute Bed Days Lost to Delayed Discharge (Aged 18+ including Adults with Incapacity) *(DECREASE)* (MSG data)	**1,788**	1,893	2,284	1,860	2,704	↑
No. of A & E Attendances (adults) *(DECREASE)* (NHSGGC data)	**12,748**	Data only	12,943	12,587	12,503	↑
Number of Emergency Admissions: Adults *(DECREASE)* (NHSGGC data)	**6,859**	Data only	6,801	6,916	6,908	↓
No. of A & E Attendances (adults) *(DECREASE)* (MSG data)	**20,090**	18,332	20,212	19,344	18,747	↑
Number of Emergency Admissions: Adults *(DECREASE)* MSG	**7,504***	7,130	7,320*	7,432	8,032	↓
Emergency admission rate (per 100,000 population) for adults *(DECREASE)* NI-12	10,568*	11,492	10,368*	10,482	11,419	–

Strategic Priority 6 - Working together with our colleagues in primary and acute care to care for people to reduce unplanned admissions to hospital						
Indicator	**2019/20**	**Current Target**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
Emergency bed day rate (per 100,000 population) for adults *(DECREASE)* NI-13	103,456*	117,000	114,744*	120,419	122,193	↑
Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges) *(DECREASE)* NI-14	**76***	100	79*	79	83	↑
A & E Attendances from Care Homes (NHSGGC data) *(DECREASE)*	**338****	340**	429	541	n/a	↑
Emergency Admissions from Care Homes (NHSGGC data) *(DECREASE)*	**233**	240	261	338	166	↑
% of last six months of life spent in Community setting *(INCREASE)* MSG	**88%***	86%	86%*	85%	86%	↑

* Full year data not available for 2019/20. Figure relates to 12 months Jan-Dec 2019.
Previous year (2018) gives calendar year figure for comparison. Data from ISD release, 5 June 2020
**To end Jan 19/20

Strategic Priority 7 - Working together with people who care for someone ensuring they are able to exercise choice and control in relation to their caring activities						
Indicator	**2019/20**	**Current Target**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
People reporting 'quality of life for carers' needs fully met (%) *(INCREASE)*	**92%**	72%	78%	72%	70%	↑

Organisational measures						
Indicator	**2019/20**	**Current Target**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
Percentage of days lost to sickness absence for HSCP NHS staff *(DECREASE)*	**7.3%**	4.0%	6.8%	8.5%	7.2%	↓
Sickness absence days per employee - HSCP (LA staff) *(DECREASE)*	**19.1**	10.9	16.4	13.0	13.6	↓
Percentage of HSCP (NHS) complaints received and responded to within timescale (5 working days Frontline, 20 days Investigation) *(INCREASE)*	**83%***	70%	80%	100%	63%	↑
Percentage of HSCP (local authority) complaints received and responded to within timescale (5 working days Frontline; 20 days Investigation) *(INCREASE)*	**72%**	100%	72%	81%	68%	–

*Mid-yr 19/20 figure

4.3 National Integration Indicators

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

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

4.3.1 Scottish Health and Care Experience Survey (2017/18)

Information on 9 of the National Integration Indicators are derived from the biennial Scottish Health and Care Experience survey (HACE) which provides feedback in relation to people's experiences of their health and care services. The most recent survey results for East Renfrewshire relate to 2017/18 and are summarised below.

National indicator	2017/18	Scotland 2017/18	2015/16	East Ren trend from previous survey	Scotland trend from previous survey
NI-1: Percentage of adults able to look after their health very well or quite well	**94%**	93%	96%	↓	↓
NI-2: Percentage of adults supported at home who agreed that they are supported to live as independently as possible	**74%**	81%	80%	↓	↓
NI-3: Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	**64%**	76%	77%	↓	↓
NI-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%	↓	↓
NI-5: Total % of adults receiving any care or support who rated it as excellent or good	**77%**	80%	82%	↓	↓
NI-6: Percentage of people with positive experience of the care provided by their GP practice	**84%**	83%	88%	↓	↓
NI-7: Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	**76%**	80%	79%	↓	↓
NI-8: Total combined % carers who feel supported to continue in their caring role	**37%**	37%	45%	↓	↓
NI-9: Percentage of adults supported at home who agreed they felt safe	**82%**	83%	82%	-	-

Data from ISD release, 7 June 2019

4.3.2 Operational performance indicators

National indicator	2019/20	Scotland 2019/20	2018/19	2017/18	2016/17	Trend from previous year
NI-11: Premature mortality rate per 100,000 persons	**n/a**	432	308	301	297	–
NI-12: Emergency admission rate (per 100,000 population) for adults	**10,568***	12,602*	10,368*	10,484	11,419	↓
NI-13: Emergency bed day rate (per 100,000 population) for adults	**103,456***	117,478*	114,744*	120,419	122,193	↑
NI-14: Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges)	**76***	104*	79*	79	83	↑
NI-15: Proportion of last 6 months of life spent at home or in a community setting	**88%***	89%*	86%*	85%	86%	↑
NI-16: Falls rate per 1,000 population aged 65+	**22***	23*	24.1*	22.4	21.2	↑
NI-17: Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	**84%**	82%	84%	88%	88%	–
NI-18: Percentage of adults with intensive care needs receiving care at home	**n/a**	62%	64%	63%	58%	↑
NI-19: Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	**160**	793	171	117	228	↓
NI-20: Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	**20%***	23%*	22%*	24%	23%	↑

Data from ISD release, 5 June 2020

*Calendar year data. Full year data not available for 2019/20. Figure relates to 12 months Jan-Dec 2019. Calendar year data used for previous year (2018) for comparison

The indicators below are currently under development by NHS Scotland Information Services Division (ISD).

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

4.4 Ministerial Strategic Group Indicators

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

MSG Indicator	2019/20	Target 19/20	2018/19	2017/18	2016/17	2015/16	Trend from 2018/19
Number of emergency admissions (adults)	**7,504***	7,130	7,320*	7,432	8,032	7,922	↓
Number of emergency admissions (all ages)	**8,598***	8,331	8,313*	8,513	9,199	9,123	↓
Number of unscheduled hospital bed days (acute specialties) (adults)	**58,311***	57,106	61,383*	62,967	62,901	58,271	↑
Number of unscheduled hospital bed days (acute specialties) (all ages)	**59,764***	58,899	62,875*	64,769	64,455	60,064	↑
A&E attendances (adults)	**20,090**	18,335	20,212	19,344	18,747	18,332	↑
A&E attendances (all ages)	**27,567**	25,299	27,850	27,011	25,888	25,300	↑
Acute Bed Days Lost to Delayed Discharge (Aged 18+ including Adults with Incapacity)	**1,788**	1,893	2,284	1,860	2,704	2,366	↑
% of last six months of life spent in Community setting (all ages)**	**88%***	86%	86%*	85.2%	85.8%	85.6%	↑
Balance of care: Percentage of population at home (supported and unsupported) (65+)	**n/a**	Data only	95.9%	95.8%	95.7%	95.6%	↑
Balance of care: Percentage of population at home (supported and unsupported) (all ages)	**n/a**	Data only	99.0%	99.0%	99.0%	99.0%	–

Data from ISD release, 28 April 2020 (MSG Indicators)

* Full year data not available for 2019/20. Figure relates to 12 months Jan-Dec 2019. Previous year (2018) given as calendar year.

** Data from ISD release, 5 June 2020 (Core Suite of Integration Indicators)

4.5 Inspection performance 2018/19

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 2020.

Key to Grading:
1 – Unsatisfactory, **2 –** Weak, **3 –** Adequate, **4 –** Good, **5 –** Very Good, **6 –** Excellent

Service	Date of Last Inspection	Quality of Care and Support	Quality of Environment	Quality of Staffing	Quality of Management & Leadership
Adoption Service	11/10/2019	5	Not applicable	5	Not applicable
Barrhead Centre	23/02/2018	6	Not applicable	Not applicable	6
Fostering Service	11/10/2019	5	Not applicable	5	Not applicable
Care at Home	04/09/2019	1	Not applicable	2	1
HSCP Holiday Programme	21/07/2017	6	Not applicable	Not applicable	5
Thornliebank Resource Centre	07/04/2016	4	Not applicable	Not applicable	4
HSCP Adult Placement Centre	25/10/2019	5	Not applicable	5	5

The Care Inspectorate launched the new evaluation framework in July 2018, which is based on the Health and Social Care Standards. Bonnyton House and Kirkton have been inspected under the new quality inspection framework.

Service	Date of Last Inspection	How well do we support people's wellbeing?	How good is our leadership?	How good is our staff team?	How good is our setting?	How well is care and support planned?
Bonnyton House	22/11/2019	3	3	3	3	3
Kirkton	23/7/2019	5	Not assessed	Not assessed	Not assessed	5

4.6 Key performance achievements

Key areas where we have seen improvement or continued strong performance over the past 12 months are as follows:

Indicator	2019/20		2018/19
	Target	Actual	Actual
Children and families *(SP1: Working together with children, young people and their families to improve mental wellbeing)*			
% of positive response to Viewpoint question "Do you feel safe at home?" *(INCREASE)*	92%	**98%**	93%
Children and young people starting treatment for specialist Child and Adolescent Mental Health Services within 18 weeks of referral *(INCREASE)*	90%	**78%**	74%
100% of parents of children who have received an autism diagnosis have opportunity to access Cygnet post diagnostic programme within 12 months of receiving diagnosis. *(INCREASE)*	100%	**100%**	100%
Increase in improved outcomes for children after parent/carer completion of POPP *(INCREASE)*	84%	**96%**	89%
Balance of Care for looked after children: % of children being looked after in the Community (LGBF) *(INCREASE)*	Data only	**98%** (18/19)	93.6% (17/18)
Criminal justice *(SP2: Working together with our community planning partners on new community justice pathways that support people to prevent and reduce offending and rebuild lives)*			
Criminal Justice Feedback Survey - Did your Order help you look at how to stop offending? *(INCREASE)*	100%	**100%**	100%
% Change in women's domestic abuse outcomes (*INCREASE)*	70%	**79%**	64%
Living independently *(SP4: Working together with people to maintain their independence at home and in their local community)*			
SDS (Options 1 and 2) spend as a % of total social work spend on adults 18+ (LGBF) *(INCREASE)*	Data only	**8.2%** (18/19)	7.5% (17/18)
Percentage of people aged 65+ who live in housing rather than a care home or hospital *(INCREASE)*	97%	**96%** (18/19)	96% (17/18)
Percentage of adults with intensive care needs receiving care at home *(INCREASE)*	62%	**64%** (18/19)	63% (17/18)
Supporting people experiencing mental ill-health *(SP5: Working together with people who experience mental ill-health to support them on their journey to recovery)*			
% of people waiting no longer than 18 weeks for access to psychological therapies *(INCREASE)*	90%	**65%**	55%
Reducing unplanned hospital care *(SP6: Working together with our colleagues in primary and acute care to care for people to reduce unplanned admissions to hospital)*			

People (18+) waiting more than 3 days to be discharged from hospital including AWI (NHSGGC data) *(DECREASE)*	0	**3**	4
Bed days lost to delayed discharge (Adults) (MSG data) *(DECREASE)*	1,734 (11 month target)	**1,629** (Apr 19 - Feb 20)	2,037 (Apr 18 – Feb 19)
Unscheduled hospital bed days (all acute) (MSG data) *(DECREASE)*	57,056	**61,191** (Oct 18 – Sept 19)	61,672 (Oct 17 – Sept 18)
% of last six months of life spent at home of in a community setting	86%	**89%** (at Q3 19/20)	86%
Supporting carers *(SP7: Working together with people who care for someone ensuring they are able to exercise choice and control in relation to their caring activities)*			
People reporting 'quality of life for carers' needs fully met (%) *(INCREASE)*	72%	**92%**	78%

4.7 Indicators we are seeking to improve

Ongoing improvement is sought across all services within the HSCP and the performance management arrangements in place are designed to facilitate this. There are specific areas we would like to improve going forward and these are set out in our current Strategic Plan.

Key indicators we would like to improve on include the following:

Children and Young People

- Children and young people starting treatment for specialist Child and Adolescent Mental Health Services within 18 weeks of referral
- Child and Adolescent Mental Health - longest wait in weeks at month end

Criminal Justice

- Community Payback Orders - % of unpaid work placement completions within Court timescales

Living independently

- Number of people self-directing their care through receiving direct payments and other forms of self-directed support.

Mental Health services

- Percentage of people waiting no longer than 18 weeks for access to psychological therapies
- Waiting times for Primary Care Mental Health Team (Bridges)

Unscheduled care: Working in partnership with NHS acute services

- People waiting more than 3 days to be discharged from hospital into a more appropriate care setting
- Number of A&E Attendances
- Number of Emergency Admissions

Appendix One - National Outcomes

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

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

The National Outcomes for Children are:

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

The National Outcomes for Criminal Justice are:

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