EAST RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

East Renfrewshire Council

NHS Greater Glasgow and Clyde

Working Together for East Renfrewshire

East Renfrewshire Health and Social Care Partnership (HSCP) Annual Performance Report 2023-24

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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 eighth report for the East Renfrewshire Integration Joint Board. It sets out how we delivered on our vision and commitments over 2023-24. As required, we review our performance against agreed local and national performance indicators and against the commitments set out in our 2022-25 Strategic Plan.

The HSCP provides care, support and protection for people of all ages, to enhance their wellbeing and improve outcomes for them as children, young people, families and adults. Over the course of 2023-24, our teams in collaboration with our partners and communities have continued to deliver this work in the context of changing demands on health and care services and pressures on available resources. We continue to respond to higher demands for support, supporting individuals with higher levels of emotional distress, complex needs and limited informal support networks. Our teams respond compassionately, creatively and with an unwavering commitment to improve outcomes for the individuals and families we support.

This report looks at our performance during another extremely challenging 12 month period. We continue to see changing patterns of demand in the aftermath of the Covid-19 pandemic and significant financial constraints for the health and social care sector locally and nationally. The main elements of the report set out:

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

Throughout 2023-24, we have continued to maintain and deliver safe and effective services to our residents. Our performance information shows that despite this very challenging period, there has been strong performance across service areas. Over the year, we have seen excellent collaboration across the HSCP and with our independent, third and community sector partners. And we are seeing positive performance across many of our strategic performance indicators.

1.2 Local context

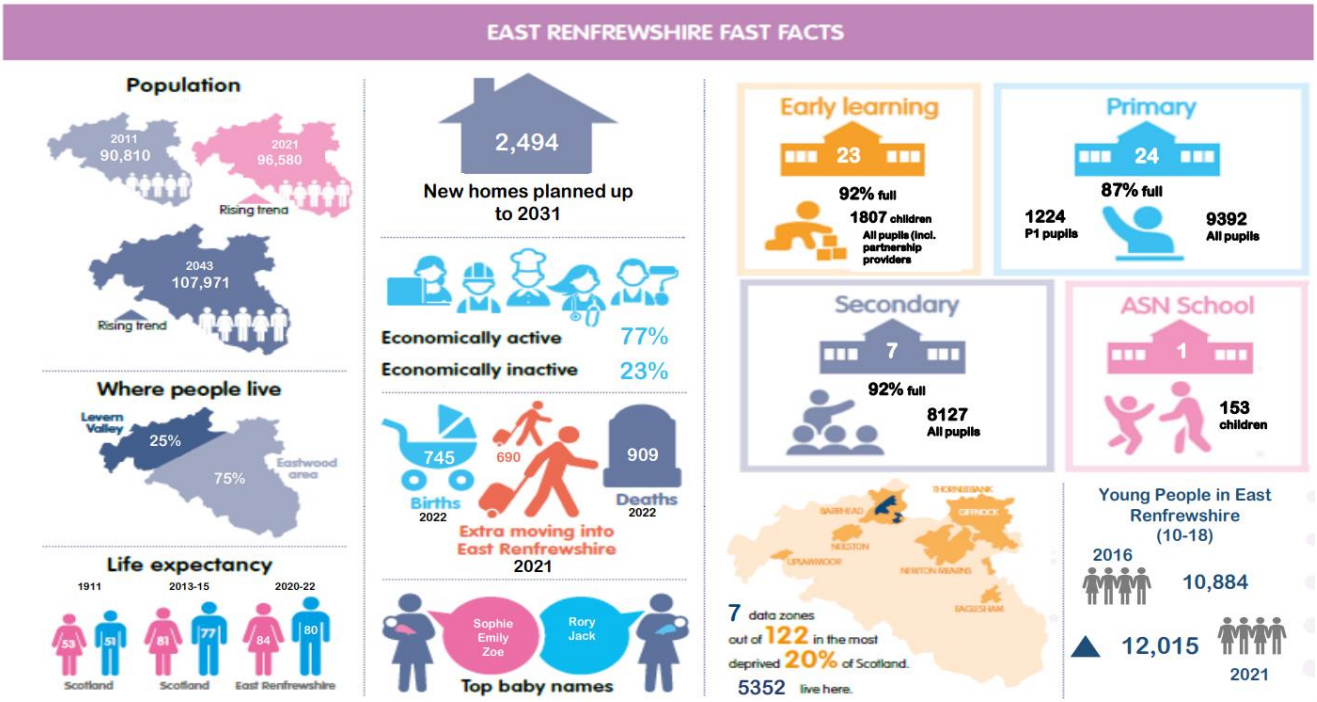
East Renfrewshire covers an area of 174 square kilometres and borders the city of Glasgow, East Ayrshire, North Ayrshire, Renfrewshire and South Lanarkshire.

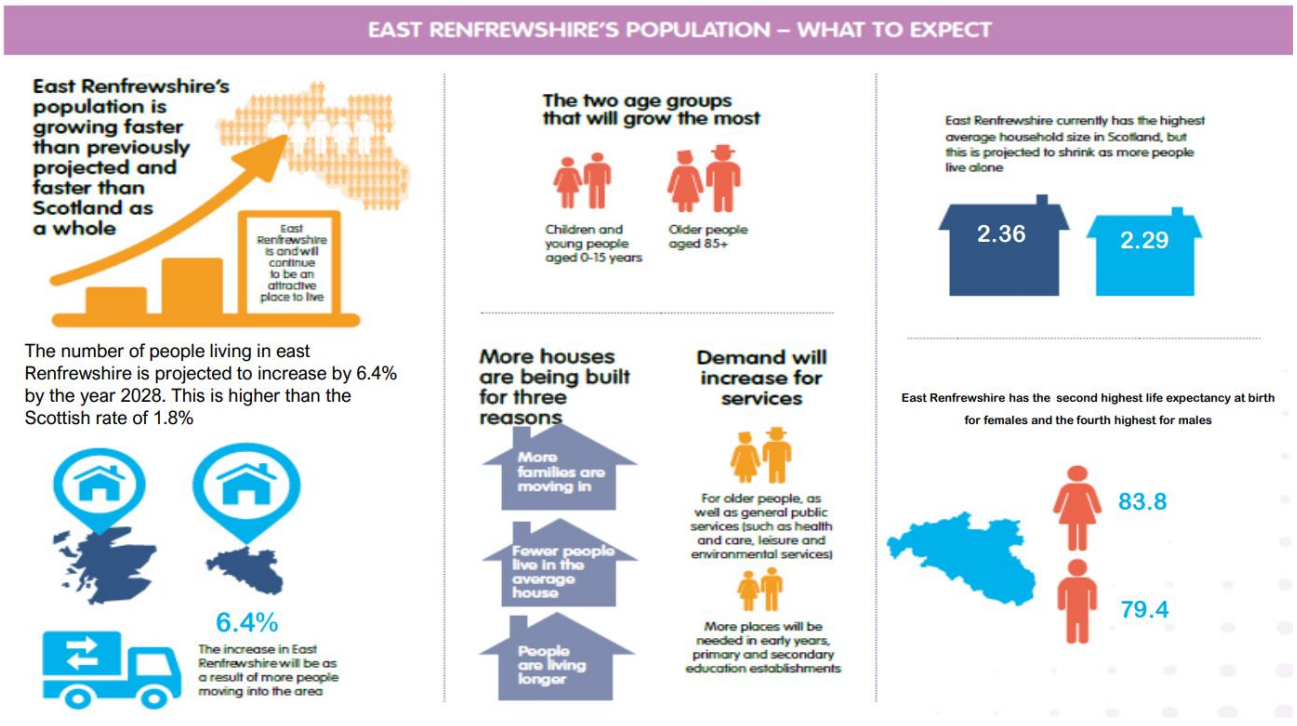
Our population continues to grow and reached 97,160 in 2022. 74% of the population live in the Eastwood area (Busby, Clarkston and Williamwood, Eaglesham and Waterfoot, Giffnock, Netherlee and Stamperland, Newton Mearns and Thornliebank) and 26% live in the Barrhead area (Barrhead, Neilston and Uplawmoor).

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

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

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





East Renfrewshire Health and Social Care Partnership (HSCP) was established in 2015 under the direction of East Renfrewshire's Integration Joint Board (IJB) and it has built on

the Community Health and Care Partnership (CHCP), which NHS Greater Glasgow and Clyde and East Renfrewshire Council established in 2006.

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

During the last 18 years our integrated health and social care management and staff teams have developed strong relationships with many different partner organisations. Our scale and continuity of approach have enabled these relationships to flourish. We have a history of co-production with our third sector partners and we are willing to test new and innovative approaches.

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

The integrated management team directly manages over 900 health and care staff, this includes 52 social workers who are trained and appointed as council officers. ER HSCP has long-established relationships with third and independent sectors to achieve our strategic aims around early intervention and prevention. In addition, the HSCP hosts the Specialist Learning Disability Inpatient Services, Adult Autism Service on behalf of the six HSCPs in NHSGGC and the Scottish Centre of Technology for the Communication Impaired (SCTCI) which provides specialist support for Alternative and Augmentative Communication to 12 Scottish Health Boards. The services within East Renfrewshire are community based with the exception of the inpatient wards for people with learning disabilities. There are no acute hospital sites or prisons in East Renfrewshire.

1.3 Our Strategic Approach

1.3.1 Our Strategic Vision and Priorities

In East Renfrewshire we have been leading the way in integrating health and care services. From the outset of the CHCP we have focused firmly on outcomes for the people of East Renfrewshire, improving health and wellbeing and reducing inequalities. Under the direction of East Renfrewshire's IJB, our HSCP builds on this secure foundation. Throughout our integration journey during the last 17 years, we have developed strong relationships with many different partner organisations. Our longevity as an integrated partnership provides a strong foundation to continue to improve health and social care services.

Our Vision

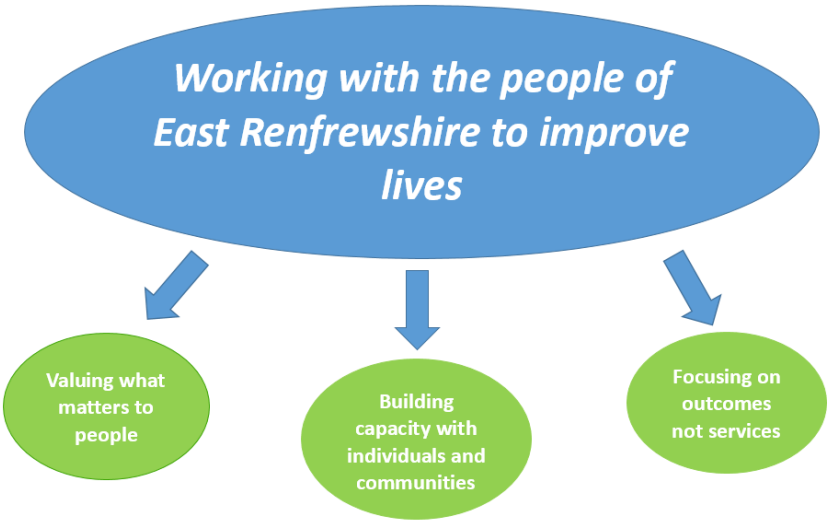
Our vision statement, *"Working together with the people of East Renfrewshire to improve lives"*, was developed in partnership with our workforce and wider partners, carers and members of the community. This vision sets our overarching direction through our Strategic Plan. At the heart of this are the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

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

- *Valuing what matters to people*
- *Building capacity with individuals and communities*

- *Focusing on outcomes, not services*

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



Our Strategic Plan

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

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

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

Our third 'full' Strategic Plan covers 2022-25. The plan was developed in consultation with stakeholders and East Renfrewshire residents, despite the continuing challenges we faced from the pandemic. This included a highly participative engagement process coproduced with wider partners through our Participation and Engagement Network and a comprehensive strategic needs assessment.

The consultation found that people were supportive of our strategic priorities and the key areas of focus set out in the plan. Many people emphasised the crucial importance of partnership and collaborative working and there was a focus on ensuring the necessary support is in place for our staff and for local unpaid carers. Key changes we made to our strategic plan in light of the consultation included:

- Strengthening the emphasis in the plan on safety, preventing harm and addressing rising incidence of violence against women and girls following the pandemic.
- Reference to the practical supports available for digital solutions; and recognition to the role of peer support in recovery and supporting independence.

- More emphasis on how we are working to enhance mental health support through primary care; and local initiatives using the Community Mental Health and Wellbeing Fund.
- More recognition of the impact of the Covid pandemic on unpaid carers and increased pressures for carers including increased caring requirement.
- In our existing discussion of health inequalities, greater reference to the wider impacts of poverty and focus on supporting people with protected characteristics.
- For our priority supporting staff wellbeing recognition our intention to be a 'listening' partnership; and outlining activities including wellbeing group, plan and appointment of wellbeing lead.

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

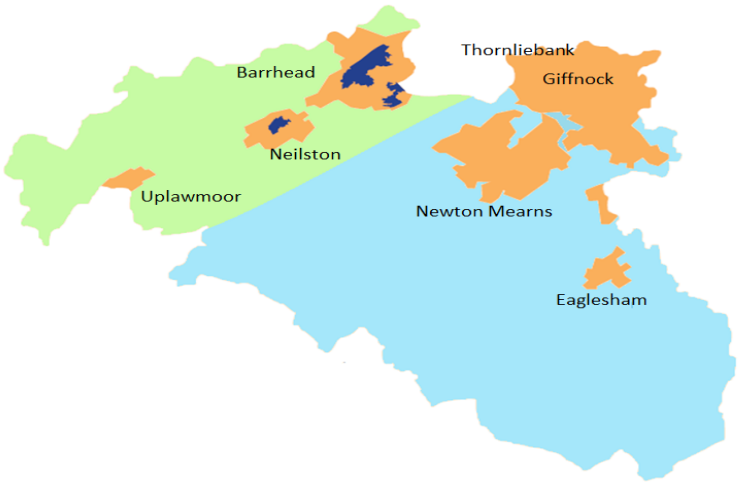
- Working together with **children, young people and their families** to improve mental and emotional wellbeing;
- Working together with people to maintain their **independence at home** and in their local community;
- Working together to support **mental health and wellbeing**;
- Working together to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

The plan illustrates how the HSCP will contribute to the priorities established in the East Renfrewshire Community Plan and Fairer East Ren. Under our strategic priorities we set out our key activities and critical indicators that link to the HSCP contribution to East Renfrewshire Council's Outcome Delivery Plan. The plan also links to relevant planning at NHSGGC Board level, including the priorities set out in Moving Forward Together, and commitments set out in supporting plans including: the Public Health Strategy, the Adult Mental Health Strategy, the Primary Care Strategy and the Public Protection Strategy. The plan fully recognises the implications from the Independent Review of Adult Social Care and planned National Care Service.

1.3.2 Locality planning in East Renfrewshire

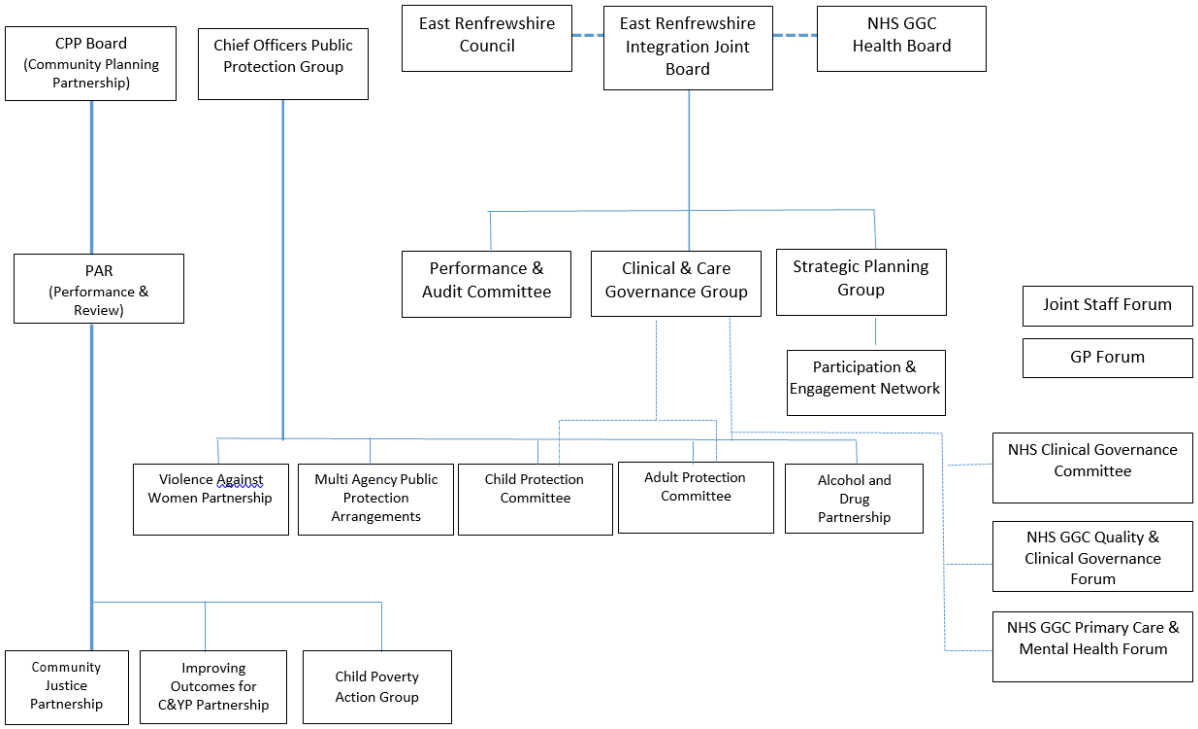
Our previous 2018-21 Strategic Plan reduced our locality planning areas from three to two localities – one for Eastwood and another for Barrhead. This allowed us to coordinate our approach with our local GP clusters while also reflecting the natural communities in East Renfrewshire.

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



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

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



1.3.3 Our integrated performance management framework

We have a commitment to integrated performance management. Our performance management framework is structured around our Strategic Plan, with all performance measures and key activities clearly demonstrating their contribution to each of our nine

strategic planning priorities. The framework also demonstrates how these priorities link to the National Health and Wellbeing Outcomes and East Renfrewshire's Community Planning Outcomes.

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

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

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

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

1.3.4 Supporting People Framework

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

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

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

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

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

- Promote, support and preserve maximum independence and resilience where practical and practicable
- Promote equitable access to social care resources
- Adhere to the principals of early and minimum intervention
- Target resource to those vulnerable individuals most at risk of harm or in need of protection.

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

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

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

2 Delivering our key priorities

2.1 Introduction

This section looks at the progress we made over 2023-24 to deliver the key priorities set out in our Strategic Plan and how we are performing in relation to the National Health and Wellbeing Outcomes. For each area we present headline performance data showing progress against our key local and national performance indicators. In addition to an analysis of the data we provide qualitative evidence including case studies and experience from local people engaging with our services. Our intention is to illustrate the wide range of activity taking place across the partnership.

A full performance assessment covering the period 2016-17 to 2023-24 is given in Chapter 4 of the report.

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

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

2.2.1 Our strategic aims and priorities during 2023-24

Improving the mental and emotional wellbeing of children and young people continues to be one of the highest priorities for East Renfrewshire HSCP. Our multi-agency approach to supporting the needs of children and young people in East Renfrewshire is set out in our Children and Young People's Services Plan 2020-2023. Together all partners in East Renfrewshire are building an approach to mental health support for children, young people and families that will ensure they receive the right care and interventions at the right time and in the right place. We aim to provide a holistic range of appropriate supports through our multi-stakeholder Healthier Minds Service which works alongside our Family Wellbeing Service and links to GP practices and the Child and Adolescent Mental Health Service (CAMHS).

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

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

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

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

2.2.2 Our performance in 2023-24

During 2023-24 our children's services have continued to see increasing demand and higher levels of complexity among referrals. We continue to work with an increasing number of children with diagnosed neurodevelopmental disorders and a high prevalence of families in crisis.

Headline performance data includes:

- Care experienced children – 14.4% with more than one placement in the year, down from 20.8% in 22/23. And no children in East Renfrewshire with 3 or more placements
- Child protection - 100% of child protection cases with increased safety – maintaining excellent performance from 22/23
- 92% of care experienced children supported in community rather than a residential setting (22/23 figure) – a high rate and better than the Scottish average (89%) but performance dropped slightly from the previous year
- % of children subject to child protection offered advocacy increased to 65% from 61% in 22/23.
- Child protection re-registrations within an 18 month period increased during 2023-24 form 0% to 12.5%. This was due to a very small number of children requiring re-registration in the year.

2.2.3 Ways we have delivered in 2023-24

East Renfrewshire's multi-agency Children and Young People's Services Plan 2023-2026 recognises mental and emotional wellbeing as a key priority. The Covid-19 pandemic exacerbated the circumstances of many children, young people and families, and we have seen a rise in the number of those experiencing challenges with their mental health and wellbeing and this also includes those who have a neurodevelopmental diagnosis.

We continue our efforts to alleviate pressure on **CAMHS** by developing appropriate (Tier 2) alternatives that work with young people and families to support recovery and minimise crisis. In 2023-24 this has successfully reduced pressures at the CAMHS 'front door' bringing down the proportion of people having to wait more than 18 weeks and reducing the longest waits that families have experienced.

A key success has been seen with the ongoing development of the multi-stakeholder **Healthier Minds Service** aligned to school communities was developed to identify and ensure delivery of mental wellbeing support to children and families.

Healthier Minds referrals continue to primarily come from schools and other agencies including GPs, CAMHS, Social Work, RAMH, Woman's Aid and Children 1st and more importantly includes self-referrals from young people. A total of 1443 children and young people have been referred to the weekly screening hub (since the service began in November 2020). Last year a total of 385 children and young people were referred, resulting in children, young people

and their families being supported timeously. Another extensive calendar of training has been delivered in the current year with more planned for the new school year. The support offered by the Healthier Minds team continues to result in positive outcomes for children and young people with 97% reporting improved mental and emotional wellbeing. All parents who completed the post support evaluation noted they would recommend the service to others, ongoing since 2020.

Healthier Minds Service 2023-24

- 385 children and young people referred during the year
- 21% with ASC/ADHD diagnosis at point of referral (there is a large number of those referred displaying traits or with a query of a neurological diagnosis)
- Increased level of distress reflected in the four main reasons for referral:
  - Anxiety/stress
  - Suicidal ideation
  - Emotional regulation
  - Trauma
- 97% of children and young people supported by Healthier Minds reported improved mental and emotional wellbeing – up from 93% in previous year.

East Renfrewshire's **Family Wellbeing Service** supports children and young people who present with a range of significant mental and emotional wellbeing concerns. The services 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.

Holistic whole family support – Family First

A range of services have developed for families requiring support with parenting and caring for their children. Family First are the main universal service within East Renfrewshire who provide holistic support on a wide range of issues from housing and money advice, to help with behaviour, sleeping, diet and isolation. The service can work with families and their children individually or in a group format. Staff deliver PoPP, Incredible Years, Triple P and positive evaluation across these programmes post intervention is high with families reporting more able to manage and respond to their children's needs. Family First plays a key role in preventing difficulties escalating and last year their focus on supporting families with children with additional needs was hugely beneficial. Similarly the service reached out to minority ethnic communities to determine need and this has resulted in a significant increase in uptake from families from ethnically and religiously diverse backgrounds.

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

- Love will no longer be the casualty of the 'care system,' but the value around which it operates.

- Wherever safe to do so, Scotland will make sure children stay with their families and families will be actively supported to stay together.
- Children, young people, and their families will be listened to, respected, involved and heard in every decision that affects them.

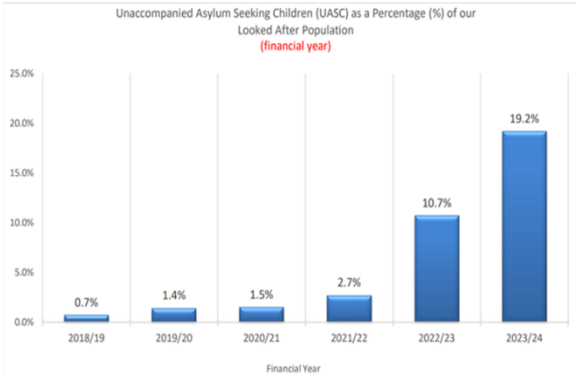
Delivering The Promise in East Renfrewshire

East Renfrewshire Council and East Renfrewshire HSCP have over many years demonstrated a strong commitment to improving the life chances of our looked after and care experienced children and young people. Through our multi agency East Renfrewshire Improving Outcomes for Children and Young People Partnership - led by East Renfrewshire Council and East Renfrewshire HSCP - we have worked hard since 2020 to promote and implement the Promise. Firstly by consistently raising awareness of the role of Corporate Parents we believe that all partners now understand that when a child or young person becomes looked after – at home or away from home - the local authority, health board, and a large number of other public bodies take on the statutory responsibility of Corporate Parent. This shared understanding that Corporate Parenting is the collective responsibility of the all of us is key to successfully keeping The Promise.

We are now over four years into the Promise's ten year plan with the current plan focusing on the period from 2021 until 2024. The five priority areas of Plan 21-24 - A Good Childhood, Whole Family Support, Planning, Supporting the Workforce, and Building Capacity and the 25 actions contained within - are reflected in the new East Renfrewshire's Children's Services Plan 2023-2026 titled "At Our Heart – The Next Steps". Progress with implementation is reported through Children's Plan annual review process which is a statutory duty. The 21-24 Plan also indicates 5 fundamentals to drive systems and cultural change across Scotland and these are: What Matters to Children and Families, Listening, Poverty, Children's Rights and Language.

The key message signed up to by partners is that "we want the best for our looked after children and young people, to see them flourish with good health, to be safe and happy, to do well in education and enjoy healthy relationships with family, carers and friends. Similarly, we want them to make the most of the available cultural and leisure opportunities, and to develop towards adulthood fully prepared to lead independent lives. Importantly, we want young people to progress into a positive post school destination, whether this be further or higher education, or employment, and to be financially secure". Over the remaining two years left of our local Children's Plan we will further progress this agenda and the fulfilment of our ambition for the children, young people, and their families.

The HSCP provides support to **unaccompanied asylum seeking children** arriving in the local authority area. The average frequency of contact for all arrivals is twice per week and newly arrived young people are supported seven days per week for the first few weeks. We have well established links with the Equality Development Officer for faith and culture groups; and additional support is provided to young people by Aberlour Guardianship Service. The number of unaccompanied asylum seeking children continues to rise and make up almost a fifth of our looked-after population. In addition, 9.2% of the after-care population are now UASC.



We continue to support young people with complex needs as they transition from one life stage to another. We have seen an increase in the numbers of young people being referred for

transitions assessment, planning and support, with numbers forecast to continue increasing in future years. A new **HSCP Transitions Team** has been created to support improvement in this activity. This Team works between ERC Education, HSCP Children and Families Services, and HSCP Adult Services. The aim is to provide an improved transition from children's services to adult services for young people with very complex needs. To this end a multi-agency mapping exercise has been undertaken to ensure all of the young people have a bespoke Transition Plan in place that they and their families contribute to. More work is required to ensure the experience is positive for the young person and their family and more partners will be involved as the roll out of the new way of working is implemented.

Supporting transitions – some key achievements 2023-24

Transitions Hub – we developed a shared working space for multi-agency and partnership working focussed on transitions. This promotes collaboration and utilisation of third sector and community resources with a focus on developing networks and independence.

Transitions Resource Enablement Group (REG) and Peer Professional Review Group (PPRG) - Development of transitions-specific REG and PPRG process. Highlights positive collaboration between children and adult services and ensure consistency of eligibility criteria application.

Introduction of Transitions Planning Framework - Governance of transitions planning and development across all HSCP services and third sector partners.

Transitions – supporting mental health

CAMHS are working in partnership with HSCP Transitions Team and Children and Families Services, to ensure young people who will require adult community mental health services as young adults have a seamless transition from one service to another. This multi-agency and multi-disciplinary approach is evolving and key agencies are being identified to participate in the model including the third sector. Young people on the CAMHS waiting list have been prioritised if they are 16/17 year of age to ensure the right support and treatment is in place prior to them accessing adult services. This is particularly important for those on the Neurodevelopmental Pathway who may require ongoing medication and monitoring.

We continue to develop and improve our practice supporting vulnerable children and young people, including the **Signs of Safety** model, led by the Chief Social Work Officer and the Head of Education Services (Equality and Equity). The model supports practice improvement, with a particular focus on developing relational interventions with children, young people, their families and carers in order to reduce risk and improve children's wellbeing. The approach recognises the need to define harm, outline danger and identify safety goals. Implementation of the Signs of Safety model is overseen by a multi-agency implementation group consisting of key partners. As a result, one assessment framework/paperwork is being used across a variety of statutory and non-statuary work including Child Protection assessments,

disability/Section 23 assessments, Child in Need and SCRA assessments. During 2023-24 we undertook a number of review and evaluation activities with the aim of revising and updating our implementation plan targets. We have had a number of new staff across the system and therefore further training has been required and have ran further refreshers courses for staff members. The implementation oversight board have identified key areas of process and improvement, which has resulted in sub committees with a focus on upskilling staff, managing risk, and progressing whole system implementation.

During 2023-24 we completed the implementation of the **Scottish Child Interview Model (SCIM)** which supports children who have experienced abuse. There is now a fully operational trauma recovery team who support children and their families following interview where required. During the year, we completed 211 interviews under this model and maintained an overall disclosure rate of 80%. We had our opening launch of the first ever **Bairns' Hoose** in United Kingdom in August 2023 and its premises are here in East Renfrewshire. The vision behind this trauma-informed environment has received positive praise and recognition from far and wide and plans are now in place to have the justice space in operation over the coming months. This should ensure no child has to experience the fear and alarm of attending an adult court environment and provide their evidence via remote link.

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

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

Participation and engagement activities take place across the service, however our **Champions Board** and **Mini-Champs** are active groups of young people and children who meet regularly and inform strategy and practice. 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. The Champions Board offers looked after young people leadership opportunities 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.

Champions Board activity 2023-24

The Champions Board have recently been helping design a collaborative housing pathway and service for young people who are leaving care. They have also attended national conferences and met with The Promise Scotland to share their views.

The Champions Board held a relaunch event in June 2023 whereby our Young Champions shared the journey of the Champions Board and next steps with new Elected Members and Directors and to ask for support moving forward as East Renfrewshire embeds The Promise. Following this, young people have spent time with Adult Champions.

We continue to raise awareness and promote the creativity of Care Experienced Children and Young People with the support of this sector partners. This has included a Hip-Hop Showcase where young people performed on stage a SWG3. Two of our Young Champions are also depicted on a mural dedicated to Care Experience on Strathclyde University.

We are currently working alongside Community Learning and Development to ensure representation of Care Experienced Young People, including our separated young people seeking asylum, in UN Convention on the Rights of the Child (UNCRC) forums.

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

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

2.3.1 Our strategic aims and priorities during 2023-24

Ensuring as many East Renfrewshire residents as possible can maintain their independence at home remains a priority of the partnership. Our approaches are person-centred and focused on the rights of individuals to exercise choice and control. We are able to deliver on this priority thanks to the enthusiasm and commitment of our partner providers and community support organisations and will continue to promote collaborative approaches.

We work to minimise isolation and engage with those in need through approaches such as befriending, peer support and the work of our Kindness Collaborative and Talking Points, linking people to local supports. We will continue to build on this collaborative working with the third sector and our communities and aim to increase the community supports and opportunities available. We will make best use of technology and health monitoring systems to support independence and self-management. We are committed to increasing choice and control and delivering the full potential of Self-directed Support. As more people live longer with more complex conditions it is important that we work collaboratively with housing providers to support independent living in our communities.

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

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

2.3.2 Our performance in 2023-24

Over 2023-24 we have continued to support people to live independently and well at home, despite additional demand pressures on our services due to more people seeking support at home as well as increased levels of frailty and complexity. During 2023-24 we have seen continuing pressure on our Care at Home service with increased referrals and reducing capacity among partner providers. Targeted activity has meant that we have been able to improve outcomes for people receiving re-ablement supports and have supported independent living for those in greatest need.

Headline performance data includes:

- 96.8% of local people aged 65+ live in housing rather than a care home or hospital – meeting our target and better than the Scottish average.
- 64% of people had a reduced care need following a period of reablement / rehabilitation support – up significantly from 48% in 22/23.
- % of people reporting outcome of 'living where you/as you want to live' increased to 91% from 89%, now ahead of target (90%)

- % of people aged 65+ with intensive care needs (plus 10 hours) receiving care at home dropped from 64.4% to 62.5% although still within our agreed target of 62%.
- The number of people self-directing their care through direct payments and other forms of self-directed support increased to 548 for 2023-24 (up from 488 in 22/23).
- In East Renfrewshire, spend on direct payments for adults as a % of total social work spend for adults was 9.3% in 22/23 – up from 8.9% in the previous year and better than the Scottish average (8.7%).

2.3.3 Ways we have delivered in 2023-24

The HSCP continues to promote Community Led Support which emphasises more local, personalised and flexible services. More than ever, we recognise the importance of strong community and third-sector links to ensure people can access the supports they need in their community, helping people to live independently and well.

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

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

During 2023-24 there have been some wide-scale changes within the HSCP seeing key personnel changes resulting some service re-design and shifting of priorities. Further development of the Talking Points partnership has seen a shift towards a closer links between 3rd sector providers, community activities and the public sector under The Community Hub Collaborative.

The Community Hub – ensuring support is available in our communities

The Community Hub continues to demonstrate the benefits of collaborative working across East Renfrewshire, playing a key strategic role in the development and implementation of the HSCP's supporting people framework. Developing the scope and reach of our online community directory and helpline is central to the implementation of our single access point for local supports and activities.

Talking Points @ The Community Hub plays a pivotal role in diverting moderate to low level supports away from the HSCP front door, being picked up and supported by appropriate community and 3rd Sector providers. During 2023-24, The Community Hub picked up and supported 702 requests for assistance:

- 503 linked with Community Information

- 178 signposted/referrals directly to 3rd sector organisations
- 158 requiring further multi agency supports via the Talking Points screening group.

2023-24 witnessed an increase in demand for capacity supports to groups, community activities and support services. There is a clear indication that many groups/organisations are facing and will continue to face financial difficulties. This led to a funding session being held in January 24 (6 organisations); with authority-wide engagement planned, on a locality basis, during 2024/25. The range of supports provided during 2023-24 (including our virtual supports) consisted of:

- Organisational supports delivered to:
  - Social Enterprises 20
  - Charities/Community groups 51
- Supports provided Included:
  - Policies, Good Governance & Constitution Reviews: 33
  - Funding & Finance: 37
  - Charity Compliance & Information: 14
  - Legal Structures: 2
  - Asset Transfers: 1
  - Other: 8

Development of our Community Hub website has allowed for more targeted information for individuals whilst promoting volunteering opps, activities, supports and information available. Our Community Hub website brings together information and access to support services, community activities and volunteering opportunities in one person centred community page. Over 150 groups registered new activities on the Community Hub Directory and in April 2023 we launched a new directory focused on ASN children and young people.

The Community Hub website has seen 5600 users with 14,600-page views for community activities and support information. The development work carried out across the Talking Points collaborative has seen a further development during 2023-24 of our online referral form for partners and the development of a self referral form to be launched in 2024-25.

The Community Hub collaborative continue to work together to design an approach to data sharing and service design that is fit for purpose and meets the changing needs of our most vulnerable residents. Development of Talking Points support hubs within Thornliebank Resource centre, The Community Hub @ The Barrhead Centre and The Community Hub @ Kelburn Street started towards the end of 2023-24 offering Talking Points partners the opportunity to have a shared work space, that facilitates cross agency support and delivery. This will be further developed during 2024-25.

Find out more about the work of Talking Points by watching this video:
https://www.youtube.com/watch?v=IK88PRexpfs

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

Over all this year we have supported:

- 35 Kindness buddies

- 30 residents supported.
- 4 new collaboratives set up.

Kindness Buddies
Our Kindness Buddies project focused on supporting Live Active, Home Safely and Time out for Carers to recruit volunteers and maintain relationships and support across these local areas of need

Our most successful achievement over this year has been the positive impact delivered by our volunteers. They have cemented the relationship with the people they support and have also developed their own peer support network meeting for coffee and walks. Our Kindness Buddy role is a true mutually beneficial relationship between our volunteers and the residents looking for support.

This year our volunteers and the people they support all attended the East Renfrewshire Big Lunch together, with other isolated residents looking to develop new connections and learn about the support services and social activities available across East Renfrewshire.

Kindness Collaborative
Our lead has focused their work this year on extending the successful work with Home Safely, Live Active and Time out for Carers to be integrated into our Talking Points network. Working closely with our HSCP colleagues and wider third sector partners we have been able to identify gaps in current community support provision and work collaboratively to try and meet those needs. These identified needs include; shopping requests, social support buddies and a need for general peer support across our vulnerable residents mainly older people or those with a long-term condition. Examples of the work delivered by the Kindness Collaborative in 2023-24 are given below.

Crookfur Cottages
A local sheltered housing complex with The Retail Trust as housing provider. They are redeveloping their communal space, to provide a range of services that reflect community need; potentially delivered by local people.
The Kindness team supported The Retail Trust to engage with other local groups and organisations that are already providing supports in the area to connect and collaborate; ensuring there development was not duplicating but adding additional capacity to the community.

Sporting Memories
Men's group/dementia sporting friendly groups are a gap in this area. KC supported them to set up a regular group that is volunteer led, out of our Barrhead community hub with a regular weekly attendance of between 3-5. Now being advertised across a number of local pubs as a way of supporting their regulars to receive support during the day.

Age Concern Eastwood
A new board member contacted us to get support to update their services and supports to meet local needs. We connected them with local partners through Talking Points and the wider 3rd Sector i.e. Retail Trust, Generations Working Together and our own youth volunteer team. This was really about how they could increase their volunteer offer, create some intergenerational work to help bridge the gap between young people and older people and to help enhance the local developing young workforce offer to create a new local generation of workers interested in skilled working within health and social care.

Thornliebank Parish Church
Volunteer support request, and looking for local support speakers to share local provision and increase awareness of what support is available locally. The Parish Church run a community café and social groups. We introduced them to the Prevention Team (to raise awareness of scams), Family First (to encourage wider community reach), CAB older peoples support worker, MART (Money Advice & Rights) and our Youth team again to encourage intergenerational supports.

Healthy Activities initiative
We now have 10 walks taking place with 102 participants and 18 volunteers.

Additionally, local strength and balance classes had 82 participants with 4 volunteers supporting them.

Parkinson's Support group
Again through Talking Points Parkinson's support has been highlighted as a gap in provision. Together with our HSCP partners, members of the local community and our local Carers Centre we have been working with Parkinson's UK to develop a peer support group. The first public meeting was held in March 2024; with 9 local residents in attendance and a further 4 people expressing an interest.

Long Covid Peer Support
We were approached by a local resident at the same time as our HSCP Talking Points Partners to help set up and develop a long Covid support group. Our team supported the establishment of two peer support groups, with 6 regular attendees. The group has been supported to make connections with local people experiencing the long term effects of Covid-19, we have sourced national and local specialist information ranging from health Improvement, MART and NHS interventions. We continue to support this group with an aim to recruit a volunteer to take over leading the group as and when they are ready.

In partnership with VAER we support the delivery of **Home Safely** linking with the HSCP Home from Hospital and Intermediate Care Teams. The project aims to support vulnerable residents to feel more supported to settle home following discharge from hospital/care setting. The intention is also that residents are more connected to social activities and support services and HSCP staff are more connected to community activities. The Home Safely project provides short term support (6-8 weeks) for isolated East Ren residents to re-connect with their communities after a stay in hospital. During 2023-24 we saw:

- 37 Referrals (11 declined, 4 on-going)
- 22 Residents matched with volunteers. Participants now attending activities within their local area.

During the year we have established close working links. We undertook a review of referral pathways and combined professional oversight of Rehabilitation team and Reablement to maximise support for individuals being discharged from hospital directly home or into an intermediate care setting - promoting home first ethos.

The Kindness Collaborative continues to provide range of support mechanisms for practical and emotional support to individuals. The community volunteering programme is designed to remove financial, digital and practical (transport/mobility) barriers to accessing community assets. There was a successful test of change with East Renfrewshire Culture and Leisure Trust for strength and balance exercise provision. This resulted in an increased number of individuals attending Vitality classes, increased attendance rates, strong communication links and pathways between HSCP and Leisure Trust ongoing.

East Renfrewshire HSCP's **Care at Home** service provides care to around 515 East Renfrewshire residents covering on average 9,250 visits and 3,115 hours of care per week.

There have been significant capacity issues within Care at Home both locally and across Scotland leading to continuing pressure on the HSCP's in-house care at home service.

During 2023-24 our **Learning Disability Team** underwent an unannounced inspection by the Care Inspectorate. The Inspection recognised the service as being 'Very Good' for both Leadership and Health and Wellbeing indicators.

During the year we also saw the transformation of former Learning Disability Day Services buildings into Community Hubs in partnership with VAER. This approach is supporting the developing resources and activities available to all. In order to enable a shift from Day Services to Day Opportunities to provide person-centred and outcome-focussed support in a variety of forms, the service was successfully registered as a dispersed service, a sub-category of Care at Home.

Community Pathways offers day opportunities and community outreach support to people with learning disabilities in East Renfrewshire, including transitions support for younger people. Around 40 people use the service on a permanent basis with a larger number of people participating in short term placements at any one time.

The service is based in Thornliebank Resource Centre but also makes use of other community-based buildings across East Renfrewshire. People can access a wide variety of groups, projects and activities aligned to their outcomes. This includes partnership working with 3rd Sector Organisations such as Include Me 2, Voluntary Action and The Trussel Trust. The service also offers workshops to develop independent living skills and skills for work.

Following an unannounced inspection in March 2024 the service received a highly positive report from the Care Inspectorate, commended for the person-centred approach taken by staff, the interesting and fulfilling activities on offer and an enthusiastic and well trained staff team.

The inspection found that the service works well in partnership with other health professionals and support providers and implements guidance received to improve people's wellbeing, such as eating and drinking advice and using techniques to limit stress and distress. The findings were based on evidence gathered from people who use the service and their families, who told the inspection team that key workers are the best thing about the service.

We continue to promote the positive impacts of **digital technology** on living well in East Renfrewshire, including through participation in the East Renfrewshire Digital Inclusion Partnership. We have continued to develop our digital offer, ensuring groups, organisations and individuals have access to the latest information. VAER have developed an interactive online directory of community activities that can be searched on the basis of interest, geography and access. However, we also appreciate that not everyone is comfortable with accessing or using digital information, therefore we continue to use traditional methods such as leaflet drops, information posters and face-to-face drop-ins.

During 2023-24 the partnership has continued to deliver 1:1 IT/Digital supports with 76 appointments carried out by our Digital Champion with The Market Place @ The Avenue.

Through our Talking Points Collaborative we have continued to promote the benefits of digital technologies to support independent living through referrals for community alarms, promoting dementia friendly technologies and referrals to the Tech enabled Care team within HSCP.

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

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

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

Last year the service received 116 referrals from 11 health boards. Most of those referrals resulted in SCTCI recommending a communication device. Client feedback in a recent video created by an AAC user for the Health Board included: ‘’I think SCTCI is a great service. They are always there when I am trying out new communication devices or when my clamp falls off. They work quickly. AAC is one of the biggest parts of my life. It doesn't just give myself a voice, it has given me so many opportunities writing blogs, public speaking and campaigning. So AAC is really important to me.”

SCTCI is a nationally recognised service not only in Scotland but is also represented at many events throughout the UK. It received recognition from the Communication Matters Charity as the setting of the year award in 2019.

The service regularly travels across Scotland. Recent visits have been to Orkney, Aberdeen and Thurso. It has strong networks and links to Speech and Language Therapists from all over Scotland who are in regular contact for all AAC related queries.

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

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

The service received recognition from the Communication Matters Charity at their 2023 awards ceremony. The CHAT service won The Samantha Hunnisett Access Award – an

award for an individual or team, whose innovative work has broken down barriers to access assessment or the use of AAC or Electronic Assistive Technology (EAT).

The team was commended for their excellent work in breaking down barriers to ensure equal opportunities and access to AAC assessment and provision. This has meant that 50 AAC users in Glasgow alone were provided with the communication aid they needed last year, most within three weeks from application.

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

CHAT has a number of projects ongoing which aim to improve procurement of devices and identify the training needs of the workforce in Greater Glasgow and Clyde. It also compliments the review work carried out by the Scottish Government as part of their AAC User Engagement Project. The service model has been recognised across Scotland as excellent with many other services requesting to replicate it.

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

MACMILLAN CANCER SUPPORT

Macmillan Improving the Cancer Journey (MICJ) – East Renfrewshire

The East Renfrewshire Improving Cancer Journey (ICJ) Service is a partnership between Macmillan Cancer Support and the HSCP. The ICJ Service launched in East Renfrewshire in July 2023 and at present has funding secured until 2029. The launch of the East Renfrewshire service means that every local authority in the Greater Glasgow and Clyde NHS area is able to offer this dedicated support.

In addition to the extensive range of support available through Macmillan services, the ICJ Service also links to the East Renfrewshire Money Advice and Rights Team and the East Renfrewshire Culture and Leisure Trust's partnership with Macmillan to provide an information and advice service with support provided by volunteers many of whom have lived experience of living with a cancer diagnosis.

The ICJ Service has 3 part-time members of staff who although employed by the HSCP, are registered as Macmillan professionals and are therefore able to access a wide range of supporting materials and opportunities that support the people referred.

ICJ is primarily a signposting role. The Wellbeing Practitioners work alongside people with a cancer diagnosis to complete a holistic needs assessment (Holistic Needs Assessment (HNA) | Healthcare professionals | Macmillan Cancer Support) which identifies the persons concerns which in turn enables the Wellbeing Practitioner to ensure that the appropriate support and advice is available.

Although the ICJ Service started in July 2023, the Service was only officially launched in May 2024. At the time of writing, the ICJ Service has received 161 referrals and 136 people have completed care plans of support.

Partnerships have been established with a range of community partners including Cancer Support Scotland, Beatson Cancer Charity, East Renfrewshire Carers' Centre and East Renfrewshire Community Transport.

We very much look forward to the ICJ Service continuing to expand its reach and supporting more people diagnosed with cancer, and working with partners to provide an offer of comprehensive and holistic information, advice and support.

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

2.4 Working together to support mental health and wellbeing

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

2.4.1 Our strategic aims and priorities during 2023-24

During the pandemic we adapted our approaches across services to support the mental wellbeing of the people we work with. We are focused on good mental wellbeing, and on ensuring that the right help and support is available whenever it is needed. We recognise that different types of mental health need will continue to emerge as time passes and that we will need to continually adapt our approach to reflect this. We are focused on close collaboration with primary care, and further enhancing the mental health and wellbeing supports within primary care settings. We will work with GPs, third sector partners and people with lived experience to develop our approach to ensure people get the right service, in the right place at the right time. We are enhancing our approach to minimising drug and alcohol related harms and deaths and improving overall wellbeing amongst people with harmful drug or alcohol use and their families.

We will continue to work in partnership with people who use services, carers and staff to influence the Greater Glasgow and Clyde Adult Mental Health Strategy and contribute to its delivery to ensure the needs of East Renfrewshire residents are met. We will ensure a particular focus on prevention, early intervention and harm reduction; high quality evidence-based care; and compassionate, recovery-oriented care recognising the importance of trauma and adversity and their influence on well-being.

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

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

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

2.4.2 Our performance in 2023-24

During 2023-24 our teams have continued to deal with increased demand across mental health and addiction services due to increases in complexity. There has been high demand across all teams (Alcohol and Drug Recovery Service, Adult Mental Health Team, Primary Care Mental Health Team, Older Adult Mental Health Team). For older people we continue to see wellbeing impacted by issues such as isolation and reduction in mobility. All services have had unforeseen staffing absences and vacancies during the year, contributing to limited appointments being available and increasing waiting times. Nevertheless, our teams have been working to minimise any decline in performance.

Headline performance data includes:

- Mental health hospital admissions remain low (at 1.2 admissions per 1,000 population)
- 84% waiting no longer than 18 weeks for access to psychological therapies – a significant improvement from 75% in 22/23
- 93% accessing recovery-focused treatment for drug/alcohol within 3 weeks – a slight decline from 96% in 22/23 but we are maintaining performance ahead of target (90%)
- 568 alcohol brief interventions undertaken in 23/24 – up from 173 last year, reflecting continued support for this service.
- % of people moving from drug/alcohol treatment to recovery services in the year declined from 5% to 4%. This can be impacted by circumstances for individuals including crisis or ill health but remains an area of focus for the HSCP.

2.4.3 Ways we have delivered in 2023-24

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

The partnership takes a holistic approach to promoting mental health and wellbeing including promote physical activity linked to mental wellbeing, in partnership with VAER. During 2023-24, work with our communities to promote positive mental health and wellbeing has included:

- 10 community **health walks** running per week. Delivered by Volunteer Community Walk Leaders, supported by VAER Health & Wellbeing Development Worker.
- **New wheelchair group** established in March 2024 in Barrhead area.
- 7 community **Strength and Balance classes** running per week delivered by community volunteers, supported by the Voluntary Action East Renfrewshire Health & Wellbeing Development Worker.
- 12 new **volunteers recruited and trained** as Walk Leaders or Strength and Balance Leaders. Further volunteer recruitment underway, with volunteer training booked for May 2024.

Walking for Wellbeing

We are currently supporting 10 walks across East Renfrewshire and we hope to be supporting 14 walks by the end of July 2024.

This year, a number of new initiatives have been launched. The Wheelie on Wednesday is an opportunity for wheelchair users to get out and about in the community and launched in April. This has been a successful venture; the participants had complained that there was nothing to do for wheelchair users in Barrhead and a number of them expressed concern that they had a tendency to become reclusive and lacked social contact. This in turn, had affected their mental health. Since the launch of the Wheelie, the Wheelers have taken to it with enthusiasm. One of the participants, Dave Hill, completed Wheel-leader training and is now a volunteer. It has improved his confidence immeasurably and he has seen real improvements in his mental and physical health. Additionally, another Wheeler, Elaine Clark, is intending to do Wheelie Leader training in the near future.

Additionally, two existing walks run by fundraiser Anwar Rafiq (Well Walks) in Neilston are due to be absorbed into the Paths For All framework in the next week. These walks are longer than the normal PFA walks and can last up to two hours. There are two major benefits to this. Firstly, several walkers across East Renfrewshire have been asking for a more challenging and longer walk as they feel like they have progressed enough to try something harder. Secondly, one of Anwar's Walks is on a Saturday and allows for individuals who work or otherwise cannot attend the weekday walks to participate.

We are also in the process of setting up a walk with a Weight Watchers group in Thornliebank. The participants are very motivated to look after their health due to the nature of the class. The risk assessment and route has been completed and the new walk will begin soon.

Participant stories

Sarah began attending the First Steps in Eastwood Park Walk about a year and a half ago and has become an ever-present on my register. Before attending the walks Sarah had begun to suffer from a number of health conditions caused by a sedentary and unhealthy lifestyle – she was overweight, had high blood pressure and diabetes. She made the decision to make a positive change to her health because in her words she wants to "see my grandchildren grow up". Since attending the walks she has seen great physical improvement – she is now a healthy weight and has her blood pressure and diabetes under control. Additionally Sarah now attends 3 walks a week – First Steps in Eastwood Park, The Rouken Ramble and the Crookfur Walk. Kind-hearted and gentle by nature, Sarah volunteers for another charity and, after some consideration, she decided to do the Walk Leader training and has become my newest Walk Leader. As with most of the participants on the walks, she has very complimentary about the positive mental benefits and support network which build up around them. She says that people tend to open up in this sort of environment as walking side-by-side is less confrontational than sitting opposite someone.

Elaine attends the Giffnock Walk on a Monday. As a carer for her husband who has dementia, Elaine felt that she never had any time for herself and was struggling emotionally and physically with the demands of caring over the past few years. After organising for her husband to attend a lunch club for 2 hours with the Stables she began attending the Giffnock Walk. Elaine says that the company and support she has received from the group has had an extremely positive effect on her mental health; many of the other participants have experienced similar issues in the past and she feels very grateful that she has people with whom she can talk to about the demands of caring whilst also being able to talk about more light-hearted things which take her mind off of things. Physically, she has improved vastly – she had been neglecting herself before to care for another, looked very gray and strained. Now, she has more colour in her face and looks less careworn and stressed. Elaine says that she feels rejuvenated by the walk and it allows her to return to caring for her husband in a happier frame of mind and with more mental strength to deal with the challenges of caring for someone with dementia. She has recently secured the help of another dementia club on a Friday afternoon and is looking to join the Clarkston Walk too.

We are committed to working together with community planning partners on activities that support mental wellbeing and resilience across our communities, with Voluntary Action East Renfrewshire taking a leading role. We have continued to support delivery of the **Community Mental Health and Wellbeing Fund** in partnership with VAER successfully implementing the second year of support to local community. Year 3 funding has been announced for 2024/2025 and there is a focus on tackling loneliness and isolation. Our **Dementia Buddies** programme supported 12 individuals during the year; 11 volunteers received training provided by Alzheimer Scotland, Mearns Kirk Helping Hands, and East Renfrewshire Culture & Leisure Trust.

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

Seasons for Growth aims to build resilience and bring hope and confidence to children, young people and adults who have experienced significant change or loss. Three Seasons for Growth training sessions have been delivered to Mearns Kirk Helping Hands and Jewish Care staff and volunteers.

The following training courses have been delivered in 2024 with over 200 staff and volunteers participating: Scottish Mental Health First Aid, Applied Suicide Intervention Skills Training (ASIST), Alcohol Brief Interventions, Seasons for Growth, Peer Support, as well as awareness raising sessions around suicide, self-harm and mental health and wellbeing.

In the last year, four staff have completed the training to become Peer Supporters. There are now nine Peer Support Champions working across East Renfrewshire to support the mental health and wellbeing of staff and partners.

Peer support provision continued throughout 2023-24 in mental health, alcohol and drugs service settings, jointly funded by Action 15 and Alcohol and Drugs Partnership funding. We have enhanced and diversified our multi-disciplinary teams through the addition of occupational therapy resources within the Alcohol and Drugs Recovery Service (ADRS). Additional clinical psychologist leadership has been put in place for the Primary Care Mental Health Team to support service delivery, in particularly delivering on psychological therapy waiting times.

Delivering on shared priorities across Greater Glasgow and Clyde

The **NHSGGC Mental Health Strategy** was recently refreshed. East Renfrewshire Mental Health and Recovery Services are implementing a number of elements of the strategy including:

- Working with commissioned providers on **peer support** provision, including work to improve the flow of supported people through the service, reduce waiting times and increase recording of recovery outcomes. To ensure more direct access to peer support, in 2024-25 the service will move from a commissioned model to NHS peer workers embedded in multi-disciplinary teams, building on learning from the past four years of service delivery
- The adult mental health team (AMHT) has implemented the **Patient Initiated Follow-Up Pathway** (PIFU), which enables patients to access appointments when their symptoms or circumstances change, and avoid unnecessary appointments. This system is working well with 94 patients on PIFU, maximising capacity in our AMHT.

We continue to deliver the priorities in the **East Renfrewshire Alcohol and Drugs Strategy,** with implementation led and overseen by the Alcohol and Drugs Partnership. During 2023-24, significant progress was made in a range of areas including:

- Developing a business case for investing Alcohol and Drugs Partnership reserves in the design and implementation of a **Community Recovery Hub**. The business case was greatly strengthened by the feedback from lived experience communities and was approved by the Scottish Government. Work is now progressing on the recovery hub initiative. Draft building plans have been developed and discussed with members of the recovery community and local partners. The community steering group in the

process of being established, with three engagement meetings held and a site visit to the potential hub premises.

- A range of activities to ensure that service user experiences shape services including interviews and focus groups to gather feedback on implementation of the Medication Assisted Treatment Standards conversation cafes to inform the development of occupational therapy within the Alcohol and Drug Recovery Service.
- ADRS and children and families social work worked together on a **whole family support** programme for family members of all ages affected by alcohol/drug harms. Aspects of the programme include group work with young people, family inclusive events, development of a play therapy programme, outdoor learning programme for children and young people
- 22 staff from across the alcohol and drugs partnership participated in Community Reinforcement and Family Training (CRAFT) which will build **capacity** and enhance **professional practice** in supporting families affected by alcohol and drugs.

Glasgow Council on Alcohol (GCA) have been commissioned to deliver **Alcohol Brief Interventions (ABIs)**, alcohol counselling sessions and training on the delivery of ABIs to staff across the HSCP and partners. 568 ABIs have been delivered to date (target 419) along with 379 alcohol counselling sessions. These interventions have taken place in leisure centres, libraries, Voluntary Action market places, community centres and food banks. Staff training on ABIs was delivered during the year.

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

During 2023-24 the full staffing complement to deliver the MAT Standards was achieved with the successful recruitment of an occupational therapist, healthcare assistant and Alcohol and Drug Recovery Service nurse, in addition to the pharmacist prescriber who joined the team in 2022. A significant work programme was undertaken to gather the comprehensive evidence required to demonstrate implementation of the MAT Standards. In particular, experiential evidence of service users was required to inform improvement plans for the coming year. A formal Red/Amber/Green (RAG) assessment has been completed by Public Health Scotland and East Renfrewshire is expected to be rated as Green for all standards, including delivering rapid access to treatment (on same day where possible), offering choice of medications, and undertaking proactive assertive outreach for people at high risk.

Virus testing

The East Renfrewshire Alcohol and Drug Recovery (ADRS) Service achieved a 122% increase in Blood Borne Virus (BBV) testing in clients who are receiving Medication Assisted Treatment, which was recognised by the health board at the NHS Hepatitis C Education event.

99% of service users receiving Medication Assisted Treatment have now been tested, with the other 1% declining to participate.

Blood Borne Virus (BBV) testing and linkage to care is key to improving patient outcomes and reducing the risk of onward transmission to others. BBV tests are for Hepatitis B, Hepatitis C and HIV.

The team are unique in that both health and social work staff are trained to deliver dry bloodspot testing and to provide information and advice regarding the transmission of BBVs

and how to reduce transmission through safer practices. The Pharmacist Independent Prescriber, nursing staff, health care support worker and social care staff are integral to achieving this.

During Covid the rate of testing dropped significantly and it has taken a lot of dedication and hard work from the team to bring the rate back up to the high standard that they achieved and maintained prior to the pandemic.

The team have a system on the patient record for prompting when the next test will be due in order to maintain this high level of testing, and support is given to those who test positive.

We continue to work collaboratively with our partners on **suicide prevention** activities and our commitment and priorities for action are reflected in the recently approved East Renfrewshire Suicide Prevention Strategy and Action Plan 2024 – 2027.

A shared approach to suicide prevention in East Renfrewshire

East Renfrewshire has the lowest number of deaths by suicide across Scotland. Although this is positive, every death is a tragedy and reminder of the work to be done to support suicide prevention. Local analysis of suicide deaths over the five year period from 2018 to 2022, highlights males to be an at risk group with 80% of the individuals who died over this period being male. Adults, specifically older adults aged 55-75 years are shown in local data to be an at risk group. Locally, there is no consistent trend in relation to the Scottish Index of Multiple Deprivation (SIMD) of those who have died, highlighting poor mental health and suicide can impact all individuals regardless of deprivation levels.

The **East Renfrewshire Suicide Prevention Strategy and Action Plan 2024 - 2027** has been developed following the publication of the national strategy and action plan "Creating Hope Together"; a joint strategy between Scottish Government and COSLA. This national strategy leads the way for development of local strategies and action plans across all local authority areas in Scotland.

Our local strategy and action has been developed following analysis of both local, board wide and national evidence based data including reviews of local Sudden Adverse Events (SAER). This data, alongside engagement and consultation with partners, stakeholders and community members provided insight and evidence into the local priorities and needs for East Renfrewshire in relation to suicide prevention activity and action. Data collation, analysis and evaluation alongside community engagement are integral to this plan both now and for future planning.

The long term vision for this strategy is: ***Good Mental Health and Wellbeing for All***. The principle of collaboration and partnership working will be key in driving this work forward. Our HSCP Community Mental Health Team and Alcohol and Drugs Recovery Services supported 1,842 local residents during the period April 2022 to March 2023. Our local services provide quality care and support for those in need and whom may be at increased risk of suicide. However, local data highlights that only one third of individuals who have died by suicide have been known to services and therefore confirms our principle of collaboration and partnership working. The need for a community-wide approach is critical in relation to awareness raising, training and capacity building.

The delivery of the new strategy and action plan is integral to our role as a Health and Social Care Partnership (HSCP), supporting individuals and communities as well as closely aligning with the NHSGGC Mental Health Strategy 2023-2028 and supports the same principles and priorities such as partnership working, workforce education and prevention focus. Locally we will continue to work in partnership with NHSGGC and wider partners to

achieve the best outcomes for East Renfrewshire residents and communities, focusing on the following priority areas:

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

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

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

2.5.1 Our strategic aims and priorities during 2023-24

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

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

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

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

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

2.5.2 Our performance in 2023-24

As a result of the continuing pressures on the social care sector and particularly our care at home service during the year, we saw a higher than usual average number of delayed discharges and the number of hospital bed days lost to delayed discharge as a result of the continuing pressures on the social care sector and particularly our care at home service. Increased pressures on care at home services through higher demand and staff capacity issues, and higher levels of frailty and complexity among people return to the community from hospital impacted performance on delays. However, we continue to be one of the best performing partnerships for minimising delays in Scotland. Our Hospital to Home team work to deliver timely and appropriate discharges from hospital. Our performance for delays remains among the best in Scotland. We continue to support the hospital discharge efforts by

promoting the use of intermediate care beds where a care at home package cannot be immediately accommodated.

In East Renfrewshire, unplanned hospital attendances and admissions are stable (having increased slightly but remaining within target) and have not returned to pre-pandemic levels.

Headline performance data includes:

- Discharge with delay – averaged 7 delays for 23/24 – down from 8 for 22/23 but historically high, having sat at 3 or 4 before the pandemic.
- Adult bed days lost to delayed discharge increased slightly to 4,821 (2023 fig), up from 4,652 for 22/23
- Adult A&E attendances – 17,824 (2023 fig) – up slightly from 17,356 22/23 but ahead of target
- Adult Emergency admissions – 6,943 (2023 fig) – again, up slightly from 6,692 in 22/23 and ahead of target
- Emergency admission rate (per 100,000 pop) – 9,606 up from 9,215 for 22/23
- Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges) – 73, up from 69 in 22/23

2.5.3 Ways we have delivered in 2023-24

During 2023-24 the HSCP has continued to work with other partnerships and acute services in the Glasgow area to develop services and pathways to prevent admissions and support people return home following a stay in hospital.

Our dedicated **Hospital to Home** service (which facilitates complex hospital discharges) includes a team focussing on the appropriate and effective use of intermediate care beds. This supports timely hospital discharge where the required homecare package is not immediately available and delivers improved outcomes from assessment activity carried out in this setting (versus hospital). The targeted work by the team includes requests for intermediate care beds, care home liaison, occupancy tracking, data collation, arranging interventions / reablement and carrying out outcome-focussed reviews and care planning. The collaborative working between these teams has ensured that delays in hospital discharges have been minimised and kept within manageable levels.

We are also working to implement our **discharge to assess** protocol to help minimise discharges with delay. There has been ongoing joint working between Acute Services and Hospital to Home Team, Intermediate Care and Rehab Service to support individuals to be discharged home or to alternative community setting to ensure safe discharge without delay and ongoing assessment. We provide **enhanced community support** and **intermediate care models** in partnership with HSCPs across Glasgow. To support timely discharge from hospital through intermediate ('step-down') provision, we provide a 6-bed unit in Bonnyton Residential Home and block, or 'spot' purchase additional beds for intermediate care in local Care Homes. Ongoing use of the 6 intermediate beds in Bonnyton is supported by partnership working across social work, community nursing, Reablement and Rehab services, and primary care services.

Addressing discharges with delays for Adults with Incapacity (AWI)

Despite our proactive activity to support discharge from hospital, the HSCP is still challenged with delays resulting from Adults with Incapacity (AWI) and family choice/indecision and delays due to Power of Attorney (PoA) not being in place. In partnership across Greater Glasgow and Clyde we are working to improve processes for AWI patients.

Although the GGC-wide review of the current AWI procedures is at an early stage, we have begun work to update our documentation for individuals. This should streamline the referral pathway for all departments within the partnership. A 6-month audit of all hospital discharges subject to delays as a result of Guardianship Applications commenced in January this year. The data from this will be analysed to identify any barriers to progressing AWI applications timeously and any learning from this will be reflected within the updated AWI procedures. The **Mental Health Officer (MHO)** service continues to provide a responsive service to the Hospital to Home Team as all requests for 13za reviews and AWI case conferences continue to be allocated and arranged at point of referral. The dedicated MHO based within the hospital team remains a key factor in ensuring that statutory work to facilitate hospital discharge is prioritised, and ensures a rapid and responsive service to individuals requiring a legal framework to facilitate hospital discharge.

During 2023-24 our **Community Rehabilitation Teams** continue to experience significant demand pressures in the aftermath of the Covid pandemic, with high levels of frailty and frailty-related falls among our older population. Average weekly referrals into the service are approximately 60% higher than before the pandemic. Due to increased complexity of need and deconditioning, the service is finding that people are requiring longer and more frequent inputs, adding to demand pressures. More than 40% of referrals to the service require urgent assessment and input (same day / within 72 hours).

Supporting frailty in our population

During the past year we have continued our work to implement frailty pathways and support initiatives to address frailty in our communities. There has been ongoing development of **Home First Response/Frailty service** including the appointment of two WTE Advanced Practitioners in Frailty aligned to Community Rehab Multidisciplinary team. There has been further development of community falls and frailty pathways across HSCP to identify and provide appropriate guidance, support and interventions both for community referrals and hospital discharges. We continue to work to improve our use of data and we have reviewed our 'frailty matrix' which details appropriate services across the frailty pathway. During the year we have seen increased use of Rockwood Dalhousie Frailty Scoring, with frailty scores being recorded on our systems and in Anticipatory Care Plans.

- 110 patients referred for Frailty Practitioners input in past 6 months. A new referral pathway has been established from primary care pharmacists undertaking polypharmacy review.

Our **community falls pathway** with Scottish Ambulance Service (SAS) continues and we are now looking to extend scope to include frailty presentations. We have sustained the target numbers of monthly referrals from SAS at 5 per month, or 30 for 6 month period.

- During 2023-24, all individuals referred through the have been reviewed same/next day and maintained in community with no ED attendance within 5 days.

We are working with primary care colleagues to identify test of change opportunities for proactive identification and management of frailty, building on a previous test of change with primary care pharmacy.

To prevent crisis and emergency use of acute services, we continue to work to improve the quality and quantity of **Anticipatory Care Plans (ACPs)**. In GGC anticipatory care plans are being rebranded as **Future Care Plans**. East Renfrewshire HSCP have completed 343 ACP's since the launch of the programme in 2021. Our target has increased by 10% from 2023 to 62 per quarter and we are on target to meet this. East Renfrewshire local ACP group continues

to meet every 12 weeks and staff training across HSCP is ongoing. District nurses and frailty practitioners are undertaking majority of ACPs. Care home liaison nurses have been supporting care homes to record ACPs on clinical portal. The East Renfrewshire ACP audit team meet quarterly to submit audits to central team and the quality of ACPs has been assessed as being high and an exemplar for other HSCPs. A pathway for the East Renfrewshire carers centre to refer carers and the cared for ACP's has received 26 referrals since commencing in May 2023.

To support our local **care homes** and minimised hospital attendances and admissions we have established a **Call Before You Convey** pathway. Between December 2023 and March 2024 - 47 calls came through the pathway, with all residents supported to remain within their care home. There has also been proactive targeted input to care homes from Rehab team AHPs including 240 residents' transfers/mobility and equipment reviewed to maximise safety.

Supporting local care homes

Our partnership works closely with local care home providers which include both independent and charity sectors. Commissioning and contracts staff continued to support homes with weekly welfare calls to homes, or more often if needed. Weekly multidisciplinary Care Home Assurance Meetings have now changed to fortnightly and there is a four-weekly Care Home Managers Forums with managers. Regular support meetings take place with care homes experiencing any issues/risks. The HSCP Adult Support and Protection team has worked closely with homes advising and investigating to keep the most vulnerable individuals safe from harm. Bespoke support is provide to care homes particularly where there was a Large Scale Investigation and closer monitoring is required to ensure the wellbeing of staff and residents continues to be a high HSCP priority. The Commissioning and Contracts team also supports the Care Home Assurance visits, alongside the clinical nursing team and senior managers for communities and wellbeing. The team is also providing input at various internal and external meetings, such as the weekly vaccination meeting, and Greater Glasgow care home assurance group.

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

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

2.6.1 Our strategic aims and priorities during 2023-24

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

Our Carers Strategy 2024-26 sets out how we will work together with partners to improve the lives of East Renfrewshire's carers. Through our local engagement and discussion we know that we need to develop our workforce, pathways and supports for carers. We have committed to working together with East Renfrewshire Carers Centre (ER Carers) to improve access to accurate, timely information. We will continue to encourage collaboration between support providers for advice, information and support for carers ensuring local provision that best meets carers needs. We will provide information and training to raise awareness of the impact of caring responsibilities. We will continue to support the expansion of personalised support planning in collaboration with our unpaid carers and ensure that self-directed support options are offered to all adult carers who have been identified as eligible for support.

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

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

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

2.6.2 Our performance in 2023-24

Through our new Carers Strategy and working in partnership with East Renfrewshire Carers Centre, we have continued to ensure that carers have had access to guidance and support throughout the year. Training and awareness-raising on the issues affecting carers have been delivered. Work has continued on the development and promotion of support planning for carers and the partnership continues to develop approaches to short breaks for carers.

Headline performance data includes:

- 84.5% of those asked reported that their 'quality of life ' needs were being met – up from 80% in 22/23 and continuing to perform ahead of target.

2.6.3 Ways we have delivered in 2023-24

Throughout the year we have maintained our positive partnership working with the **East Renfrewshire Carers Centre (ER Carers)**, continuing to deliver community-based integrated support for carers in East Renfrewshire including access to tailored advice, support, planning and community activities.

In partnership with the ER Carers we ensure **information and training** is available to raise awareness of the impact of caring and requirements of Carers Act. The Equal Partners in Care (EPIC) Training Programme was paused and underwent a full redesign and relaunch as of at the start of 2023-24. New HSCP staff and student placements spend time at the Carers' Centre and are provided with information about the Carers legislation and the support services available locally.

As part of the role out of the HSCP's **Supporting People Framework**, the revised eligibility framework for carers was included in the staff training and "toolbox" talks. This was followed up with meetings with all HSCP teams. During the year, the Carers Lead and SDS Lead also delivered sessions specifically for third sector and Talking Points partners and continue to link with this network. **East Renfrewshire Carers Screening Group** with representation from HSCP, Carers' Centre and Talking Points met throughout 2023 with a focus on Adult Carer Support Plans.

During the year we have continued to work in partnership to ensure carers are being engaged and involved in **planning services** that affect them. The East Renfrewshire Carers Collective meets monthly to discuss a range of topics, and a carers led on a programme of engagement meetings during the year with over 50 carers participating. The Carers Collective also delivered a training session to members of the Integration Joint Board (IJB). All carers referred to the carers centre are routinely informed of their rights. The Centre also delivered 4 group sessions with 65 participants.

We continue to implement **carers' support planning** including planning for emergencies with individual carers. Following introduction of the Supporting People Framework we have developed our process for Adult Carer Support Plans (ACSPs). The new process incorporates Emergency plans with an increased focus on promoting Anticipatory Care Plans (ACP) for both carers and the people they support. Carers Centre staff have undertaken training to promote Anticipatory Care Plans and there is a new Carers Pathway for ACP with links to the Community Nursing Team. A senior social worker was seconded to support ACSP processer and introduced a 'carers tracker' on the HSCP client recording system to improve review uptake and monitoring. We have introduced a multi-agency ACSP screening group that reviews all ACSPs and decides if cases should go to the Resource Enablement Group (REG) for further discussion. An abbreviated ACSP has also been introduced for carers with no requirement for statutory support from the HSCP. This allows the Carers Centre to record support plans for all carers referred for support. A total of 176 support plans were created last year.

Short Breaks are undoubtedly an important support to ensuring carers can maintain their caring role while maintaining their own health and wellbeing and having a life away from being a carer.

The East Renfrewshire **Short Breaks Working Group** includes the HSCP, Carers Centre and carers and has informed development of local practice on short breaks. Funding has been secured from the **Promoting Variety Project** to explore the use of volunteers to support short breaks. The Carers Centre has successfully secured **Time to Live** funding which provides 'microgrants' to unpaid carers so that they can take a short break. The aim of the funding is to increase the range and availability of short breaks across Scotland. Funding was also secured for the development of the **Dementia Walking Buddies** project. The ER Carers Lead participates in Resource Enablement Group (REG) and Peer Professional Review Group (PPRG) meaning ideas about respite can be shared with colleagues and partners.

Short Breaks Statement

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

- Carers will be recognised and valued as equal partners in planning for Short Breaks.
- Planning and assessment will be outcomes focused to ensure that we focus on what both the carer and the cared for person wants to happen.
- By using our eligibility framework we will have an equitable and transparent system for determining eligibility for funding Short Breaks that is consistent and easily understood.
- There will be timely decision making.
- Planning a short break will be a safe, respectful and inclusive process with every carer treated equally.
- When planning a Short Break questions about needs and outcomes will have a clear purpose for carers, not just to inform the support system.
- Prevention will be key. Planning and assessments for support should prevent deterioration in the carer's health or the caring relationship.

Our Short Breaks Statement will be refreshed during 2024/25.

We continue to work with partners to ensure supports are available to carers to minimise the impact of **financial hardship** as a result of caring. The Carers Centre continues to work closely with East Renfrewshire **Money Advice and Rights Team (MART)** to support local cares making referrals as appropriate. Carers Centre staff provide advice on carer related benefits and attendance allowance, and have delivered sessions throughout the year in partnership with Social Security Scotland. During 2023-24, the Centre secured additional winter hardship funds and worked with East Renfrewshire Citizens' Advice Bureau to ensure that the benefit of this funding was maximised.

Supporting carers with cost of living challenges

Supporting unpaid carers continues to be a strategic priority for the HSCP. Working with carers to identify what was important to them, we refreshed our Carers Strategy for the period 2024 to 2026 and will work with our Carers Collective to progress and monitor progress of the key activities that will deliver positive outcomes for carers.

We recognised that as a group, carers have been adversely impacted by the current cost of living challenges. We secured additional funding for the Carers' Centre to work in partnership with the East Renfrewshire Citizen's Advice Bureau to provide grants to mitigate some of the additional caused carers face as a consequence of their caring role.

Over 200 grants were awarded for carers, predominantly for increased electricity and heating costs but also for items such as winter clothes, laundry costs and heated blankets.

The partnership between the Centre and CAB ensured that carers were offered holistic support covering all their practical and emotional needs and the evaluation of the partnership was very positive, after receiving the grants, carers fed back that they felt more appreciated and valued.

The relief from getting some breathing space financially, allowed them to focus more on their caring role and indeed themselves.

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

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

2.7.1 Our strategic aims and priorities during 2023-24

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

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

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

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

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

2.7.2 Our performance in 2023-24

The provision of Community Payback Orders (CPOs) was significantly impacted by the pandemic. However, the proportion of CPOs completed within court timescales has continued to improve steadily. We continue to support people with convictions into employment and volunteering. A new justice employability programme began in June 2023, resulting in a 181% increase in participants.

Headline performance data includes:

- 89% of unpaid work placement completions within Court timescale – up from 83% and ahead of target (80%)
- 83% Community Payback Orders (CPOs) commencing within 7 days – down slightly from 86% in 22/23 but ahead of target (80%)

- 83% of people reported that their order had helped address their offending – down from 100% and impacted by the low number of people completing the voluntary survey.
- Positive employability and volunteering outcomes for people with convictions – 57% down from 64% in 22/23. Although missing our target of 60% all other participants demonstrated a positive training/education outcome.

2.7.3 Ways we have delivered in 2023-24

The HSCP delivers accredited programmes aimed at reducing reoffending in partnership with East Renfrewshire Council. During 2023-24 we continued to deliver this activity in a group work capacity and we have overseen the transition of the programme from Moving Forward, Making Changes to **Moving Forward 2 Change (MF2C)**. Training for the staff in the new MF2C programme will take place later in 2024.

Minimising risk

The criminal justice service uses appropriate risk assessment tools to identify need and reduce the risk of further offending and all staff access accredited risk assessment tool training. Justice Social Workers have undertaken training in the Throughcare Assessment Release Licence (TARL) process which will strengthen collaborative risk assessments between community-based and prison-based Social Work. All Justice staff are now trained in this approach.

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

Structured Deferred Sentences

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

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

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

We aim to ensure that people subject to statutory and voluntary supervision including licence have early **access to community mental health, alcohol and drug recovery services**. Staff continue to work closely with colleagues in East Renfrewshire Alcohol and Drug Recovery Service and Adult Services to provide **holistic supports** to service users. Staff continue to refer people with any identified needs to the associated ERCAT or Community Care teams. This includes regular contact with Adult Services to seek advice on possible referrals and potential interventions. Justice Social work and East Renfrewshire Alcohol and

Drug Service have revised local policies for Drug Treatment and Testing Orders to better meet the current needs of those requiring this service. Justice staff are now trained in the administering of opioid overdose prevention medication Naloxone. Staff regularly liaise with colleagues in mental health services whenever it is identified as necessary for successful outcomes for service users.

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

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

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

2.8.1 Our strategic aims and priorities during 2023-24

We are committed to the local implementation of Greater Glasgow and Clyde's Public Health Strategy: Turning the Tide through Prevention which requires a clear and effective focus on the prevention of ill-health and on the improvement of wellbeing in order to increase the healthy life expectancy of the whole population and reduce health inequalities. This includes a commitment to reduce the burden of disease through health improvement programmes and a measurable shift to prevention and reducing health inequalities through advocacy and community planning.

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

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

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

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

2.8.2 Our performance in 2023-24

As a partnership we are focused on tackling health inequalities and improving life chances for our residents. Although we remain below our target, we have seen an increase breastfeeding rates in our most disadvantaged neighbourhoods for the last two years. The premature mortality rate has dropped significantly and East Renfrewshire now has the lowest rate in Scotland.

- Our premature mortality rate remains significantly below the national average at 264 per 100,000 (22/23 fig) – down from 333 the previous year. Scotland average is 442 per 100,000.
- 19.2% of infants in our most deprived areas (SIMD 1) were exclusively breastfed at 6-8 weeks (22/23 fig) – up from 17.9% for the previous year and 7.5 for 2020/21.

2.8.3 Ways we have delivered in 2023-24

Working in partnership with our communities and other local services and supports we continue to explore all opportunities to support **health improvement interventions**. Examples of activity during 2023-24 include:

- NHSGGC has awarded £49,341 to the HSCP to deliver a new **child healthy weight/child poverty** programme. VAER has been commissioned to host a Programme Coordinator role for one year.
- Funding has been agreed with NHSGGC to develop a range of training around **community nutrition**.
- £5k has been awarded for 10 nurseries to complete the **Nourish Peas Please** pilot, encouraging vegetable consumption. Training will be delivered to nursery staff to support upskilling staff on activities to support this.
- £40k has been awarded to support delivery of a community nutrition framework. An action plan has been developed to provide **food education** to improve communities' knowledge and understanding of food and nutrition and the impact on health. Training opportunities have been commissioned including REHIS Food Hygiene, REHIS Food and Health, Emergency first aid at work, and cooking skill, to support employability and skills development.
- **Smoking cessation** sessions continue with the return of face-to-face sessions and telephone support. We are achieving LDP target of Quit attempts for our 40% most disadvantaged areas.
- Funding has been awarded to support dissemination of the NHSGGC **Health and Wellbeing Survey** (HWBS) report and VAER will support delivery of workshops and will link in results with wider policies and other relevant survey findings.

We continue to deliver **tailored health improvement programmes** and activities in communities experiencing greater health inequalities.

Addressing childhood obesity

In East Renfrewshire**,** based on 2022/23, using epidemiological thresholds, 16.4% of P1 Children are at risk of being overweight or obese. This is consistent with the previous two years.

- 9.4% of P1 are at risk of being overweight (114 children)
- 7% of P1 are at risk of obesity (85 children)

The HENRY approach is being developed locally to provide practical interventions that deliver key messages to change family lifestyle habits and behaviours. Health Visitors and relevant staff in early years have attended HENRY 0-5 training. An agreement with NHSGGC & Early Years Scotland has been reached and Early Years Scotland will deliver HENRY groups with families in East Renfrewshire.

Supporting the health and wellbeing of BSL users

In partnership with Community Planning and NHSGGC Equality team, a workshop was held on 13th February with British Sign Language users. Building on the feedback a 20024 – 2030 BSL plan for East Renfrewshire has been developed.

The 2011 Census showed that 133 in East Renfrewshire live in households where BSL is used and improved dated data on BLS users across East Renfrewshire is a key action agreed.

Tackling harmful effects of smoking

P1b at Giffnock Primary School were the annual Jenny and the Bear winner.

The Jenny and the Bear resource is a story which is part of a coordinated programme and aims to increase awareness about the effects of second hand smoke on children and what parents/carers can do to ensure their children are not exposed to its harmful effects.
The programme is aimed at Primary 1 classes and consists of a story being read to the class followed by a classroom activity (lesson plans provided) to agree a name for the bear in the story, which is then entered into the competition to win a Teddy Bear mascot for their classroom. All children who take part in the programme are given a booklet version of the story to take home.

The HSCP is working to ensure people in our most disadvantaged community are able to **access** digital and other opportunities that support independence and wellbeing.

NHSGGC have established a Steering Group for the development of a Health Visitor app. Once finalised this will act as a central point of accessible national and local information, including breast feeding groups.

East Renfrewshire HSCP funded six **strength and balance classes**, making them free at the point of access for the population of East Renfrewshire. These classes are part of East Renfrewshire Culture and Leisure's Vitality programme and operate at levels 1 and 2. This test of change will assess whether removing financial and/or digital barriers will lead to increased participation and adherence, thus leading to improved health outcomes at an earlier stage.

We have seen significant improvement in the past year in the percentage of children exclusively breast fed within our most deprived neighbourhoods (data to 22/23). Barrhead is an area of higher deprivation within the HSCP with SIMD 1 and 2 with lower **breastfeeding** rates in comparison to our Eastwood area. The Barrhead Health Visiting team continue to follow an enhanced pathway in the early postnatal weeks to provide additional support for mothers within areas of SIMD 1 and 2 to provide extra support to mothers that are breast feeding. With the introduction of the antenatal pathway, this has allowed for early discussions on breast feeding with all mothers

Achievements in supporting breastfeeding

Unicef Accreditation for Gold Standard has been achieved for 2023.

ER HSCP provide Board wide leadership for breast feeding. The Health Improvement Lead Chairs the NHS GGC Breast feeding Public Acceptability Group linking in the national developments with NHS GGC Maternal Infant Feeding Group.

The East Renfrewshire Maternity and Infant Nutrition Group continue to meet six weekly and link in activity delivered by National Childbirth Trust and other local partners.

An early year's programme of training has been developed and available for Early Years staff on TURAS. Work continues to develop the roll-out of the Breast Feeding Friendly Scotland Scheme. Currently 12 organisations are signed up to the scheme in East Renfrewshire.

During 2023-24 the partnership has continued to support local activity to tackle child poverty and mitigate its effects.

Supporting local activity to tackle Child Poverty

32 out of 37 early years establishments deliver the Childsmile Tooth brushing programme in East Renfrewshire.

100% of Primary Schools participate in Childsmile tooth brushing.

Work is ongoing with the Oral Health directorate to support workforce development and involvement in East Renfrewshire activities.

Work continues with ERC Strategic Services and a Cost of Living Dashboard has been developed. Child Poverty was agreed to be Priority 1 for data collection.

The Cost of Living Working Group continues with a health and wellbeing perspective. The annual Cost of Living roadshow focused on mental wellbeing promoting the My Mental Health app, hosted by NHS Scotland Right Decision System.

All local authority areas were tasked with developing an emergency infant formula pathway. A local short-life working group was established and met three times to review pathways from other areas in Scotland. A pathway has been developed and ER HSCP contributed to a national food insecurity toolkit. The pathway will now be aligned to wider pre-5 food insecurity activity.

Thrive Under-5 Programme Implementation is underway. To date an NHS GGC and local ER Steering Group has been established. Two 0.5 WTE Programme Coordinators have been appointed in VAER and are undergoing induction.

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

The ER Macmillan **Improving the Cancer Journey (ICJ)** programme launched on 20th July 2023. Three 0.5 WTE Macmillan Wellbeing Practitioners completed both ERC and Macmillan induction. A development session was held in August 2023 to develop internal processes for referrals. Our Initial Contact Team Business Support are an integral part of the ICJ programme. Between July 2023 and March 2024, 195 people were referred to the ICJ service. Of the 134 engaged with the programme 109 care plans were established. A communication plan was developed and an evaluation proposal agreed by the local ICJ Programme Board. We continue to work in partnership with Edinburgh Napier University on the national evaluation. One ER ICJ case study was presented at the UK Annual Macmillan Professionals conference.

Monitoring of **cancer screening** programme continues and ER HSPC participate in the NHS GGC Community implementation for screening inequalities working group and national Equity in Screening Network. Breast Screening & Bowel Screening programmes continue to achieve uptake target. Cervical screening uptake is below the 80% target at 76.3% in 2023. Work is ongoing to review best practice to optimise uptake.

The partnership continues to work to **understand the needs** of the population and address longer term impacts from the pandemic on our communities and protected characteristic groups. The **NHSGGC Health & Wellbeing Survey** has been completed with 1058 East Renfrewshire residents interviewed. The survey report has been circulated with partners. A presentation on the findings has been developed and presented at the ERC Policy Network to date. Workshops within the community are planned for 2024/25 to share the findings and gather more information, building on the report. A small fund has been secured for VAER to support the workshops and the wider dissemination plan.

The report provides vital information on the experiences of our residents. As this is the first Health & Wellbeing Survey post-covid, it is vital we understand and act on information regarding ongoing and emerging population health issues. The content includes:

- Health and Illness
- Health Behaviours
- Social Health
- Social Capital
- Financial Wellbeing
- Demographics

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

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

2.9.1 Our strategic aims and priorities during 2023-24

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

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

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

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

2.9.2 Our performance in 2023-24

Supporting staff wellbeing has been a key focus of the partnership, particularly since the Covid pandemic. The way staff have been working has changed significantly with home working becoming the norm for large groups of employees. Our dedicated Health and Wellbeing Lead has supported the implementation and delivery of wellbeing programmes across the health and social care landscape. The lead has had significant success to date, with comprehensive options in place. Support is accessible to HSCP staff, Care Homes, Primary Care, Care Providers, Third and Community Sector (staff and volunteers). Key measures in our iMatter staff engagement survey have shown improvement despite taking place during a period with significant pressures on our workforce.

Headline performance data includes:

- 89% of staff agreed that "My manager cares about my health and wellbeing" – up from 85% in previous iMatter staff survey
- 75% agreed that "I feel involved in decisions in relation to my job" – up from 71% in previous survey
- 77% agree that "I am given the time and resources to support my learning growth" – up from 74% in previous survey

2.9.3 Ways we have delivered in 2023-24

Over the course of the year we have continued to ensure that all staff have access to universal information with regard to health and wellbeing across the partnership's services. **Wellbeing information points** are in place at both Health Centres to promote universal information sharing. Both formal and informal communication methods are used to communicate the wellbeing offer to staff. There has been ongoing use of all communication channels, both online and in-person, including new whatsapp groups for yoga, health walks, working carers and fitness class. The Lead Officer has been a key mechanism for sharing updates, answering queries and encouraging attendance.

There has been ongoing focused work to engage managers to develop **leadership competencies** relating to wellbeing. Managers have ongoing access to all current wellbeing offers and training opportunities, including specific team wellbeing events. A forum for managers was publicised and arranged during 2023 at both Health Centres with the aim of increasing engagement with managers to focus on supporting and developing wellbeing competencies.

We continue to work to ensure that regular **wellbeing conversations** are taking place between staff and teams. Staff are offered 1-to-1 wellbeing conversation support and teams have the opportunity to participate in wellbeing related activities such as **focussed team wellbeing events**.

The Lead Officer has been working to develop cost effective delivery models and capacity building for wellbeing support. During the year there has been ongoing development of the NHSGGC wellbeing peer support network. East Renfrewshire HSCP is now a HUB location, with training taking place on-site in April 2024. We now have 9 qualified wellbeing peer supporters, and 2 qualified Level=2 trainers, plus 1 qualified Level-1 – Looking After Yourself and Others trainer.

During the year, the Health and Wellbeing Lead has continued to promote **relaxation, emotional support, physical activity** opportunities and practical support across the partnership. There is an ongoing offer of a variety of in-person and online relaxation and exercise activities across East Renfrewshire HSCP for all staff and volunteers, on a weekly basis.

We continue to support the development of **wellbeing spaces** (indoor and outdoor) to promote positive and safe use of spaces, and to support increased participation in wellbeing related activities, and nourish a positive wellbeing environment, both practically and aesthetically. 2023-24 has seen the ongoing development of outside spaces for wellbeing, including two balconies at Barrhead HC, courtyard at Eastwood HC, GP Practice outside spaces at Eaglesham and Carolside, and the development of a wellbeing room at St Andrews House Barrhead. Indoor and outdoor spaces continue to be used at both health centres for yoga and fitness class. Staff volunteers maintain the outside balcony growing spaces at Barrhead HC.

Supporting active travel for wellbeing
Awarded 3 awards in April 2024: Cycling Scotlands Cycle Friendly Employer Award for Barrhead and Eastwood Health Centres; and Paths for All walk at work awards for East Renfrewshire HSCP
Active travel events set for both Health Centres again in May 2024, delivered in partnership with Melo Velo and Includeme2 cycle charities.

2.10 Protecting people from harm

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

2.10.1 Our strategic aims and priorities during 2023-24

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

2.10.2 Our performance in 2023-24

- Improvement in safety and wellbeing outcomes for women who have experienced domestic abuse – 93% up from 90% in 22/23 - target met.
- People agreed to be at risk of harm and requiring a protection plan have one in place – continues to be 100% of cases

2.10.3 Ways we have delivered in 2023-24

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

Our approach to protecting vulnerable adults

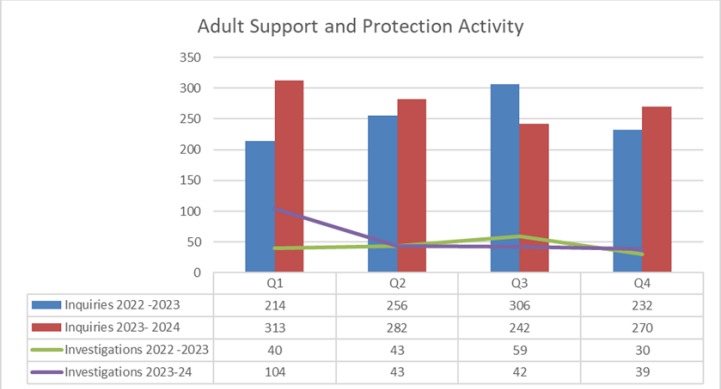
We have established strong relationships between partner agencies, promoting an approach to **adult support and protection (ASP)** that keeps all partners involved and included in discussions and planning, particularly in our routine ASP work and in the undertaking of Large Scale Investigations. In recent years, we have seen increased partnership working with a focus on keeping adults and their families and carers engaged and informed.

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

The dedicated ASP team has greatly strengthened and streamlined our approach to screening and triaging adult protection referrals and application of the 3-point test. The team have provided coaching and mentoring support to council officers across the HSCP

and strengthened relationships between locality services, external partners, and Police and Fire Service colleagues. The ASP Team is supported on a rota basis by council officers and managers across the HSCP.

The HSCP has seen a steady increase in **demand from ASP activity** over a number of years and this continued in 2023-24. The volume of ASP Inquiries increased a further 10% on last year, having increased 30% in the previous year. ASP Investigations increased 25% on last year, having increased 33% from the previous reporting period.



	Q1	Q2	Q3	Q4
Inquiries 2022 -2023	214	256	306	232
Inquiries 2023- 2024	313	282	242	270
Investigations 2022 -2023	40	43	59	30
Investigations 2023-24	104	43	42	39

Supporting residents in a Large Scale Investigation (LSI)

A Large Scale Investigation (LSI) was conducted in relation to a privately-operated care home in the 2023-24 period. This LSI began on the 24/04/2023 and concluded on the 24/08/2023. This was a significant undertaking involving 10 Council Officers, supported by a range of professionals across the HSCP undertaking 59 ASP Inquiries and Investigations for all of the residents (including both ERC residents and placing authority HSCP residents). Three residents died during the first month of the LSI. These residents were receiving end-of-life care and died of natural causes. There were eleven ASP case conferences held with six residents being placed on a Protection Plan.

A voluntary moratorium was agreed on 06/04/2023 ending on 28/08/2023 when the LSI concluded. Before concluding the LSI all residents had a planned Social Care review, with feedback indicating very positive changes and residents and their relatives describing significant changes in their care provision since the LSI was initiated. All of the residents had full clinical health assessments, which were reviewed to ensure any recommended actions were completed.

The Care Home Management have advised that they have felt the LSI to be a very beneficial and supportive process. They advised that they had never experienced this from any other authority, indeed they felt previous experiences of LSI were punitive rather than supportive.

They advised they are keen to share their positive experience with staff in their other care homes as part of their ongoing learning and development. We view this as a positive outcome, and indicative of the good collaborative work undertaken during the whole LSI process.

The partnership recently received a Joint Inspection of Adult Support and Protection carried out by the Care Inspectorate in collaboration with Healthcare Improvement Scotland and HM Inspectorate of Constabulary in Scotland. The inspection reported in June 2023 and reported the following key strengths at the partnership:

- Adults at risk of harm experienced improvements in their circumstances because of timely, person-centred, and efficient adult support and protection interventions.
- The overall quality and effectiveness of core adult support and protection processes was a key strength for the partnership.

- Initial inquiries and investigations were highly effective and always determined the correct outcome for adults at risk of harm.
- Oversight of key processes supported staff and ensured consistent robust decision making for adults at risk of harm.
- Strategic leadership for adult support and protection was enthusiastic and focused. This supported targeted and meaningful improvements.
- The adult protection committee offered strong leadership for adult support and protection and offered effective oversight for the delivery of key processes.
- Strategic leaders promoted a culture of learning and continuous improvement which supported the development of adult support and protection services for adults at risk of harm.
- Health was a strong adult support and protection partner. Health services delivered innovative, early and effective interventions for adults at risk of harm.

The inspection set out a number of priority areas for improvement, including: improving the quality of chronologies; greater involvement of adults at risk of harm and their unpaid carers at a strategic level; enhanced multi-agency quality assurance practices; and, building on existing practice to ensure the full involvement of all key partners in relevant aspects of ASP practice going forward.

Domestic abuse continues to be the predominant reason for referral to our children's services and features as one of the most common concerns within child protection interagency referral discussions. Through our multi-agency approach we work collaboratively to deliver a significant range of actions to ensure an effective and sustainable approach to preventing, reducing and responding effectively to domestic abuse and all forms of violence against women and girls. This includes the implementation of **Routine Sensitive Enquiry**, **Multi Agency Risk Assessment Conference (MARAC)** and **Safe and Together** practice to ensure a perpetrator pattern based, child centred, survivor strengths approach to working with domestic abuse. We continue to strengthen the capacity of our services and action across the whole system to address the long-term effects of trauma and abuse experienced by women, children and young people.

We worked collaboratively with our partners in Rape Crisis Glasgow and Clyde to launch a new sexual violence outreach support service in East Renfrewshire for women and girls (age 13+). This is an important addition to the specialist support available for women and girls who have experienced rape, sexual assault or sexual abuse. The drop-in operates monthly in Barrhead Health and Care Centre and Eastwood Health and Care Centre.

As part of our work to protect people from harm and abuse, we have established and continue to support a MARAC in East Renfrewshire for high-risk domestic abuse victims. In 2023-24 we continued to see an increase in support required as a result of domestic abuse with 155 victims and 260 children discussed at MARAC. This is an increase of 15.6% and 33% respectively in cases discussed compared to the previous year. 21.32% of victims did not have children and this is important as women without children were not previously visible in the domestic abuse pathway and this demonstrates continued increase in awareness and risk assessment across the range of services and improved pathway response.

MARAC referrals from all statutory services nationally continue to be low overall and may suggest that unless a victim in Scotland reports domestic abuse to the Police or seeks out support from a specialist domestic abuse service, they are unlikely to be referred to their local MARAC. This is not the case locally as East Renfrewshire demonstrates a higher proportion of referrals from children and families and wider statutory services with 33% locally compared to 10% nationally and therefore we are able to capture families that might not be known to another services.

We continue to work together with **East Renfrewshire Women's Aid Service** to provide direct support for women and children who have experienced domestic abuse. Following a significant increase in calls to the helpline and drop-in following the pandemic the service is now seeing a move back towards levels experienced pre pandemic. During the period, East Renfrewshire Women's Aid Service supported 1059 women and children across the three core services and helpline in 2023-24, a reduction of 2.5% from the previous year.

Women's Aid further launched a new Children Experiencing Domestic Abuse Recovery (CEDER) Programme. This is a 12 week group work programme for women and children to support their recovery from domestic abuse.

Women supported by the service recently met with the Promise lead planner to discuss their experiences of seeking support and how services could be improved. Women gave positive feedback about their experiences of Women's Aid and described their experiences of being supported as employees and feedback on family-oriented support such as health visiting, education and after school care.

Training and Capacity Building

Domestic Abuse, Risk Assessment, MARAC and Safe and Together training continues to be delivered in addition to the provision of bespoke sessions tor key partners. Over the course of the last year 181 staff were trained across a range of disciplines including Adult Services, Children & Families, Mental Health, Alcohol and Drugs, Housing, Education, Care at Home, Community Learning and Development and Health Visiting.

Additionally domestic abuse training sessions were delivered to HR and managers to support the implementation of the new policy for HR and managers. Bespoke training was delivered to all community pharmacies across East Renfrewshire and a further 25 participants took up the offer to attend and observe a MARAC. Workers are further supported out with training with specialist domestic abuse advice as required (on average 3 workers per week) were supported.

We participated in the national campaign 16 Days of Action to end violence against women and girls by developing a specific local programme of key messaging and campaign activity delivered through-out the 16 days and concluded the campaign by launching our new Domestic Abuse Policy and Revised Guidance for employees.

2.11 Hosted Services – Specialist Learning Disability Service

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

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

The number of admissions achieved during 2023-24 has dropped further by just over 33% with only 7 admissions throughout the full year. This is directly due to a significant reduction in the number of discharges achieved during 2023-24.

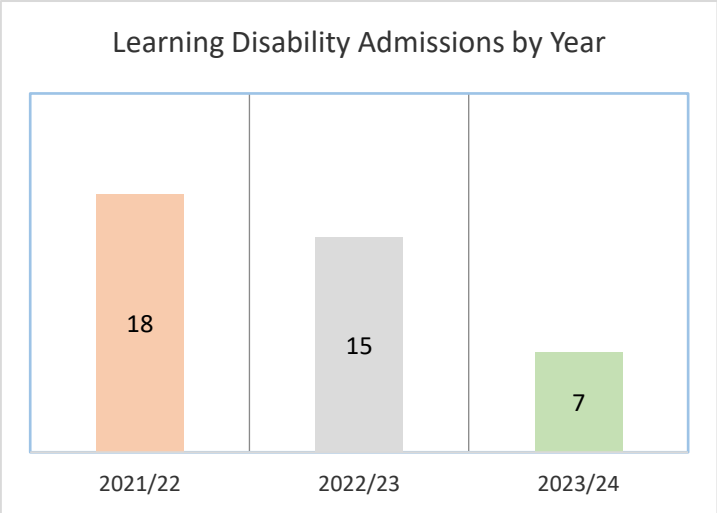
Delayed discharges remain a significant issue for the service. Delays are at the highest rate they have been for several years and this continues to create significant issues, with a high number of patients having no discharge plan for a significant period of time nor a home to return to. The reasons for delay across the partner areas were due to lack of suitable accommodation and/or no providers in place and/or providers in place having real difficulty with recruitment.

The main barrier to patient flow is the number of delayed discharges from placement breakdowns and the length of time taken to organise a new placement. This is generally longer for patients in the LD inpatient service compared to patients with LD in the mental health inpatient service.

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

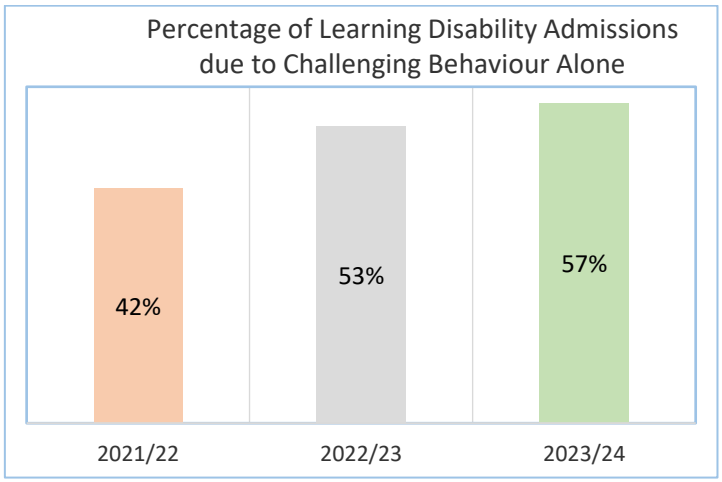
Establishing a new package of care and support is the primary reason for delays.

2.11.1 Admissions



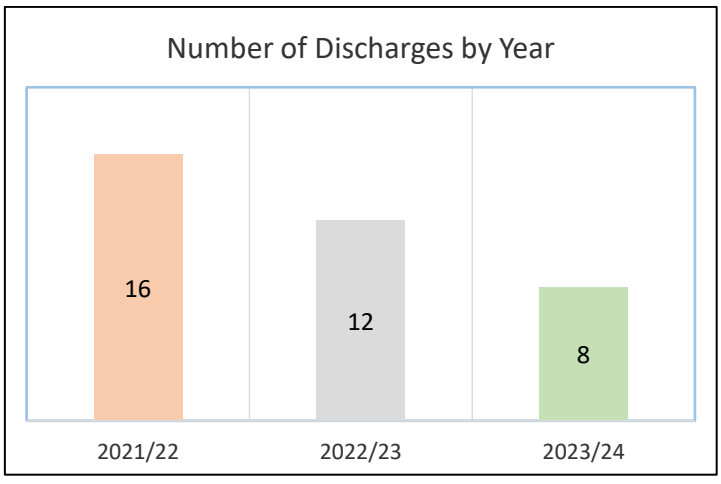
The service received 23 referrals for admission but only a total of 7 people were admitted to the LD inpatient service in 2023-24. This is just under half the number of admissions from the previous year and relates directly to a smaller number of discharges and increasing lengths of

stay / delays. This is the lowest number of admissions the service has ever experienced. Of the seven admissions the age range was between 16 – 59 years.



Of the seven admissions, four were admitted with long-standing challenging behaviour. The service is experiencing more referrals for people with behaviours that challenge and less with acute mental illness. Admissions due to challenging behaviour alone increased from previous years with 57% during 2023-24 compared to 53% in 2022-23 and 42% in 2021-22. This appears to be the result of instability in community supports for those with the most difficult to manage challenging behaviour, but also partly because patients in need of urgent admission due to mental illness or less complex challenging behaviour are more likely to be admitted to the mental health inpatient service due to the lack of availability of LD inpatient beds.

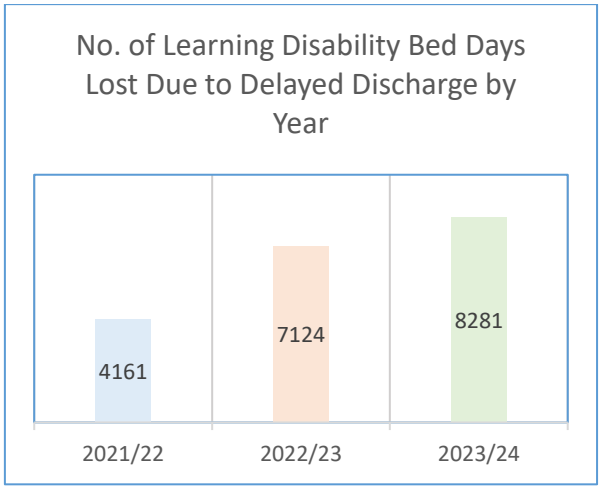
2.11.2 Discharges



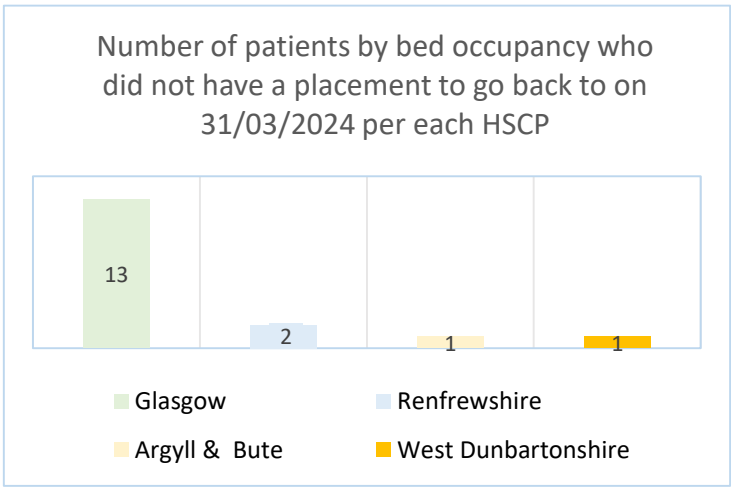
Eight patients were discharged from the LD inpatient service during 2023-24. The number of discharges has continuously decreased in recent years from 16 discharges in 2021-22 reducing to 12 in 2022-23 and just 8 in 2023-24. Overall the average length of stay counting all LD inpatients discharged during 2023-24 was 325 days with a range of 33 – 1113 days.

There is a correlation between length of stay and accommodation status on admission. Of the eight discharges, four were returning to the home they were admitted from, two had a support package identified on admission and two had no placement at the point of admission. The average length of stay for the four patients returning home was 104 days. For patients that had a new placement identified on admission the average length of stay was 282 days and for

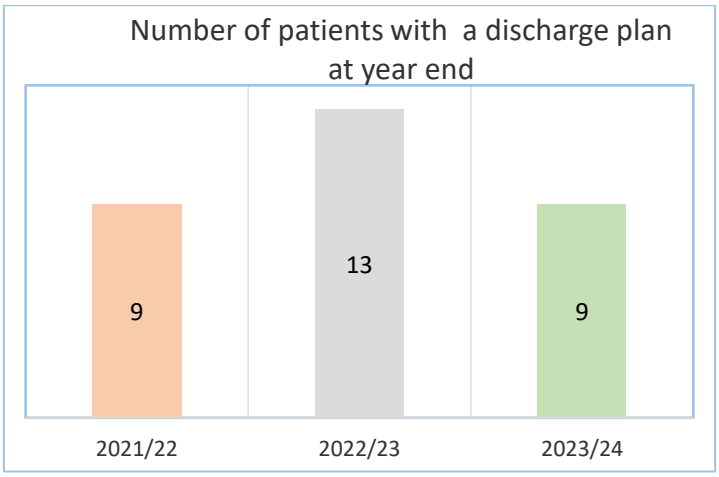
the two patients who required a new placement to be identified during their admission the average length of stay was 810 days. The inpatient service had 1 long stay patient discharged in 2023-24. There are 5 remaining long stay patients who now all have plans in place to be discharged to a community based model currently under development.



There was a 14% increase in beds days lost due to delayed discharges from 2022-23 to 2023-24.



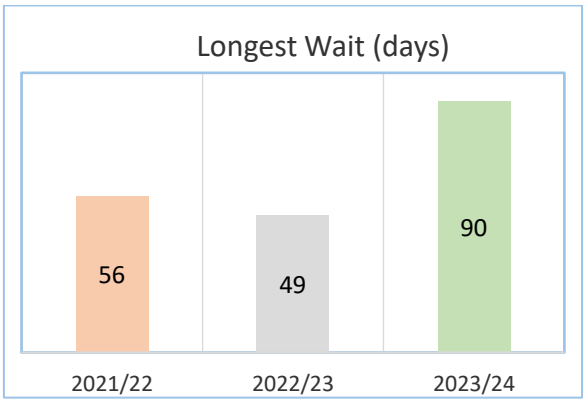
On 31 March 2024, 17 patients who were ready for discharge did not have a confirmed discharge plan / community placement.



Only 9 out of 26 LD inpatients had a discharge plan on 31/03/2024.This was a reduction in the number from the previous year of 13. Some patients have been waiting a long and

unacceptable time for discharge. The complex mix of patients who are delayed leads to high risks in the ward environment in particular around interpersonal risks and an increase in incidents of violence and aggression. This can only be mitigated in the ward environment with increased levels of special observations. The longer people are in hospital the more challenging it can be to identify suitable accommodation as there is a perception the risks can only be managed in this environment creating a further barrier to discharge.

2.11.3 Waiting times



The longest wait for admission to a learning disability inpatient bed was 90 days. As a result of continuous occupancy, the service is now typically unable to directly admit people requiring specialist learning disability assessment and treatment.

A group of people were removed from the waiting list as admission was no longer required or an alternative had been established before a bed became available for them.

Blythswood House is a learning disability in-patient service provided across Greater Glasgow and Clyde, and is managed by East Renfrewshire HSCP on behalf of the health board. The 15 bed unit provides assessment and treatment for adults who have a diagnosis of learning disability, mental illness and behavioural difficulties. The service is focused on creating a positive and supportive environment for vulnerable people prior to moving to a community setting with the right resources to support them.

The service **received highly positive feedback from the Mental Welfare Commission** in a recent visit. The nursing team were praised for the activity schedule, both group and individual, and it was noted that this was having a positive impact on the wellbeing of patients and reducing incidents of violence and aggression.

The team was commended for positive leadership. Managing risk and keeping people safe is a critical part of this service and the team were commended for high standards of all paperwork, including legal papers and care plans.

The team recognised work that had been undertaken to make the spaces within Blythswood pleasant and personalised for patients within very limited budgets. The feedback from families and carers was universally positive and a full report will be published later in the year.

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 2023-24 is our statutory financial report for the year. We regularly report our financial position to the IJB throughout the year.

This was a very challenging year for the HSCP as we worked to balance meeting the demand for services within the allocated budget. We needed to deliver just over £7 million of savings as part of our plans to balance our budget and we were not able to do this. We used £1.9 million reserves as planned to support us to redesign how we deliver services and we achieved £2.7 million of savings during the year. This meant we had a £2.5 million shortfall against planned savings and when this shortfall is combined with the additional cost pressures from delivering services we ended the year with a deficit of £4.7 million.

This meant that during the financial year 2023-24 we moved to a financial recovery position and had a number of discussions with both of our partners; East Renfrewshire Council and NHS Greater Glasgow and Clyde. Both partners have provided additional funding, on a non-recurring basis, for 2023-24 to eliminate this deficit:

- East Renfrewshire Council provided an additional £2.6 million
- NHS Greater Glasgow and Clyde provided an additional £2.1 million

The main operational challenges that led to the increased cost pressures were meeting demand for Care at Home, the cost of special observations within the Learning Disabilities In-Patients service which we host on behalf of all six HSCPs within Greater Glasgow and Clyde and the costs of prescribing through our GP practices.

The main area we fell short on delivering planned savings was from our Supporting People Framework. This framework is based on eligibility criteria and was put in place early in the financial year to support reviews of the level of care we provide as we knew we would have to stop providing lower levels of need. We underestimated the impact and timeframe for the culture and practice changes required to implement such significant change alongside managing the expectations of the individuals and families we support.

As the year progressed it became clear that our approach was not delivering the level of cost reductions and savings needed and a formal financial recovery process was invoked at the November 2023 meeting of the Integration Joint Board.

Part of this process was to ensure that all possible earmarked and general reserves were released towards reducing the deficit, however this alone was insufficient and the difficult decision was taken by the IJB to move to delivering only substantial and critical levels of service. This means the IJB is in breach of its reserves policy, however the actions to mitigate cost pressures and the savings shortfall outweigh this.

Detailed discussions took place with both partners and culminated in additional funding, on a one-off basis, for 2023-24 to fund the deficit of £4.7 million. The IJB received an additional £2.1m from NHS Greater Glasgow and Clyde and £2.6 million from East Renfrewshire Council.

The savings shortfall and service pressure have been addressed by the IJB in the budget set for 2024-25.

3.2 Financial Performance 2023-24

The annual report and accounts for the IJB covers the period 1st April 2023 to 31st March 2024. The budgets and outturns for the operational services (our management accounts) are reported regularly throughout the year to the IJB, with the final position summarised:

Service	Unaudited Budget	Spend	Variance (Over) / Under	Variance (Over) / Under
	£ Million	£ Million	£ Million	%
Children & Families	13.777	12.989	0.788	5.72%
Older Peoples Services	27.544	27.764	(0.220)	(0.80%)
Physical / Sensory Disability	6.234	6.348	(0.114)	(1.83%)
Learning Disability – Community	19.248	19.687	(0.439)	(2.28%)
Learning Disability – Inpatients	9.959	11.330	(1.371)	(13.77%)
Augmentative and Alternative Communication	0.295	0.219	0.076	25.76%
Intensive Services	15.788	18.287	(2.499)	(15.83%)
Mental Health	6.274	5.733	0.541	8.62%
Addictions / Substance Misuse	2.417	2.155	0.262	10.84%
Family Health Services	30.411	30.475	(0.064)	(0.21%)
Prescribing	17.318	19.780	(2.462)	(14.22%)
Criminal Justice	0.074	0.086	(0.012)	(16.22%)
Finance and Resources	9.488	8.726	0.762	8.03%
Net Expenditure Health and Social Care	**158.827**	**163.579**	**(4.752)**	**(2.99%)**
Housing	0.449	0.449	-	-
Set Aside for Large Hospital Services	30.194	30.194	-	-
Total Integration Joint Board	**189.470**	**194.222**	**(4.752)**	**(2.99%)**
Additional Funding from NHSGGC	2.095	-	2.095	-
Additional Funding from ERC	-	(2.657)	2.657	-
Total Integration Joint Board	**191.565**	**191.565**	**-**	**-**

The operational overspend, before the additional funding from both partners is applied, is £4.752 million (2.99%) and is marginally better than the last reported position taken to the IJB which was £5.361 million of an overspend. The main variances to the budget were:

- £2.499 million overspend within Intensive Services from Care at Home cost pressures combined with unachieved savings
- £2.462 million overspend in prescribing resulting from both increased volume and costs
- £1.371 million overspend in the Learning Disability In-Patients service resulted from the level of additional staffing for special observations and managing the patient dynamics

- £0.788 million underspend in Children and Families was mainly from vacancy management and maximising available reserves
- The remaining overspends were primarily not achieving savings and the underspends were from vacancy management and release of reserves

Detailed reporting is taken to each meeting of the IJB throughout the year and in the latter months of 2023-24 frequent discussions took place with both partners as part of the financial recovery process.

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

2022/23 £000	Services Prvided to East Renfrewshire IJB by Other IJBs within NHSGGC	2023/24 £000
476	Physiotherapy	556
50	Retinal Screening	68
788	Podiatry	520
306	Primary Care Support	318
419	Continence	457
631	Sexual Health	603
1,183	Mental Health	1,597
978	Oral Health	899
374	Addictions	479
232	Prison Health Care	223
156	Health Care in Police Custody	185
4,032	Psychiatry	5,197
n/a	Specialist Childrens Services*	3,344
9,625	**Net Expenditure on Services Provided**	**14,446**

*Hosted by East Dunbartonshire IJB from 1 April 2023

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

2022/23 £000	Learning Disability In-Patient Servies Hosted by East Renfrewshire IJB	2023/24 £000
6,872	Glasgow	9,010
1,834	Renfrewshire	1,370
521	Inverclyde	97
291	West Dunbartonshire	658
-	East Dunbartonshire	-
9,518	Learning Disability In-Patients Services Provided to other IJBs	11,135
73	East Renfrewshire	195
9,591	**Total Learning Disability In-Patient Services**	**11,330**

2022/23 £000	Augmentative and Alternative Communication (AAC) Hosted by East Renfrewshire IJB	2023/24 £000
124	Glasgow	93
27	Renfrewshire	55
32	Inverclyde	10
5	West Dunbartonshire	6
27	East Dunbartonshire	23
215	AAC Services Provided to other IJBs	187
50	East Renfrewshire	32
265	**Total AAC Services**	**219**

3.3 Reserves

We used £4.562 million of reserves in year and we also added £0.344 million into earmarked reserves. The year on year movement in reserves is summarised:

	£ Million	£ Million
Reserves at 31 March 2023		6.046
Planned use of existing reserves during the year	(4.526)	
Funds added to reserves during the year	0.344	
Net decrease in reserves during the year		(4.182)
Reserves at 31 March 2024		1.864

The purpose, use and categorisation of IJB reserves is supported by a Reserves Policy and Financial Regulations, both of which were reviewed in September 2023.

The reserves of the IJB fall into three types:

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

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

Ring-Fenced Reserves
The spend in year was £1.113 million on existing initiatives and £0.1 million was added towards the end of the year for new Drug Intervention funding. The funding to support the development of a Recovery Hub at £0.489 million is the material element of the £0.8 million balance taken to 2024-25.

Earmarked Reserves
Our earmarked reserves are in place to support a number of projects and included bridging finance to support the delivery of savings. We used £3.141 million during the year and will take £1.064 million into 2024-25. This balance supports commitments already in place and the three main areas are supporting the whole family wellbeing project, trauma informed practice and the learning disability community living change fund. There are no bridging finance reserves remaining for 2024-25.

General Reserves
Our general reserve is now nil as we used the £0.272 million we held as part of the financial recovery process. The IJB recognises that this means it is not compliant with its Reserves Policy which advocates a 2% of budget should be the level of reserves held.

The use of reserves was reported to the IJB within our routine revenue reporting and during 2023-24 and this included the decision to un-hypothecate every reserve possible to mitigate cost pressures.

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.

	2023/24	2022/23	2021/22	2020/21	2019/20
SERVICE	**(Over) / Under £ Million**	**(Over) / Under £ Million**	**(Over) / Under £ Million**	**(Over) / Under £ Million**	**(Over) / Under £ Million**
Children and Families	0.788	0.460	(0.020)	0.410	0.637
Older Peoples & Intensive Services	(2.719)	0.888	0.189	0.327	(0.866)

Physical / Sensory Disability	(0.114)	0.219	0.031	0.099	0.030
Learning Disability - Community	(0.439)	(0.727)	0.458	(0.267)	(0.095)
Learning Disability - Inpatients	(1.371)	(0.032)	0	0	0.002
Augmentative & Alternative Communication	0.076	0	0	0	0
Mental Health	0.541	0.337	0.136	0.192	0.189
Addictions / Substance Misuse	0.262	0.083	0.021	0.052	0.013
Family Health Services	(0.064)	0.002	0	0	-
Prescribing	(2.462)	(0.774)	0	0	(0.311)
Criminal Justice	(0.012)	0.030		0.011	-
Planning and Health Improvement *			0.005	0.065	0.098
Management and Admin / Finance & Resources	0.762	0.104	0.017	(0.056)	0.238
Net Expenditure Health and Social Care	**(4.752)**	**0.590**	**0.837**	**0.833**	**(0.065)**
Additional Funding ERC	**2.657**				
Additional Funding NHSGGC	**2.095**				
Net Expenditure Health and Social Care	**0.00**				

* In 2022/23 this was subsumed into the relevant adult / children's services

Additional funding was provided on a non-recurring basis as part of the financial recovery process for 2023-24.

3.5 Best Value

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

3.6 Future Challenges

The IJB continues to face a number of challenges, risks and uncertainties in the coming years and this is set out in our current Medium-Term Financial Plan (MTFP) for 2024-25 to 2028-29 and our Strategic Plan for 2022-23 to 2024-25. These key strategies also inform our strategic risk register and collectively support medium-term planning and decision making.

The IJB operates in a complex environment with requirements to ensure statutory obligations, legislative and policy requirements, performance targets and governance and reporting criteria are met whilst ensuring the operational oversight of the delivery of health and care services.

UK and Scottish Government legislation and policies and how they are funded can have implications on the IJB and how and where we use our funding over time.

The most significant challenges for 2024-25 and beyond include:

- delivering savings to ensure financial sustainability, ensuring sufficient flexibility to allow for slippage, shortfalls or changes
- recognising the tension between delivering a level of savings that will allow the IJB to start to rebuild reserves and protecting service delivery
- managing reduced service capacity as a result of savings and maintaining discharge without delay from hospital and other key indicators
- delivering on our Recovery & Renewal programme for areas of change, including the implementation of a new case recording system
- understanding the longer term impacts of Covid-19 on mental and physical health
- recruitment and retention of our workforce, particularly in the current cost of living crisis
- managing prescribing demand and costs in partnership with our GPs
- supporting the physical and mental health and wellbeing of our workforce and our wider population, again further impacted by the current cost of living challenges

- meeting increased demand for universal services without funding for growth, including increased population demand and new care homes opening with the area
- we may also need to prepare for the challenges and opportunities that may arise from a national care service

The IJB agreed its budget for the financial year 2024-25 on 27th March 2024 recognising the significant challenges brought forward from 2023-24 as well as new demand and cost pressures for 2024-25.

Those cost pressures are £17.023 million and are offset in part by available funding of £7.206 million; leaving a funding gap of £9.817 million. A savings programme is in place to ensure we deliver a minimum level of savings to close this gap, and ideally to achieve more savings than required, as we know that £2.316 million of the funding that offsets the pressures is non-recurring for the next two years. We do not have reserves to offset any shortfall.

Revenue Budget	**ERC**	**NHS**	**Total**
	£m	**£m**	**£m**
1. Cost Pressures			
Pay	1.043		1.043
Inflation & Living Wage	4.736		4.736
Demographic & Demand	1.997		1.997
Legacy Savings	3.843		3.843
Service Pressures	1.500	0.600	2.100
Prescribing		3.304	3.304
	13.119	**3.904**	**17.023**
2. Funding available towards pressures			
Recurring	4.894		4.894
Non-Recurring	2.312		2.312
	7.206	**0**	**7.206**
3. Unfunded Cost Pressures	**5.913**	**3.904**	**9.817**
4. Proposals to Close the Funding Gap			
Savings complete	0.871	0	0.871
Savings prioritised 1 to 4	7.021	1.889	8.91
Redesign proposals in development		2.015	2.015
	7.892	**3.904**	**11.796**
Pay award funding to be confirmed; every 1% equates to c£0.2m			

Savings progress will continue to be reported to the IJB within the routine financial reporting and the Supporting People Framework is the most significant saving at c£4 million.

The budget report sets out the detail behind each of the cost pressures and it is important to note that these include contractual and policy requirements that must be met. The full detail of all savings is included in this report.

Whilst the scale of this challenge is significant to East Renfrewshire, particularly as one the smaller HSCPs this is not unique; the national position across all public sector services shows a challenging financial outlook.

The 2023-24 budget overspend was mitigated by additional non-recurring funding from both our partners; this will not be an option in 2024-25.

Looking forward to 2025-26 and beyond in any one year the modelled cost pressure could range from £3.5 million to £8.6 million depending on the combination of factors.

It also needs to be recognised that these scenarios show the potential level of cost pressure and do not make any allowance for any funding that may offset any future cost. For example in prior years the Scottish Government has provided funding for some pay and non-pay cost pressures.

Given the current levels of uncertainty it is not possible to assume anything beyond a flat cash approach at this time.

The assumptions are also predicated on full and recurring delivery of the 2024-25 savings.

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.

Economic challenges are significant as we are seeing little recovery in the global economy and although inflation is on a downward trend, particularly with utilities, although this is a slow decline. The biggest risk remains to the IJB remains the cost volatility in prescribed drugs with inflation remaining a significant factor (around 8% in 2023-24).

The cost of pay inflation is still comparatively high and although inflation across a range of goods and services (CPI) is falling, this dropped to 4% in December 2023, this is still well above the UK target of 2%.

Our population and households are not impacted equally by the cost of living crisis and we know those with lower income are disproportionately affected.

We have successfully operated integrated services for around 20 years so we have faced a number of challenges and opportunities over the years, including delivering significant levels of savings; this means that we need to take very difficult decisions and look at radical options for change.

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

Maintaining Discharge without Delay performance is a key issue for us. In order to achieve the target we continue to require more community based provision and this is dependent on availability of care. The medium-term aspiration remains 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 through an Unscheduled Care Commissioning Plan.

The longer term impact on the on the sustainability of our partner care provider market in the post Covid-19 pandemic and current economic climate remains a significant issue. Our Strategic Commissioning plan sets out the detail on how we will work with our partners in the third and independent sectors in the coming years. The way we commission services may be impacted by the creation of a national care service. There is an increasing tension between cost expectations from care providers including those on national procurement frameworks and contracts and the funding, or more specifically the lack of that IJBs have to meet any additional increases

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

- Delivery of the required savings for 2024-25 with a deliberate intention to work to over-recover where possible to allow us to build back from financial recovery. Delivery of the Supporting People Framework savings programme is the most significant element of the programme.
- Further develop full savings options for 2025-26 and beyond; this will include development of charging options for non-residential care and support.
- Our Recovery and Renewal Programme continues and will focus on key projects to support the HSCP with major areas of change as well as short life projects to support delivery of benefits; this includes implementation of a new case recording IT system.
- We will update our Medium-Term Financial Plan on a regular basis reflecting assumptions and projections as issues become clearer; this will also inform planning for our 2025-26 budget.
- We will continue to monitor the impacts of Covid-19, economic and inflationary factors along with operational issues through our financial and performance monitoring to allow us to take swift action where needed, respond flexibly to immediate situations and to inform longer term planning.
- We will review our Strategic Improvement Plan that was agreed by the IJB in January 2020 which set out the combined actions / areas for improvement from the Joint Strategic Inspection of the IJB in 2019 and from the Ministerial Strategic Group self-evaluation and the findings from the Audit Scotland Report: Health and Social Care Integration, also 2019. This work was paused during the pandemic and will be incorporated if and where required to current plans.
- We will complete the review of our Integration Scheme; work has progressed during 2023-24 and this should be finalised in 2024-25 with partners.
- We routinely report our performance to the IJB with further scrutiny from our Performance and Audit Committee and our Clinical and Care Governance Group. 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. This partnership working is a key element to mitigating the impacts of the Supporting People Framework.
- Workforce planning will continue to support identification of our current and future requirements. Recruitment and retention of staff is key to all service delivery and we have mitigated as far as possible by minimising the use of temporary posts and developing our workforce and organisational learning and development plans. We are refreshing our 3-year workforce plan. This will also include any implications from the Health and Care Staffing (Scotland) Act 2019.

- We will continue with the redesign of the Learning Disability Inpatient bed model and progress the programme of health checks for people with a learning disability, following a successful pilot year.
- Governance Code; we have robust governance arrangements supported by a Governance Code.
- The IJB continues to operate in a challenging environment and our financial, risk and performance reporting continue to be a key focus of each IJB agenda.

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

4 Performance summary

4.1 Introduction

In the previous chapters of this report we have focused on the key areas of work carried out by the HSCP over the course of 2023-24. In this final chapter we draw on a number of different data sources to give a more detailed picture of the progress the partnership has been able to make against our established performance indicators. Quantitative performance for many of our performance indicators continue to reflect ongoing challenges being faced locally and nationally in the aftermath of the Covid pandemic.

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

4.2 Performance indicators

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

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

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

Strategic Priority 1 - Working together with children, young people and their families to improve mental and emotional wellbeing										
Indicator	**2023/24**	**Current Target**	**2022/23**	**2021/22**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
Percentage of children and young people subject to child protection who have been offered advocacy. *(Aim to increase)*	**65%**	100%	61%	62%	63%	n/a	n/a	n/a	n/a	
Percentage of children with child protection plans assessed as having an increase in their scaled level of safety at three monthly review periods. *(Aim to increase)*	**100%**	100%	100%	84%	87.5%	n/a	n/a	n/a	n/a	
Percentage of children looked after away from home who experience 3 or more placement moves *(Aim to decrease)*	**0%**	11%	0%	1.8%	1.2%	0.0%	1.4%	1.2%	7.1%	
Children and young people starting treatment for specialist Child and Adolescent Mental Health Services within 18 weeks of referral *(Aim to increase)*	**99%**	90%	86%	55%	61%	78%	74%	89%	90%	
Child & Adolescent Mental Health - longest wait in weeks at month end *(Aim to decrease)*	**18**	18	24	41	35	33	34	35	31	
Balance of Care for looked after children: % of children being looked after in the Community (LGBF) *(Aim to increase)*	n/a	Data only	**92.2%**	92.7%	91.1%	94.9%	98.0%	93.6%	91.5%	

Strategic Priority 1 - Working together with children, young people and their families to improve mental and emotional wellbeing										
Indicator	**2023/24**	**Current Target**	**2022/23**	**2021/22**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
% Child Protection Re-Registrations within 18 months (LGBF) *(Aim to decrease)*	n/a	Data only	**12.5%**	0	0	15.8%	7.7%	0%	9%	↓
% Looked After Children with more than one placement within the last year (Aug-Jul). (LGBF) *(Aim to decrease)*	n/a	Data only	**14.4%**	20.8%	20%	18.8%	24.5%	29.1%	19.6%	↑

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

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

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

Strategic Priority 3 - Working together to support mental health and well-being										
Indicator	**2023/24**	**Current Target**	**2022/23**	**2021/22**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
% of service users moving from drug treatment to recovery service *(Aim to increase)*	**4%**	7%	5%	9%	6%	16%	22%	12%	9%	↓
Achieve agreed number of screenings using the setting-appropriate screening tool and appropriate alcohol brief intervention, in line with SIGN 74 guidelines. *(Aim to increase)*	**568**	419	173	0	5	33	93	331	468	↑
Percentage of people with alcohol and/or drug problems accessing recovery-focused treatment within three weeks. *(Aim to increase)*	**93%**	90%	96%	95%	95%	89%	95%	87%	96%	↓

Strategic Priority 4 - Working together to meet people's healthcare needs by providing support in the right way, by the right person at the right time										
Indicator	**2023/24**	**Current Target**	**2022/23**	**2021/22**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
People (18+) waiting more than 3 days to be discharged from hospital into a more appropriate care setting including AWI *(Aim to decrease)* (NHSGGC data)	**7**	0	8	7	2	2	4	4	4	↑

Strategic Priority 4 - Working together to meet people's healthcare needs by providing support in the right way, by the right person at the right time										
Indicator	**2023/24**	**Current Target**	**2022/23**	**2021/22**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
Acute Bed Days Lost to Delayed Discharge (Aged 18+ including Adults with Incapacity) *(Aim to decrease)* (MSG data)	**4,821***	1,893	4,625	4,546	2,342	1,788	2,284	1,860	2,704	↓
No. of A & E Attendances (All ages) *(Aim to decrease)* (NHSGGC data)	**22,321**	Data only	21,913	20,813	18,091	23,934	24,830	23,220	22,238	↓
Number of Emergency Admissions: Adults *(Aim to decrease)* (NHSGGC data)	**6,595**	Data only	6,185	7,372	6,217	6,859	6,801	6,916	6,908	↓
No. of A & E Attendances (adults) *(Aim to decrease)* (MSG data)	**17,824***	18,335	17,356	16,877	13,677	20,159	20,234	19,344	18,747	↓
Number of Emergency Admissions: Adults *(Aim to decrease)* (MSG data)	**6,973***	7,130	6,692	7,894	7,281	7,538	7,264	7,432	8,032	↓
Emergency admission rate (per 100,000 population) for adults *(Aim to decrease)* NI-12	**9,606****	11,492	9,215	9,414	9,210	10,441	10,345	10,304	11,427	↓
Emergency bed day rate (per 100,000 population) for adults *(Aim to decrease)* NI-13	**105,211****	117,000	108,721	108,448	97,806	106,296	110,749	120,265	121,099	↑
Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges) *(Aim to decrease)* NI-14	**73****	100	69	77	98	78	79	79	83	↓

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

* Full year data not available for 2023/24. Figure relates to 12 months Jan-Dec 2023. Data from MSG release, 11 April 2024

** Full year data not available for 2023/24. Provisional figure relates to 12 months Jan-Dec 2023. Data from PHS release, 22 May 2024

***In April 2024 NHSGGC revised data for care home admissions and attendances to include previously omitted care homes. New target to be established for these performance measures.

Strategic Priority 5 - Working together with people who care for someone ensuring they are able to exercise choice and control in relation to their caring activities										
Indicator	**2023/24**	**Current Target**	**2022/23**	**2021/22**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
People reporting 'quality of life for carers' needs fully met (%) *(Aim to increase)*	**84.5%**	80%	80%	92%	91%	92%	78%	72%	70%	↑
Total combined % carers who feel supported to continue in their caring role *(Aim to increase)* NI 8	n/a	Data only	n/a	**28.4%**	n/a	35.3%	n/a	37.5%	n/a	↓

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

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

Strategic Priority 7 - Working together with individuals and communities to tackle health inequalities and improve life chances.										
Indicator	**2023/24**	**Current Target**	**2022/23**	**2021/22**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
Percentage of adults able to look after their health very well or quite well *(Aim to increase)* NI-1	n/a	Data Only	n/a	**92%**	n/a	94%	n/a	94%	n/a	

Strategic Priority 8 - Working together with staff across the partnership to support resilience and well-being										
Indicator	**2023/24**	**Current Target**	**2022/23**	**2021/22**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
% Staff who report 'I am given the time and resources to support my learning growth'. *(Aim to increase)*	**77%**	90%	74%	75%	n/a	77%	76%	70%	n/a	
% Staff who report "I feel involved in decisions in relation to my job". *(Aim to increase)*	**75%**	Data Only	71%	72%	n/a	n/a	69%	n/a	n/a	
% Staff who report "My manager cares about my health and well-being". *(Aim to increase)*	**89%**	Data Only	85%	88%	n/a	n/a	85%	n/a	n/a	

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

Organisational measures										
Indicator	**2023/24**	**Current Target**	**2022/23**	**2021/22**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
Percentage of days lost to sickness absence for HSCP NHS staff *(Aim to decrease)*	**8.3%**	4.0%	7.5%	6.9%	5.5%	7.3%	6.8%	8.5%	7.2%	
Sickness absence days per employee - HSCP (LA staff) *(Aim to decrease)*	**19.5**	17.5	20.3	14.7	13.6	19.1	16.4	13.0	13.6	

4.3 National Integration Indicators

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

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

4.3.1 Scottish Health and Care Experience Survey (2021-22)

Information on nine of the National Integration Indicators are derived from the biennial Scottish Health and Care Experience survey (HACE) which provides feedback in relation to people's experiences of their health and care services. The most recent survey results for East Renfrewshire relate to 2021-22 and are summarised below.

The results show that we performed better than the Scottish average for seven of the nine indicators and performed close to the national rate for the remaining two. While performance declined for all of the indicators at the national level since the previous survey, we saw improving performance for five of the nine indicators.

National indicator	2021/22	Scotland 2021/22	2019/20	2017/18	2015/16	East Ren trend from previous survey	Scotland trend from previous survey
NI-1: Percentage of adults able to look after their health very well or quite well	**91.9%**	90.9%	94%	94%	96%	↓	↓
NI-2: Percentage of adults supported at home who agreed that they are supported to live as independently as possible	**80.4%**	78.8%	78%	74%	80%	↑	↓
NI-3: Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	**73.8%**	70.6%	75%	64%	77%	↓	↓
NI-4: Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	**65.1%**	66.4%	62%	60%	69%	↓	↓
NI-5: Total % of adults receiving any care or support who rated it as excellent or good	**75.5%**	75.3%	70%	77%	82%	↑	↓
NI-6: Percentage of people with positive experience of the care provided by their GP practice	**69.7%**	66.5%	85%	84%	88%	↓	↓
NI-7: Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	**83.6%**	78.1%	78%	76%	79%	↑	↓
NI-8: Total combined % carers who feel supported to continue in their caring role	**28.4%**	29.7%	35%	37%	45%	↑	↓
NI-9: Percentage of adults supported at home who agreed they felt safe	**90.5%**	79.7%	81%	82%	82%	↑	↓

Data from PHS release, 22 May 2024. Latest available survey data relates to 2021/22. 2023/24 data available July 2024

4.3.2 Operational performance indicators

National indicator	2023/24	Scotland 2023/24	2022/23	2021/22	2020/21	2019/20	2018/19	2017/18	2016/17	Trend from previous year
NI-11: Premature mortality rate per 100,000 persons	n/a	442	**264**	338	334	259	308	301	297	
NI-12: Emergency admission rate (per 100,000 population) for adults	**9,606***	11,614*	9,215	9,414	9,210	10,439	10,345	10,497	11,427	
NI-13: Emergency bed day rate (per 100,000 population) for adults	**105,211***	110,257*	108,721	108,448	96,914	105,544	110,0628	119,011	121,099	
NI-14: Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges)	**73***	104*	68	77	98	78	79	79	83	
NI-15: Proportion of last 6 months of life spent at home or in a community setting	**88.6%***	89.2%*	88.2%	89.5%	89.8%	88%	86%	85%	86%	
NI-16: Falls rate per 1,000 population aged 65+	24.9*	22.7*	24.1	25.1	21.5	22.6	23.4	22.4	21.2	
NI-17: Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	n/a	75.2%**	**86.9%**	79.0%	84%	84%	84%	88%	88%	
NI-18: % of adults with intensive care needs receiving care at home	**64.4%***	64.8%*	65.0%	62.0%	58.4%	57.1%	63.6%	63.3%	58.0%	

NI-19: Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	**397**	902	415	342	189	156	170	117	228	↑
NI-20: Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	n/a	24.0% (2019/20)	n/a	n/a	n/a	**20.9%**	20.8%	22.4%	22.2%	↑

Data from PHS release, 22 May 2024.
*Full year data not available for 2023/24. Provisional figure relates to 12 months Jan-Dec 2023.
** Scotland fig is 2022/23.

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

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

4.4 Ministerial Strategic Group Indicators

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

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

Latest data from PHS release, 11 April 2024. (MSG Indicators)

4.5 Inspection performance

East Renfrewshire HSCP delivers a number of in-house services that are inspected by the Care Inspectorate. The following table show the most up to date grades as of May 2024.

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	Inspection Report
Adoption Service	11/10/2019	5	Not assessed	5	Not assessed	Adoption Services - InspectionReport-305
Fostering Service	11/10/2019	5	Not assessed	5	Not assessed	Fostering Services - InspectionReport-306
HSCP Holiday Programme	26/07/2022	5	Not assessed	5	4	Holiday Programme - InspectionReport-312
HSCP Adult Placement Centre	25/10/2019	5	Not assessed	5	5	Adult Placement InspectionReport-306

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 were 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  InspectionReport-317155.pdf	26/09/2023	4 (Good)	4 (Good)	Not assessed	Not assessed	Not assessed
Kirkton  Kirkton - InspectionReport-304	23/7/2019	5 (Very Good)	Not assessed	Not assessed	Not assessed	5 (Very Good)
Care at Home  Item 10. 2 of 2 InspectionReport-318	30/01/2024	3 (Adequate)	3 (Adequate)	3 (Adequate)	Not assessed	3 (Adequate)
Community Pathways  InspectionReport-318885 (2).pdf	25/03/2024	5 (Very Good)	5 (Very Good)	Not assessed	Not Assessed	Not Assessed

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

Service	Date of Last Inspection	Evaluation of the impact on children and young people			Inspection Report

Joint Inspection of adult support and protection	June 2023				 East Renfrewshire adult support and pro

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

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

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

Evaluation of quality indicator 2.1: Excellent

4.6 Use of Directions during 2023-24

Directions are the means by which the Integration Joint Board tells the Health Board and Local Authority what is to be delivered using the integrated budget and for the IJB to improve the quality and sustainability of care, as outlined in its strategic commissioning plan. Directions are a key aspect of governance and accountability between partners. Directions issued in 2023-24 are given below.

March 2024	Budget 2024/25	ERC	Direction issued to East Renfrewshire Council to carry out each of the functions listed within the Integration Scheme in a manner consistent with: the existing policies of the Council and any relevant decisions of the Council in relation to the revenue budget; and with the Integration Joint Board's strategic plan.
March 2024	Budget 2024/25	NHS	Direction issued to NHSGGC to carry out each of the functions listed within the Integration Scheme in a

			manner consistent with: the existing policies of the Council and any relevant decisions of the Council in relation to the revenue budget; and with the Integration Joint Board's strategic plan.

Appendix One - National Outcomes

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

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

The National Outcomes for Children are:

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

The National Outcomes for Criminal Justice are:

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