EAST RENFREWSHIRE
HEALTH AND SOCIAL CARE
PARTNERSHIP

Working Together

Strategic Plan for Health and Social Care 2018-2021

FOREWORD

As a longstanding integrated partnership in East Renfrewshire, we are able to build on a strong foundation for health and social care. Much of our work from our previous strategic plan will continue into the next three years. However to meet the range of challenges presented by pressures on our finances and our growing and ageing population, we must fundamentally change the way we work together.

Our partnership must extend beyond traditional health and care services to a real partnership with local people and carers, volunteers and community organisations, providers and community planning partners.

We must place a greater emphasis on addressing the wider factors that impact on people's health and wellbeing, including activity, housing, and work; supporting people to be well, independent and connected to their communities.

We recognise that emergency admissions, out of hours pressures and carer stress are signs that we do not yet have all the right systems in place. We are committed to increasing the opportunities for people to talk with us earlier, exploring what matters to them and supporting them to plan and take action to anticipate and prevent problems and crises. By putting in place just enough support at the right time we believe that we can improve lives and reduce demands on the health and care system.

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

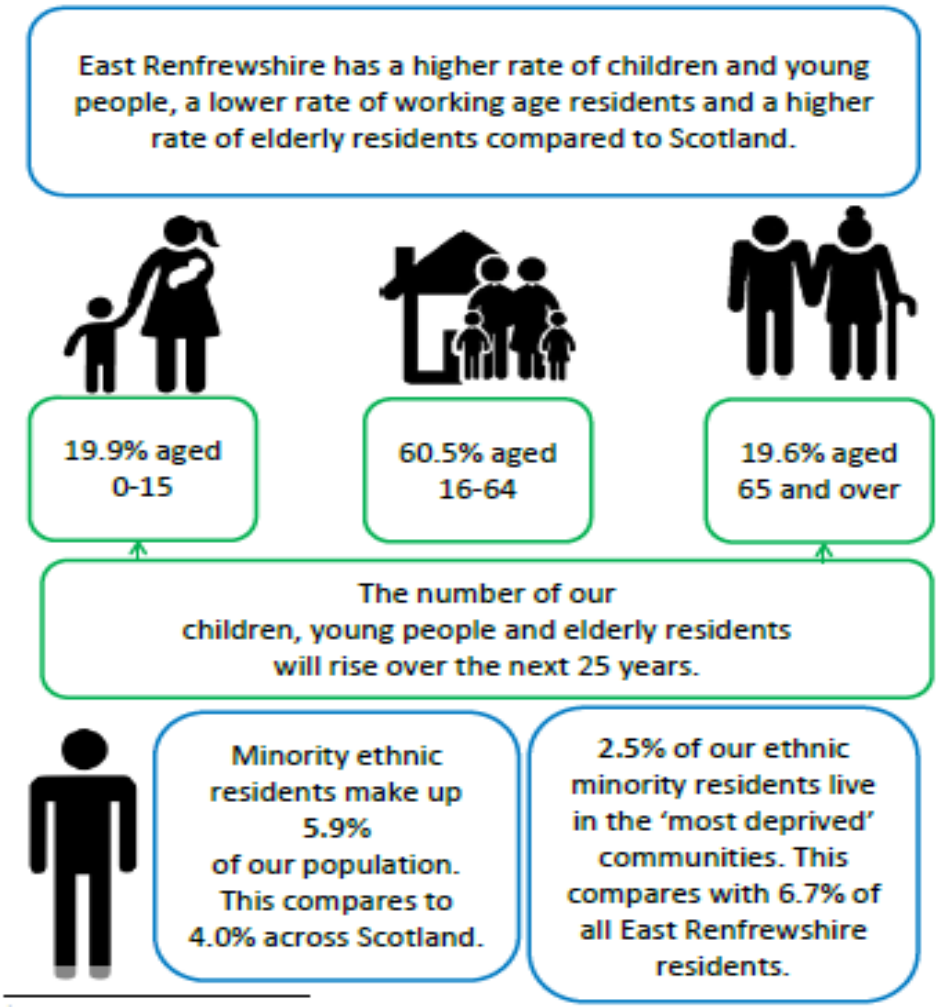
Our new strategic priorities where we need to make significant change or investment during the course of our strategic plan for 2018 – 2021 are:

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

INTRODUCTION

Our Population

From community planning work locally we know that:



The implications for us are that:

- East Renfrewshire's population is increasing. In particular both our youngest and oldest populations are increasing. These are the groups which are the greatest users of universal health care services
- People over 80 are the greatest users of hospital and community health services and social care. East Renfrewshire is attracting people of this age because more retirement and care homes are choosing to open in our area.
- People with complex health conditions and profound and multiple disabilities are living longer and require intensive health and social care supports.

Our Challenges

From our review of our first strategic plan, we are aware that we still face significant challenges:

- Increasing numbers of very old people who are at risk of frailty, dementia and often experience loneliness;
- Residents including many of our young people reporting concern about poor mental health and wellbeing
- Despite good overall population health some of our communities continuing to experience shorter life expectancy and poorer wellbeing
- Although people and their families tell us that they would like to be cared for and die at home more people are going into hospital than ever before
- People and their carers report that they do not feel that their care is well coordinated and that they don't have choice and control over their support.
- Reducing public funding and ever-increasing demand mean that all partners are facing an unprecedented financial challenge.

Our Opportunities

As an area that has planned and delivered integrated health and social care for over 10 years we have a good foundation to build on:

- Strong relationships with community, voluntary and provider partners, who have helped us redesign services and develop alternative local supports.
- Two modern purpose built health and care centres that offer flexible clinical and service delivery space.
- GPs and primary care teams who work well together and with the HSCP. Together we can develop new services and ways of working through our Primary Care Improvement Plan and GP contract changes.
- Dedicated and experienced staff who are committed to working together with people and their families
- Strengthened links with acute hospital services and other HSCPs across Greater Glasgow to support change across the health and care system
- A variety of pilots and tests of change to learn from in planning and designing our services for the future.

OUR PLANNING CONTEXT

National Outcomes

The main purpose of integration is to improve the wellbeing of people who use health and social care services, particularly those whose needs are complex and involve support from health and social care at the same time. This Strategic Plan is intended to achieve the Outcomes prescribed by Scottish Ministers:

National Outcomes for Children and Young People

- 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; and
- We have improved the life chances for children, young people and families at risk.

National Vision for Community Justice

- 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 citizens

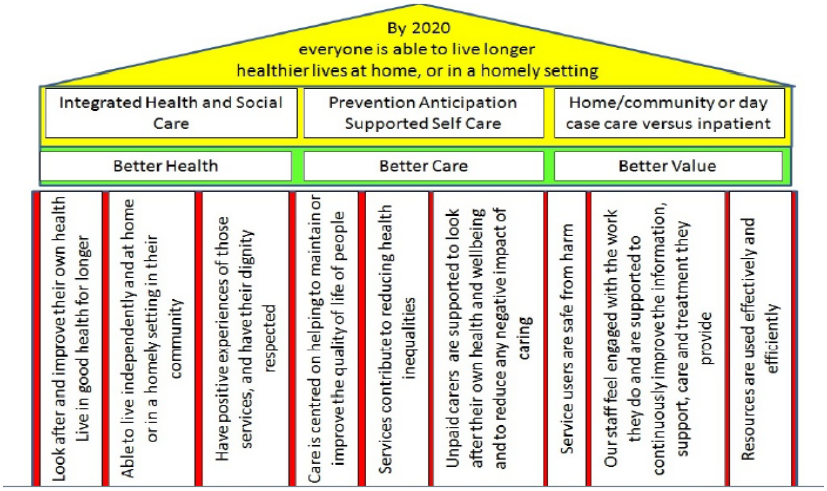
National Health and Wellbeing Outcomes

- People are able to look after and improve their own health and wellbeing and live in good health for longer.
- 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.
- People who use health and social care services have positive experiences of those services, and have their dignity respected.
- Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
- Health and social care services contribute to reducing health inequalities.
- 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.
- People using health and social care services are safe from harm.
- 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.
- Resources are used effectively and efficiently in the provision of health and social care services.

Regional Planning

Although we are responsible for health and care strategy within East Renfrewshire we sit within a complex health care system. Our Integration Joint Board along with Health Boards and Integration Joint Boards are working together across the West of Scotland to plan future NHS services. We want to ensure that boundaries are not barriers to delivering evidence based outcomes. This work will progress over the course our strategic plan. In taking this forward, we have agreed to be guided by some key principles;

- **Maximising health gain**
- **Anticipation and prevention**
- **Reducing inequality**
- **Quality, evidence and outcome**
- **Sustainability**



NHSGGC Transformational Programme

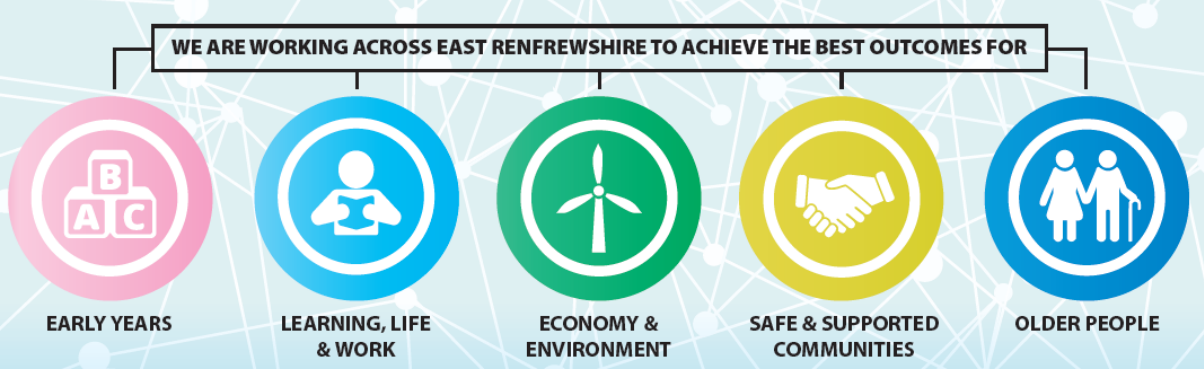
Moving Forward Together

The Moving Forward Together Programme builds on and drives forward known actions and commitments from National Delivery Plan, regional and clinical strategies – but it will also update and supplement these in light of more recent evidence and national strategic needs. The actions that this programme recommends will need to:

- **Support and empower people to improve their own health**
- **Support people to live independently at home for longer**
- **Empower and support people to manage their own long term conditions**
- **Enable people to stay in their communities accessing the care they need**
- **Enable people to access high quality primary and community care services close to home**
- **Provide access to world class hospital based care when the required level of care or treatment cannot be provided in the community**
- **Deliver hospital care on an ambulatory or day case basis whenever possible**
- **Provide highly specialist hospital services for the people of Greater Glasgow and Clyde and for some services, the West of Scotland**

Community Planning

As a community planning partner, the Integration Joint Board is committed to supporting the achievement of local outcomes set out in the Community Plan. This includes both the overarching Community Plan which sets set out the Community Planning Partnership's long term ambitions for the whole of East Renfrewshire and our Local Outcome Improvement Plan, which is known as Fairer East Ren. We also contribute to Locality Plans for areas which are experiencing significantly poorer outcomes than the rest of East Renfrewshire.



East Renfrewshire 'Outcomes on a Page' Diagram Community Plan					
	1- Early Years and Vulnerable People	**2 - Learning, life and Work**	**3 - Economy and Environment**	**4 - Safe, supportive communities**	**5 - Older people and people with long term conditions**
Community Plan Strategic Outcomes	All children in East Renfrewshire experience a stable and secure childhood and succeed.	East Renfrewshire residents are healthy and active and have the skills for learning, life and work.	East Renfrewshire is a thriving, attractive and sustainable place for residents and businesses	East Renfrewshire residents are safe and live in supportive communities	Older people and people with long term conditions in East Renfrewshire are valued; their voices are heard and they enjoy full and positive lives.
Fairer East Ren- Closing the Gap between	**1.1**- The impact of child poverty is reduced.	**2.1**- Residents have the right skills, learning opportunities and confidence to secure and sustain work.	**3.1** East Renfrewshire's transport links are accessible, attractive and seamless	**4.1**- Residents' mental health and wellbeing is improved. **5.1**- Residents are safe and are more socially connected within their communities.	
Intermediate Outcomes	**1.2**- Parents provide a safe, healthy and nurturing environment for their families. **1.3**- Children and young people are cared for, protected and their wellbeing is safeguarded	**2.2**- Children and young people are included. **2.3**- Children and young people raise their educational attainment and achievement and develop the skills they need. **2.4**- Residents are as healthy and active as possible	**3.2**- East Renfrewshire is a thriving place to invest and for businesses to grow **3.3**- East Renfrewshire is an attractive place to live with a good physical environment **3.4**- East Renfrewshire is a great place to visit **3.5**- East Renfrewshire is environmentally sustainable	**4.2**- Residents live in safe communities with low levels of crime and anti-social behaviour **4.3**- Residents are protected from harm and abuse and public protection is safeguarded. **4.4**- Residents live in communities that are strong, self-sufficient and resilient **4.5**- Residents are protected from drug and alcohol related harm	**5.2**- Older people and people with long terms conditions stay as healthy as possible **5.3**- Older people and people with long terms conditions live safely and independently in the community **5.4**- Carers are valued and can maintain their own health and wellbeing

REVIEW OF STRATEGIC PLAN 2015 -18

With our Strategic Planning Group we have reviewed our first strategic plan, considering the progress we have made towards the outcomes and strategic priorities we set for ourselves. More information on our performance is available in our Annual Performance Plan.

Children and young people

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

Community Justice

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

Health Improvement and Inequalities

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

Keeping people at home

- HSCP activity to reduce delayed discharges and reduce lengths of stay by reaching into hospitals and getting people back to East Renfrewshire has been very successful
- Whilst the HSCP started from a positive baseline, we have not reduced unplanned care in the way that we predicted. Attendance at accident and emergency and emergency admissions from East Renfrewshire increased last year.
- For us unplanned use of hospital care is a sign that as a health and care system we are not supporting people as well as we could and that we may be missing opportunities to intervene and plan earlier. A strategic priority moving forward must be working with **our colleagues in primary and acute care to reduce admissions to hospital, including at end of life.**

Living good lives independently

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

Carers

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

Mental Health and Recovery

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

OUR NEW STRATEGIC PRIORITIES

Much of our work from our previous strategic plan will continue into the next three years. In addition as a community planning partner, the Integration Joint Board is committed to a number of actions in existing plans for Improving Outcomes for Children and Young People, Community Justice and Alcohol and Drugs.

The following strategic priorities have been identified as the areas where we need to make significant change or investment during the course of our new plan.

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

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

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

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

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

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

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

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

In East Renfrewshire together with our children's planning partners, we believe that where possible children and young people's needs should be met by universal service provision in partnership with families and carers. We understand that within the general children's population there is a significant and growing number of children and young people with additional needs who, due to the complexity of these needs, require to access specialist and intensive services. In addition there is a growing population of children who are described as vulnerable due to being looked after and in our care, or on the edges of care, who need targeted interventions to safeguard their wellbeing. Our actions to address these are set out in "Getting it right with you" East Renfrewshire's Children's Services Plan 2017-2020.

Our new strategic priority is improving mental wellbeing of children and young people. We have been aware for some time of the pressures on our Child and Adolescent Mental Health Services, our disproportionate use of mental health inpatient beds and the number of GP consultations for mental wellbeing. Local community consultation confirmed this as an area of concern for local residents.

From national research we know that most mental illness begins before adulthood: research suggests that half of Adult Mental Health problems have begun by the age of 15, and three-quarters by the age of 18. About 10% of children and young people experience Mental Health problems, and once acquired they tend to persist. Mental illness in children, young people and adults is strongly correlated with exposure to childhood adversity and trauma of various kinds. Adverse Childhood Experiences (ACEs) are an established indicator of exposure to such trauma. ACEs range from verbal, mental and physical abuse, to being exposed to alcoholism, drug use and domestic violence at home.

We need to ensure that we provide the appropriate and proportionate mental health responses for children and young people who are experiencing mental health problems. With a specialist third sector provider we are testing a trauma recovery programme in a locality with high demand for clinical mental health provision. We will work together with partnerships across Greater Glasgow and Clyde to review how well our Child and Adolescent Mental Health Team arrangements are working. In addition our Child and Adolescent Mental Health Service, YISS, Young Peoples' Team, and Education will work together to support young people to be more included in their community and schools when they exit the CAMHS.

We must also make sure that we prevent and intervene early to prevent the impact of Adverse Childhood Experiences. Working together with our partners we are strengthening local identification, assessment and support of children and young people at risk, including those affected by domestic violence. Our East Renfrewshire Corporate Parenting Plan is underpinned with a pledge to East Renfrewshire's care experienced children and young people that "we - their Corporate Parents - will work together to prioritise and address their needs and we will have high expectations of ourselves to deliver the improvements needed, to make the difference for them".

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

The East Renfrewshire community justice outcome improvement plan defines our core outcomes, ***what we will deliver as partners*** and how this will ***contribute to and improve the lives of people*** with lived experience of the community justice system from point of arrest through to returning from custody.

Through the Community Justice 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 criminal justice service will promote the range of community justice services that we deliver and identify and develop opportunities for unpaid work element of community payback orders to meet the needs of the local community.

Our Criminal Justice Social Work Team is also responsible for managing all long term prisoners and those people in custody who are subject to post release supervision. On average there are around 50 people from East Renfrewshire in prison serving custodial sentences (less than 1% of the total prison population), two thirds of these cases are long term prisoners who will be subject to licence conditions on release and supervised by the department's criminal justice team.

Over the course of this plan we will strengthen our links with community services and programmes to provide greater access and support for people to stop offending. Through this work we will ensure that people moving through the criminal justice system have better access to the services they require, including welfare, health and wellbeing, housing and employability.

As part of our community planning work to protect people from harm and abuse, we will work together with police, Women's Aid East Renfrewshire to develop and implement a multi-agency risk assessment conference for high risk domestic abuse victims.

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

Locality plans have been developed for the two localities (Arthurlie, Dunterlie & Dovecothall and Auchenback) that have areas within the 20% most deprived areas in Scotland, with significantly poorer outcomes in health, education, housing and employment. Plans have been developed using a community-led approach, which supported local residents to form steering groups to drive the process. Most of this work has been led by the council's community planning team but health improvement staff have been involved in supporting the process.

Each plan has a set of priorities that reflect the unique needs of that locality. The plans form a basis for further work to which we are committed as a community planning partner.

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

We are working together with local people, community groups and organisations to redesign a new 'front door' and new ways of engaging with people in their communities. We have tested this approach setting up new local Talking Points, where people can talk to different health and care staff and community volunteers about what matters to them. Through this approach we will ensure that people have access to the right conversation at the right time and have the right support to maintain their independence. Over the course of this plan this we will make this our main approach, with a fixed talking point in every locality and regular pop up talking points in our local communities.

Through our partnership with East Renfrewshire Culture and Leisure Trust we will see an exciting and developing offer to older people under the Ageing Well programme, with a range of activities that support and encourage older people to be physical and mentally active and maintain their independence. A Health Assessment (Health MOT) service is currently being developed to provide people with a measure of their current health and fitness and to signpost people to the most appropriate activities that will support them to increase their physical activity level. Working in partnership with Alzheimer's Scotland, the Culture and Leisure Trust is carrying our Dementia Friendly training and service development. This will be rolled out across the Trust, to ensure that all ERCL services are able to meet the needs of those in our communities who are living with Dementia.

For those people who require support for their daily lives, we are moving to a model of "just enough support". In 2018 we will introduce a new individual budget calculator for self-directed support. This will remove the barriers and potential inequity of our current equivalence model and provide a more simple and transparent approach. We want to make sure that all our systems support choice and control and we will also introduce outcome focussed support plans that move away from the task and time approach and allow more innovation and flexibility. This different approach will require support, training and a culture change across our partnership.

We will continue to work in partnership with local providers as the move to individual budgets will be a change for some services that we previously funded through a block contract or grant. We will work with our providers and in-house services to support them to develop new business plans to adapt to this new approach. We will continue to work in partnership to increase the day opportunities available to people, and community involvement in our resource and health and care centres. Our work in localities will build on our strong local partnerships and social enterprise approach, encouraging innovation that supports people to live independently in the community and offers alternatives to residential care.

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

One of the Fairer East Ren Outcomes is improving the mental health and wellbeing of residents. We will work together with community planning partners on activities that support mental health improvement such as access to green spaces and reducing social isolation. We are also committed to early intervention working together with Recovery Across Mental Health to provide link workers in local GP practices.

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

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

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

We will work together across Greater Glasgow and Clyde to improve responses to crisis and distress, and unscheduled care. Integrating crisis, home treatment and OOH models so that they are provided consistently as a comprehensive Crisis Resolution and Home Treatment (CRHT) service, available for community care 8am to 11pm, 7 days a week.

This strategy signals a further shift in our balance of care moving away from hospital wards to community alternatives for people requiring longer term, 24/7 care, with mental health rehabilitation hospital beds working to a consistent, recovery-focussed model.

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

We will work together with our colleagues in primary care to put in place the new GP contact and Primary Care Improvement Plan. This will see GPs as the Expert Medical Generalist senior clinical decision maker in an extended primary health care team. The new contract will support local GPs to spend more time in managing patients with complex care needs. Over the course of this strategy we will support primary care teams to grow to support more patients in the community, with additional pharmacy, community treatment (e.g. phlebotomy), other health professionals and link workers.

We are committed to a programme of work with colleagues in acute services to ensure that only those people who require urgent or planned medical or surgical care go to hospital. Together we are looking at the most frequent preventable causes of admission and putting in place new services and pathways to support people in the community wherever possible, including at the end of life. Our first priority is people with respiratory conditions but we are also looking at people who become frail, with abdominal or chest pain and other conditions.

Our aim will always be to return people home as quickly as possible and to support people at home wherever possible. However sometimes people require additional supports. Over the lifetime of the plan we intend to develop Bonnyton House using six beds as an intensive rehabilitation resource to prevent hospital admission and to ensure a safe return home for people discharged from hospital. We will also create a further six beds so that people who need end of life care, who can't be supported to die at home, could also be supported at Bonnyton.

We have been concerned that as the building of new care homes in East Renfrewshire has led to an increase in our most frail and complex older population . This places many demands on our local services including GPs and out of hours services. We want to work together with local care homes, the people who live there and their families to ensure that they get the best care for this final stage of their lives. Over the course of this strategy we will redesign our services to focus on this ensuring that our most skilled nurses and staff are available to offer specialist advice and support.

In the past a number of people were cared for in hospitals for life. We no longer believe that hospital is the based place for people to live. The new national approach – Hospital Based Complex Care – asks the question "can this person's care needs be properly met in any setting other than a hospital?" Very few people require 24/7 hospital care and so the need for long term care beds is reducing. Locally, NHSGGC runs Mearnskirk House as a long term hospital for older people, using NHS staff, but paying for the building and other services through a contract with Walker Heath Care. This contract expires in March 2019 and will not be renewed. We will work with our NHSGGC colleagues and other Health and Social Care Partnerships to make appropriate arrangements for the care of any remaining patients and use any resource released to invest in local services.

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

The Care Collective has been engaging with local people and organisations involved in supporting carers to raise awareness of carers, gain insights into people's experiences of caring for someone else and explore the ways to enable local people to participate in developing services and strategies to best meet their needs. The aim of the Care Collective is to help local people and organisations work together so that their combined efforts add up to more than the sum of their parts. This is not solely related to the Carers Act but also to the long-term culture and ethos of working together for a 'Caring East Ren'.

Working together stakeholders including HSCP staff, the Carers Centre, VAER, the Care Collective and people with experience as Carers have considered information and guidance for the Carers Act as it emerged from Scottish Government along with our local context and implications for implementation of the Act, including local people's thoughts and experiences of caring and support for carers.

They have identified the following conditions for success.

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

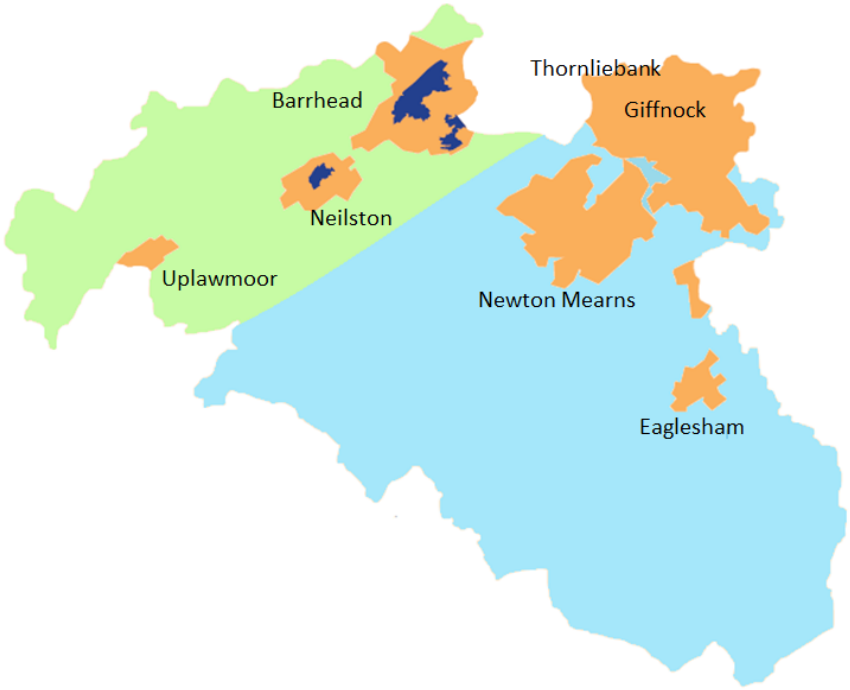
Over the course of the strategic plan we will work together to improve access to accurate, timely information that meets carers' needs and awareness of the range of supports for carers. We will continue to encourage collaboration between providers of supports to carers ensuring local provision best meets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

Through our work on self-directed support we will develop and implement a consistent and clear prioritisation framework (eligibility criteria) and ensure that carers and support organisations are aware of the availability of suitable respite care and short-break provision

Working together with education we have been developing support systems that appreciate young carers and build resilience through opportunities for peer support. We will implement a process for a young carers statement that has been designed by young carers for young carers and is owned by the young carer.

LOCALITY PLANNING

In our previous plan we divided the area into three localities based around our GP clusters. Since the last plan our GP clusters for the Eastwood area have changed with the GPs in the Eastwood Health and Care campus forming one cluster and the other Practices in Newton Mearns and Clarkston forming the other cluster. As GP practice populations do not reflect natural communities we have found it difficult to coordinate this approach so moving forward we propose to move away from a cluster based locality model. We will develop two localities one for Eastwood and one for Barrhead. The new localities also reflect our hospital flows with the Eastwood Locality linking to South Glasgow hospitals and the Barrhead Locality to the RAH, which is part of Clyde.



Our HSCP adult health and social care management arrangements will change to mirror this new structure and strengthen our ability to support and engage meaningfully in locality planning. In redesigning our HSCP services we will look to

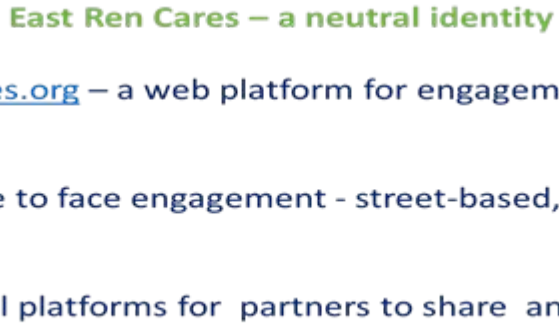
- Understand and refresh our pathways
- Redesign our Locality Services around our key pathways
- Ensure we have right person, doing the right thing at the right time
- Build on community led support and talking points
- Strengthen and build on our relationships with General Practitioners and the opportunities arising from the new GP contract

We already have co-located health and social care teams in place but our ambition is to work together in localities with staff from a range of provider and voluntary organisations, wherever possible sharing premises and information. We will work with our communities and partners building on the strengths of each local area to support people's wellbeing and feeling of being connected and more independent. We also aim to see increased locality commissioning and market facilitation encouraging more flexible service provision and social enterprises.

COMMUNITY ENGAGEMENT AND INSIGHT

Working with Voluntary Action and other partners we have been engaging with the public on the strategic priorities for Health and Social Care. We recognise the importance of developing a mature relationship between different partners, including members of the public, the third and independent sector for effective and impactful strategic commissioning. With this in mind, our engagement will be an on-going process and will deepen over the course of the Strategic Plan.

The initial focus has been on developing a systematic approach towards engagement, ensuring inclusion and developing the necessary platforms to support digital and face to face engagement. This allows us to monitor our engagement to ensure all voices are heard and enables us to evidence the extent and reach of our engagement.



Insight from the engagement work so far has shown general agreement with the strategic priorities we have identified. We are learning more about variation of need and aspiration amongst different communities – both communities of 'place' and communities of interest - that needs to shape and influence our Strategic and Locality Commissioning.

Communities experiencing shorter life expectancy and poorer health

- **Lack of access to transport affects health and care choices**
- **Poor health is often seen as normal and people do not perceive themselves as 'deserving' of support, considering that others' needs are greater than their own.**
- **Poor management or recognition of long term conditions**
- **Lack of trust of public sector**

Maintaining independence at home and in the community

- **Lack of suitable housing choices makes people stay in unsuitable housing for longer**
- **People do not perceive that the option they want (community living with like-minded people) is available**
- **Lack of awareness of support and services in local area**
- **Contracting social networks affect people's resilience and connection to their community and local information**

Mental health recovery

- People experience inflexibility of services, particularly the model of primary care mental health, and do not see this as person-centred
- Recognition of a gap between current offer of social and service support and a desire for more peer support and groups
- Accessing support is difficult
- Young people are proactive in accessing online support. They often wish to remain anonymous and this has led them to contact Samaritans.
- People unable to work due to mental health issues can become carers for other family members and this has an adverse effect on their mental health.

Reducing unplanned hospital admissions

- People don't plan to go to hospital. Their view is that services do the planning
- People make considered decisions about hospital attendance but their considerations may be access to doctors' appointments, social norms, peer advice, perceived location of technical expertise
- Attendance at A&E is because "I had no choice"
- Hospital care is considered expert and holistic and is highly valued
- People 'game' the system to get the support they want at the time they want

Choice and control for Carers

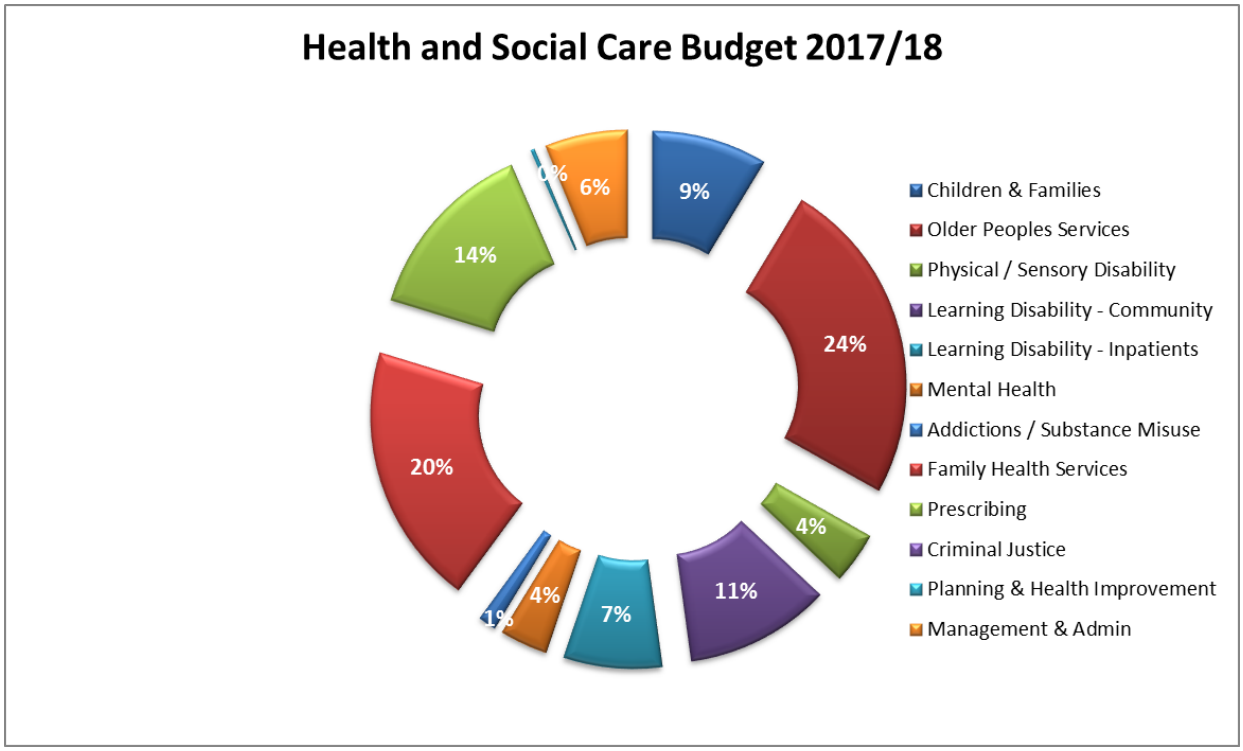
- Carers want access to information and supported planning at point of diagnosis
- Access to peer support and reduction of stigma is valued
- Relationship between Carers and paid Care at Home is important
- Post-caring support (bereavement) is often not available

Other insights from engagement

- East Renfrewshire has a relatively stable population age 45+ therefore the benefits of early intervention and prevention should stay in the system
- Small, tight social networks are strong determinants of attitude and actions. This can be behind pockets of unexpected behaviours and can have adverse effects on resilience.
- Information is the cheapest form of support but people do not have access to trustworthy, consistent, appropriate information. Information voids are filled by assumptions and peers influence
- Deprivation and ideas of not 'deserving' support leads to poor self-management and lack of support
- Failure demand – people are 'gaming the system' because the current system does not work for them
- There is more trust in hospitals and nurses (uniformed services) and a suspicion and lack of ownership of other non-uniformed care and support
- Community capacity. Better collaboration and information sharing across community groups would release more capacity for support in the community. There is willingness to work more collaboratively.

OUR FINANCIAL CONTEXT

The chart below shows how our resources were distributed in 2017/18.



With our long standing history of providing integrated health and social care services since 2006 we have already achieved the obvious savings that result from the integration of services. Whilst we strive for continuous improvement we recognised that in order to meet the 2017/18 savings challenge we had to embark on our radical change programme "Fit for the Future to streamline our management structure and optimise the skills mix of our workforce. This work is being finalised in 2018/19 and we are bridging the savings gap through planned use of our IJB reserves.

Our current funding for 2018/19 is:

	£ million
East Renfrewshire Council – Social Care	48.175
East Renfrewshire Council - Housing	0.550
NHS Greater Glasgow and Clyde – Primary Care	66.669
NHS Greater Glasgow and Clyde - Set Aside Budget	14.561
Total	129.955

OUR FINANCIAL CHALLENGE

The 2018/19 settlement was more favourable than expected with £66 million additional funding received nationally reflecting the pressures within social care. The relationship with our partners reflects the maturity of our partnership and East Renfrewshire Council passed on our full share of this funding, recognised demographic pressures and funded pay and inflation. This meant our net savings challenge in 2018/19 was reduced to £0.4 million.

NHS Greater Glasgow and Clyde passed on our share of the 1.5% uplift it received and this reduced our cost pressures by £0.9 million leaving us with a savings requirement of £0.6 million. This has been achieved through efficiencies and closure of some in patient learning disability long stay beds.

Over the next two years (2019/20 and 2020/21) we potentially face a very challenging budget settlement. East Renfrewshire Council's budget set on 2 March 2018 included indicative contributions for the IJB for 2019/20 of £46.833 million and 2020/21 of £45.496 million so allowing for assumptions for funding pay, inflation and demographic pressures there will still be a significant savings challenge. Our assumption for our NHS funding is in line with 2018/ 19, with an assumed 1.5% uplift that will partially offset cost pressures.

Potential Savings Requirement	2019/20 £'m	2020/21 £'m	Cumulative £'m
NHS Greater Glasgow and Clyde	(0.7)	(0.8)	(1.5)
East Renfrewshire Council	(3.4)	(3.4)	(6.8)
Total Possible Savings	(4.1)	(4.2)	(8.3)

The Scottish Government have given a commitment to publish a five year financial framework and that will allow us to plan on future scenarios and modelling with an increased degree of certainty. In the meantime we need to plan and consult on the most likely saving requirement based on the 2018/19 budget settlement and the latest discussion with our partners.

We will need to put in place a wide-ranging programme of change to close our financial gap of £8.3 million gap, this means identifying savings of £4.1 million in 2019/20 and £4.2 million in 2020/21. We recognise that we need to do more than change the way services are organised to ensure a sustainable local health and care system. We must also achieve a transformational reduction in demand for services.

Developing our Financial and Commissioning Strategy

This strategic plan and the consultation on our approach and strategic priorities forms the first stage in developing our longer term Financial and Strategic Commissioning Plan.

Over the next few months along with our consultation on our Strategic Plan we will develop and test options for our future budget. Our key question is *What do we need to do differently for a better result, and how are we going to resource it*? This may need us to consider reducing funding for other areas. Our budget modelling will bring together a range of financial information, together with population and health data.

We will publish our intentions within our Financial and Strategic Commissioning Plan, which will provide clarity about our strategic commissioning intentions.

Developing our Local Markets

We want to work together towards sustainable and lasting change in terms of how we commission the range of approaches for our population and stimulate our local care and support market in East Renfrewshire. We need to develop new relationships with providers, people and organisations who can influence and respond to our strategic priorities.

Developing our Equality Outcomes

We are aware that East Renfrewshire is one of the most ethnically and culturally diverse areas in Scotland, with significant Jewish and Muslim communities. We will be reviewing our strategic planning priorities and equality outcomes for all equality groups but with a particular focus on making sure we are working together with our different ethnic and cultural communities.

Working Together with Housing

Housing has an important contribution to make to our strategic plan. Over 2018/19 we will be working with colleagues in the Council and Housing Providers to update our housing contribution statement.

Developing our Workforce for the Future

We have committed to a Fit for the Future programme of operational service redesign that brings together many of the strands in our Strategic Plan. Through this work we will identify the workforce structure and skills we require for the future. Our workforce plan will link to NHS, Council and National Workforce plans.