2021/2022

EAST RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

# East Renfrewshire - Strategic Plan for Health and Social Care

1 year plan for 2021-22 recovery period

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# 1. Introduction

This strategic plan has been produced during an exceptionally challenging period for East Renfrewshire Health and Social Care Partnership (HSCP) as we continue to support local residents through the Covid-19 pandemic and make preparations for recovery.

Our response to the pandemic has seen incredible resilience, commitment and creativity from staff at the HSCP, our partner providers and community groups in East Renfrewshire. Our teams have established and adapted to new ways of working and have continued to maintain and deliver safe and effective services to our residents. During the pandemic period there has been innovation and collaborative working across the health and care system building on and strengthening local partnerships.

The partnership continues to find itself in a period of change with significant uncertainty for the months ahead. At the same time, it is essential that we fully understand the impacts of the pandemic in order to produce a strategic plan.

Recognising the need for our focus to remain principally on response and recovery from Covid-19, and that the constraints of the pandemic impact on our ability to fully engage with partners and the community, the Integration Joint Board has agreed to produce a one-year 'bridging' plan for 2021-22. This will be followed by more extensive work, as we move into recovery to develop a three-year plan for 2022-25.

This bridging plan for 2021-22:

- sets out our broad vision for the partnership;
- provides a review of progress during the period of the previous Strategic Plan;
- considers our current context, needs information and lessons learned from the pandemic;
- and summarises our approach to our revised strategic priorities.

Work to develop our full three-year Strategic Plan (2022-25) will begin in 2021 and will include a detailed strategic needs assessment and full programme of community and stakeholder engagement.

# 2. Our partnership, vision and priorities

## 2.1 Our Partnership

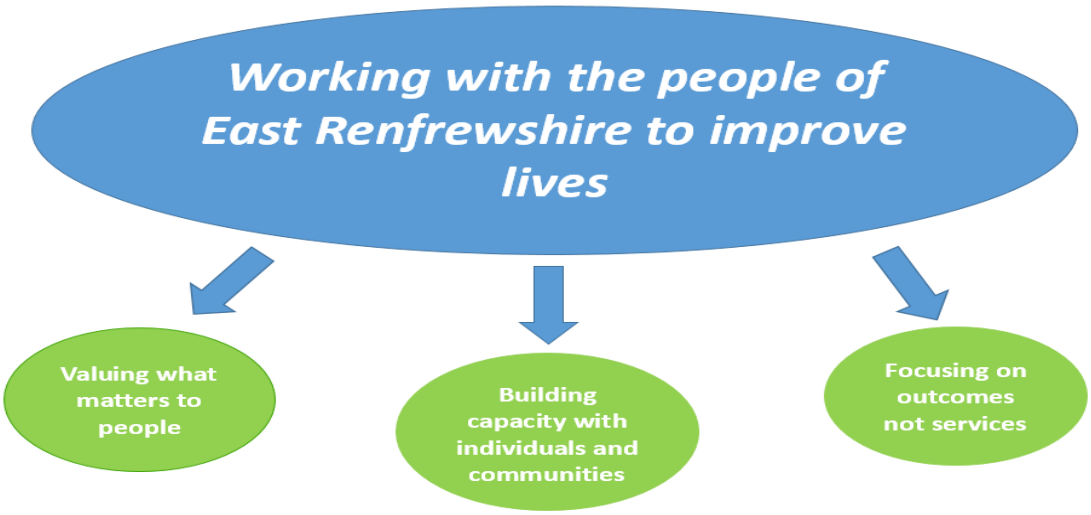
Under the direction of East Renfrewshire's Integration Joint Board (IJB), our HSCP builds on a secure footing of a 15 year commitment to health and social care partnership in East Renfrewshire. Our experiences over the Covid-19 pandemic have reinforced the benefits of working together as a broad and inclusive partnership. Moving forward we must further strengthen our supportive relationships with independent and third sector partners. It is also essential that we recognise the increased levels of participation in our communities and informal support within neighbourhoods that have developed in response to Covid-19. Our partnership must extend beyond traditional health and care services to a long-term meaningful partnership with local people and carers, volunteers and community organisations.

## 2.2 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 and remains unchanged for this iteration of our Strategic Plan.

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*



## 2.3 Our strategic priorities

In line with our vision and the wider priorities for our partnership, we have reviewed our strategic priorities for the 2021-22 plan. While our high-level strategic focus remains unchanged and the majority of our priorities from our 2018-21 plan will continue, we have decided to widen our focus on mental health to include community wellbeing and have added a strategic priority relating to the wellbeing of our workforce. Our strategic priorities are discussed in more detail at Section 5 and our operational planning will reflect how these priorities will be pursued as we continue our response and recovery from the Covid-19 pandemic.

## 2.4 Delivering our strategy during the Covid-19 pandemic

The plan covers 2021-22 during which we will continue to respond to the needs of residents resulting from the pandemic. The continuing roll-out of the Covid-19 vaccination programme is of particular importance to residents and will place significant resource requirements on the partnership over the life of this plan. We will continue to support NHSGGC to deliver the vaccination programme as efficiently as possible for East Renfrewshire residents. The programme will run parallel to our recovery activity during 2021-22 as we support services to prepare to move beyond the pandemic period.

During 2020 we established a local Covid assessment centre. As the numbers of local people requiring this service reduced this was put on hold and East Renfrewshire residents are currently directed to Linwood or Barr Street, Glasgow. We are working with colleagues in these HSCPs to support the clinical activity as required during 2021.

The HSCP has established a PPE hub that provides services and carers with protective equipment as required. We will continue to run this service for as long as it is needed. Our team also support the roll out of lateral flow testing and the admiration of outbreak testing for care homes and other social care providers.

## 3. Review of progress against strategic priorities (2018-21)

With our Strategic Planning Group (SPG) we have reviewed our strategic plan for 2018-21, considering the progress we have made towards the outcomes and strategic priorities we set for ourselves. The review recognised the impact of the Covid-19 pandemic in the final year of the plan and the emerging lessons from the period. More information on our performance is available in our Annual Performance Plan.

### 3.1 Mental wellbeing for children and young people

We have made good progress in establishing and developing more appropriate and proportionate models to support wellbeing for children and young people with a focus on prevention and holistic support to families. Our Family Wellbeing Service which supports children and young people who present with a range of significant mental and emotional wellbeing concerns is delivering positive outcomes for individuals. The service is now well established and has expanded its reach to all GP practices. We are seeing improving outcomes for children after parent/carer completion of our Psychology of Parenting Project (PoPP). The programme offers support to families experiencing difficulties with behaviour, building confidence among parents.

We continue to perform well in keeping children safe in their local community wherever possible and acting quickly to make decisions. We have made progress with the implementation of the Signs of Safety model which focuses on developing relational interventions with children, young people, their families and carers in order to reduce risk and improve children's wellbeing. We continue to shift the balance of care and now have the highest proportion of children being looked after in the community in Scotland. Further progress has been made in ensuring our care experienced young people have a voice through our Champions Board with increased levels of participation and engagement.

### 3.2 Criminal Justice pathways

The IJB has been supporting multi-agency approaches to criminal justice through East Renfrewshire's Community Justice Outcome Improvement Plan with good progress in the establishment of stronger pathways to recovery and rehabilitative services.

High quality person centred interventions have been delivered through the Community Payback Team facilitating unpaid work, reducing the risk of reoffending and supporting individuals to overcome barriers into training and employment. We have enhanced our unpaid work service by ensuring that tasks are meaningful to communities and provide learning opportunities for service users, including improving the environment and supporting charitable and voluntary organisations. We receive regular feedback from the public on the positive impact that community payback has had on their local community.

We continue to put effective interventions in place to protect people from harm and have seen improving personal outcomes for women and children who have experienced domestic abuse.

This work needs to continue into the next strategic plan.

### 3.3 Supporting health and wellbeing in our disadvantaged communities

East Renfrewshire as a whole continues to perform well ahead of the Scottish average for life expectancy and premature mortality rates. Collaborative and targeted interventions with physical activity and health awareness have been delivered in Barrhead and Neilston. In partnership with the East Renfrewshire Culture and Leisure Trust we have been progressing our Ageing Well activity to support health and wellbeing for older residents.

Health inequalities persist in East Renfrewshire and may have been exacerbated by the impact of the pandemic. We will continue to work with our community planning partners to develop our understanding of health inequalities and target interventions appropriately.

### 3.4 Supporting people to remain independent and live well at home

Supporting independence and minimising reliance on institutional care has been a significant area of focus for the IJB during the period. We have seen good progress in the development of our preventative and community-led supports, promotion of models that increase individual choice and control, and development of innovative support for people to maintain health and wellbeing in their own homes. In particular, prior to the Covid-19 pandemic, Talking Points hubs were established across East Renfrewshire as places where people can go to have a good conversation about their health and wellbeing and be directed to the right support at the right time. The approach has strengthened our work as a partnership, with clearer understanding among support providers of what is available across East Renfrewshire. This has resulted in increased availability of information and access to community supports.

The HSCP has introduced an 'individual budget' calculator to support self-directed support but further work is required to embed the new processes. We have made good progress in supporting independent living for people with learning disabilities including the development of a range of meaningful activities in the community. We have progressed independent living with the promotion of telecare and the expansion of our Home and Mobile Health Monitoring (HMHM) service with GP practices.

We would like to see more improvement in our performance that indicates a shift in the balance of care. Supporting people to live independently and well remains a strategic priority for the IJB and we will work to progress the most appropriate models of care, including making best use of digital opportunities to support local people.

## 3.5 Supporting recovery from mental ill-health

We continue to develop our approaches to ensure that people who experience mental ill-health can access the appropriate support on their journey to recovery. Community Link Workers have been introduced to all GP practices to support preventative and holistic approaches. Approximately 2000 people have benefitted from a wide range of physical, social and psychological interventions. We have progressed self-management through the promotion of computerised cognitive behavioural therapy (cCBT) and increased our referrals to specialised mental health services.

Available performance information for mental health remains limited and we will work to progress our understanding of local experiences through improved data and engagement. There is strong emerging evidence on the impact the pandemic is having on mental wellbeing across groups in the community. In recognition of this we would like to expand the scope of this strategic priority from tackling mental ill-health to supporting mental wellbeing in the community more widely.

## 3.6 Reducing unplanned admissions to hospital

Not accounting for the exceptional impact of the Covid-19 pandemic on acute care and patterns of hospital use, we have seen good progress in our development of supportive pathways out of hospital. We perform well on minimising delayed discharges and are seeing a reduction in unplanned days spent in hospital. However, the data shows that (before the pandemic) we were not reducing the volume of emergency admissions to hospital and there had been an overall increase in the number of A&E attendances over the period of the strategy (although with modest improvement for 2019/20).

To minimise unplanned presentations at hospital we have been working closely with GP practices and at cluster level and focusing on local data (e.g. frequent hospital attenders) to support to patients and minimise use of acute services. Prior to the pandemic good collaborative working with local care homes, brought down emergency attendances and admissions from this sector. We have seen good progress in supporting people at end of life with improving performance on the proportion of time people are supported in their own homes.

Our overall performance on unscheduled care indicates that we continue to be very successful at putting support in place to allow people to return to the community after as stay in hospital. However, with attendance and admission rates not improving, we must work to ensure that people have the appropriate level of support in the community. We must also continue to work to identify those at greatest risk and plan support accordingly.

## 3.7 Supporting unpaid carers to exercise choice and control

We have seen continued progress in our development of support for East Renfrewshire's unpaid carers working in collaboration with our local Carers Centre. Our most recent report shows 92% of carers reporting satisfaction with their quality of life. This indicator has improved consistently year on year and by 22% since 2016/17. However, the 2017/18 Scottish Health and Care Experience Survey showed that just 37% of carers felt supported in their caring role, although 70% of the people who responded were able to report a positive balance in terms of their caring role and other interests in their life. Whilst our performance is similar to that across Scotland, we know that this is an area that we can improve and we remain focused on ensuring that local people who provide unpaid care are valued and supported.

Working in partnership with the Care Collective (East Renfrewshire Carers and Voluntary Action East Renfrewshire), the HSCP has undertaken a range of activities to support the implementation of the Carers Act and establish a holistic approach to supporting local carers. We believe we have developed a sound continuum of support for improving outcomes for carers of all ages. Our local Carers Centre. Carers Centre staff have been trained in outcome-focussed, asset-based planning and Good Conversations and have completed Adult Carer Support Plans (ACSP) with carers. Those carers identified as having a substantial or critical need for support were referred to the HSCP for further social work intervention.

The HSCP appointed a Carers Lead in 2019/20 to promote the understanding and uptake of the legislation within East Renfrewshire. The Carers Lead is taking forward the development and implementation of the new East Renfrewshire Carers Strategy. Partners are clear that ensuring choice and control remains the key strategic priority for carers in East Renfrewshire.

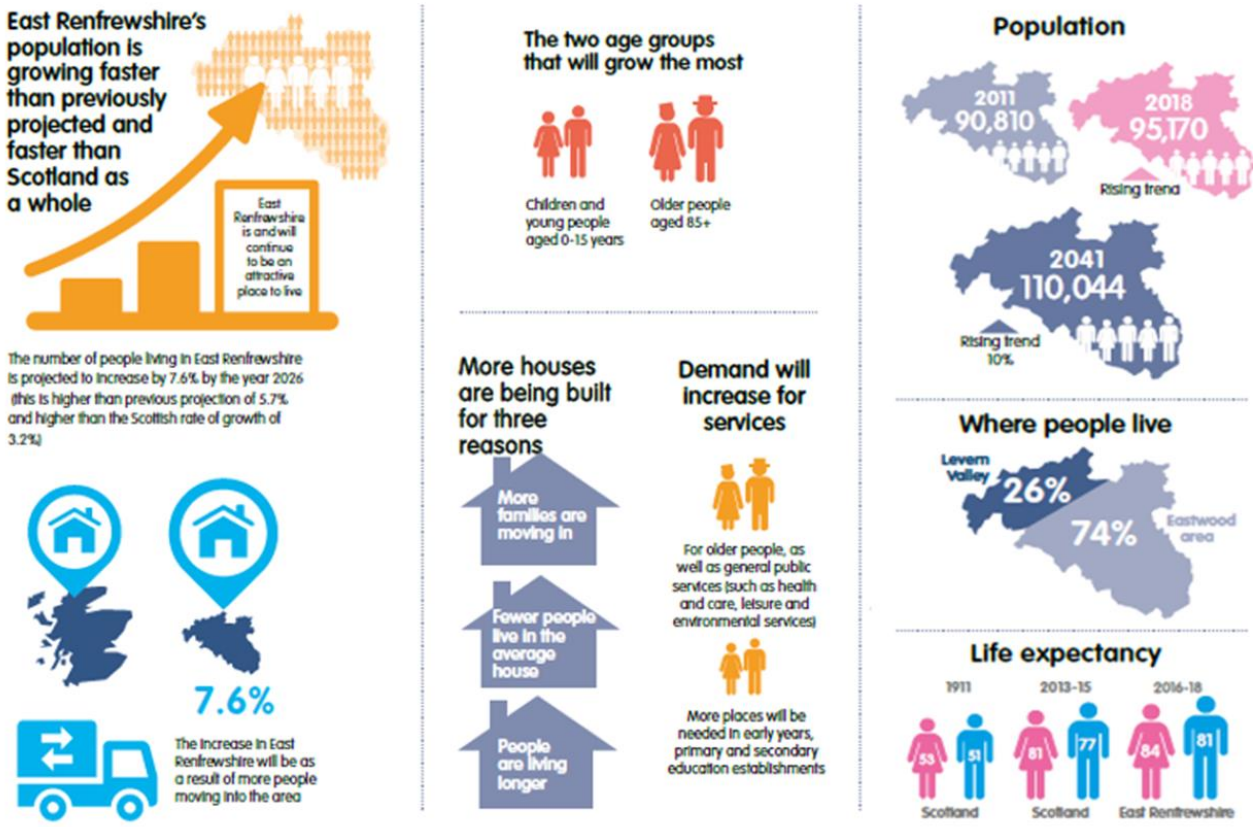
# 4. East Renfrewshire's current context

This section summarises our current context in relation to East Renfrewshire's demographic and health profile, impacts we are seeing from the Covid-19 pandemic and national priorities for recovery.

## 4.1 East Renfrewshire's demographics

Detailed needs assessment work will be carried out to support our next three-year Strategic Plan for 2022-25. Full Profiles have been developed for our two localities (Eastwood and Barrhead) giving information on population, households, deprivation, health profile, life expectancy and use of services. This section provides an overview.

### 4.1.1 Population




East Renfrewshire's population is growing and there is particular growth for our younger and older residents, who are the greatest users of universal health services.

There has been significant growth in our most elderly population with a 44% increase in the number of residents aged 85 years and over the last decade. The 85+ population is projected to increase by 18% between 2019 and 2024. People over 80 are the greatest users of hospital and community health and social care services.

### 4.1.2 Deprivation

Overall, East Renfrewshire is one of the least deprived local authority areas in Scotland. However, this mask the notable discrepancies that we see across the area with some neighbourhoods experiencing significant disadvantage.

The table below shows that more than half of East Renfrewshire's population (55%), and 67% of the Eastwood population live in SIMD datazones that are among the 20% least deprived in Scotland. 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 datazones.

| Indicators | Data Type | Time Period | Eastwood Locality | Barrhead Locality | East Renfrewshire HSCP | Scotland |
|---|---|---|---|---|---|---|
| Population in least deprived SIMD quintile | % | 2020 | 67 | 17 | 55 | 20 |
| Population in most deprived SIMD quintile | % | 2020 | 0 | 25 | 6.4 | 20 |

### 4.1.3 Health outcomes and inequalities

In line with the socio-demographic profile we see differing health outcomes for the populations in our two localities. While life expectancy at birth is above the Scottish average for East Renfrewshire as a whole, it remains below average in the Barrhead locality. Early mortality rates and the prevalence of long-term conditions including cancers are also higher for Barrhead.

Data also shows poorer outcomes for the Barrhead local in relation to the percentage of the population prescribed medication for anxiety, depression and psychosis. Hospital admission related to alcohol and drugs are also higher for Barrhead.

| Indicators | Data Type | Time Period | Eastwood Locality | Barrhead Locality | East Renfrewshire HSCP | Scotland |
|---|---|---|---|---|---|---|
| Male average life expectancy in years | mean | 2014-2018* | 81.7 | 76.3 | 80.7 | 77.1 |
| Female average life expectancy in years | mean | 2014-2018* | 84.8 | 80.2 | 83.6 | 81.1 |
| Early mortality rate per 100,000 | rate | 2016-2018 | 51 | 90 | 62 | 110 |
| Population with long-term condition | % | 2018/19 | 19 | 22 | 21 | 19 |
| Cancer registrations per 100,000 | rate | 2015-2017 | 606 | 636 | 615 | 632 |
| Anxiety, depression & psychosis prescriptions | % | 2018/19 | 16 | 20 | 17 | 19 |

Data also shows discrepancies across the two localities in our objective to reduce unplanned hospital use with poorer performance in the Barrhead locality for most measures. However, people at the end of life are more likely to be supported in their community during the last six months of life compared with the Eastwood locality. The Barrhead locality records a higher rate of mental-health related emergency admissions to hospital and unplanned bed days.

## 4.2 Emerging impacts from the Covid-19 pandemic

This section considers the impacts of Covid-19 and the changes we have made. We will continue to learn lessons as we move through and beyond the pandemic period.

### 4.2.1 Impacts of Covid-19

- **Impacts of increasing poverty on health and wellbeing.** While the full economic impact of the pandemic is still emerging it is clear that there have been negative consequences for businesses and employment prospects nationally and locally and that this is likely to worsen as supports including the furlough scheme come to an end. The evidence clearly links economic disadvantage with poorer physical and mental health outcomes. We know that the unemployment rate has risen significantly in East Renfrewshire and we have a high volume of people being furloughed. The 18-25 age group has particularly impacted with the proportion of this group claiming unemployment related benefits increasing significantly.

- **Potentially worsening health inequalities.** National evidence shows that the pandemic has had a disproportionate impact for disadvantaged communities and specific vulnerable groups. The loss of social support during the pandemic due to diminished or interrupted care and support has made disabled people, black and minority ethnic people, older people and children and young people more vulnerable. We have also seen at the UK level, that disadvantaged neighbourhoods and areas with poorer, high-density housing have been particularly badly affected by the pandemic.

- **Negative impacts on mental health and wellbeing.** Evidence indicates that the COVID-19 pandemic is associated with social isolation, distress, anxiety, fear of contagion, depression and insomnia in the general population. Studies have concluded there will be significant longer-term impacts on mental health and wellbeing. For some of the population this could exacerbate pre-existing psychiatric disorders and heighten risks of suicidal behaviour. A number of key groups are at higher risk of adverse mental health outcomes. These include front line staff, women, people with underlying health conditions, children and young people (up to age 25). Locally, we know that families and people we support are reporting worsening mental wellbeing.

- **Increased frailty and vulnerability.** Although the HSCP has succeeded in maintaining the vast majority of services throughout the pandemic we have been required to adapt provision and prioritise those in greatest need, particularly during the tightest lockdown restrictions. Some service areas have seen increasing levels of need, frailty and vulnerability among the individuals they are working with where lower level, preventative interventions have been reduced, and increased carer stress.

- **Impacts of ongoing Covid-19 restrictions.** It is unclear how long restrictions such as physical distancing will need to remain in place. These are impacting the way we are able to deliver our services, limiting the numbers of people we can bring into buildings and reducing face-to-face contact and group supports. Alternative approaches are in place and we will work with our partners to re-establish our services and preventative supports as soon as we can.

- **Impacts on the wellbeing and capacity on staff.** The Covid-19 pandemic has placed huge demands on the health and care workforce with frontline staff dealing with the immediate consequences of the pandemic and teams having to adjust to radically different ways of working. Staff teams have also had to work with reduced capacity as a result of sickness absence or staff self-isolating during the crisis. Given the level of stress staff are under and potential for staff to feel isolated it is essential that we continue to support staff resilience and connectedness.

### 4.2.2 Changes as a result of Covid-19

- **Changing patterns of service use.** The pandemic period has seen new ways that people engage with services with increased use of telephone and video contact. In some instances such as 'wellness calls' people have been able to engage with services in quicker and more convenient ways. We must ensure that we understand people's expectations and preferences when accessing services and make sure that any positive changes to service delivery are retained (while not excluding any groups e.g. those without access to digital technology).

- **Stronger communication across the partnership.** As a partnership the pandemic has brought into sharp focus our shared goals and the shared level of commitment across partner organisations. We have seen increasingly supportive working relationships between statutory, independent and third sector partners. There have been better lines of communication between health professionals, including access to expert consultant advice for GPs, other primary care professionals and care home staff.

- **High levels of community and third sector activity.** During 2020 we saw high levels of support and participation in our communities. We saw a local surge in residents offering their time as volunteers as well as informal support within neighbourhoods. The experience of the pandemic has reinforced the crucial role of the community and third sectors in delivering essential support to our residents.

- **Capacity for change and innovation.** Over the course of the pandemic we have seen incredible resilience, commitment and creativity from staff. We have seen innovation and collaboration, between partner organisations and with our communities. This capacity for change and innovation will underpin our activity as we move forward.

### 4.3 NHS Greater Glasgow and Clyde Remobilisation Plan 3 (2021-22)

Having produced a series of response and remobilisation plans over the course of the Covid-19 pandemic, NHS Boards were asked to produce an operational plan for the period 2021-22 reflecting planned activity in relation to key priority areas. Remobilisation Plan 3 covers a number of activity areas of particular relevance to the HSCP. This includes supporting staff wellbeing, recognising the importance of providing on-going support to promote both physical and psychological wellbeing over the coming year and looking to embed systems of support for the longer term.

The remobilisation plan sets out the approach to full remobilisation across adult services including the provision of advice, support and guidance to Care Homes, provision of services to support people in their own homes including care at home, respite and day care services, whilst ensuring that safety remains the top priority at all times. The plan is clear that lessons learned and innovative approaches developed during the pandemic, irrespective of setting, should be maintained and examples of best practice shared and adopted across IJBs.

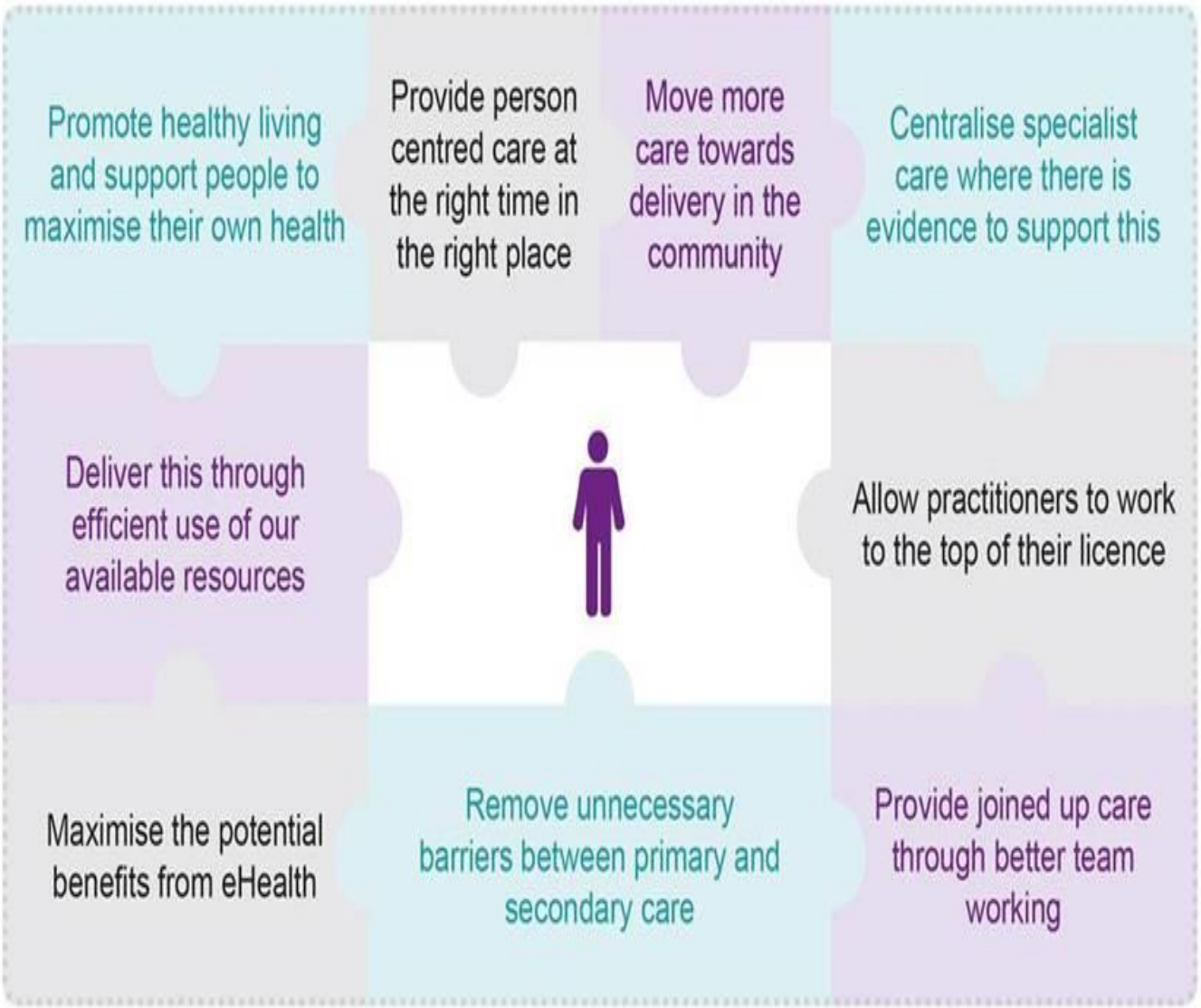
The plan supports the continuing safe delivery of (non-Covid) essential services in parallel with the response to Covid-19. It recognises that optimisation of self-care and an expansion of the role of primary care/community-based services will be a key element of the new "business as usual" following the pandemic. Key areas of activity include: enhancing the interface between primary and secondary care (including the development of Community Care and Treatment Room Services); sustaining Covid-19 pathways; primary care support to the essential roles/functions of care homes and care at home; responding to any increased demand for rehabilitation services (including potential impact of long Covid); and provision of key services in community including pain management, dentistry, and eye care.

Remobilisation Plan 3 supports a whole system approach to mental health and wellbeing in response to the mental health impacts of Covid-19, addressing the challenges that the pandemic has had, and will continue to have, on the population's mental health. In line with the national Coronavirus (COVID-19): Mental Health - Transition and Recovery Plan, the Scottish Government will support Boards and IJBs to remobilise services and to improve performance against the CAMHS and Psychological Therapies waiting times standards.

The plan aims to ensure that provision reflects the service user perspective and experience across the whole health and social care system, and is structured around patient/service user pathways rather than service boundaries. It seeks to address the health inequalities that have been exposed and exacerbated by the pandemic and, as appropriate, embed innovative practices and new ways of working that have been evident during the pandemic response.

## 4.4 Moving Forward Together

Moving Forward Together (MFT) remains the strategic document which describes the vision for future clinical and care services in Greater Glasgow and Clyde. The key principles established through MFT are summarised below:




Although the formal governance arrangements for MFT have been stood down due the pandemic, these priorities continue to be delivered in partnership between clinicians, service users and the public. There has been significant progress since the start of the pandemic in relation to: maximising the potential benefits from eHealth (with higher volume of remote consultations); centralising specialist care where there is evidence to support this; providing person centred care at the right time in the right place (through the redesign of urgent care and strengthening of pathways); and, removing unnecessary barriers between primary and secondary care (though the cross system approach to recovery and remobilisation planning).

## 4.5 Independent Review of Adult Social Care

On 1 September 2020 the First Minister announced that there would be an Independent Review of Adult Social Care in Scotland. The Review was chaired by Derek Feeley, a former Scottish Government Director General for Health and Social Care and Chief Executive of NHS Scotland. The principal aim of the review was to recommend improvements to adult social care in Scotland, primarily in terms of the outcomes achieved by and with people who use services, their carers and families; and the experience of people who work in adult social care. The independent review published its report on 3rd February 2021.

The report suggests a bold vision for adult social care support in Scotland building on the opportunity for meaningful change as we move beyond the Covid-19 pandemic.

***Everyone in Scotland will get the social care support they need to live their lives as they choose and to be active citizens. We will all work together to promote and ensure human rights, wellbeing, independent living and equity.***

It calls for new thinking and a new positive narrative around the role of social care support, recognising its 'foundational' importance in society and moving towards a human rights based approach.

| *Old Thinking* | *New Thinking* |
|---|---|
| *Social care support is a burden on society* | *Social care support is an investment* |
| *Managing need* | *Enabling rights and capabilities* |
| *Available in a crisis* | *Preventative and anticipatory* |
| *Competition and markets* | *Collaboration* |
| *Transactions* | *Relationships* |
| *A place for services (e.g. a care home)* | *A vehicle for supporting independent living* |
| *Variable* | *Consistent and fair* |

It also argues that we must strengthen the foundations of the social care system. This means: fully implementing positive approaches such as self-directed support and the integration of health and social care; as well as nurturing and strengthening our workforce and supporting unpaid carers.

The independent review calls for some structural changes such as the establishment of a National Care Service (NCS) with accountability for social care support moving from local government to Scottish Ministers. The proposed NCS would oversee improvements in the consistency, quality and equity of care and support. The report also suggests a reformed role for Integration Joint Boards in implementing the social care vision outcome measures, and delivering planning, commissioning/procurement, managing local GP contracts, as well as local planning and engagement.

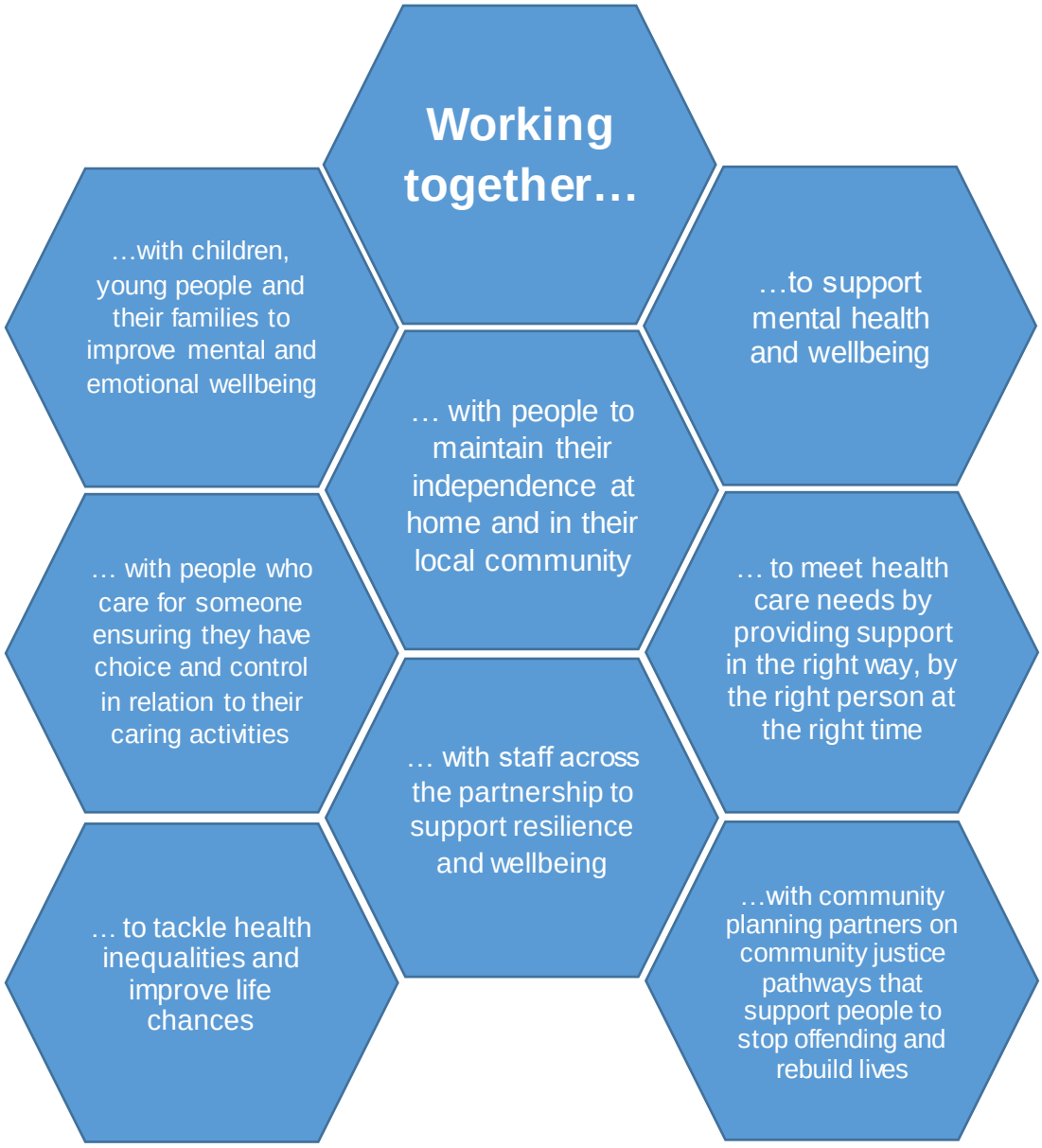
The report makes 53 wide-ranging recommendations in relation to the following priorities:

- Mainstreaming and embedding a human rights approach;
- Ensuring better, more consistent support for unpaid carers;
- Establishing a National Care Service (NCS) for Scotland;
- Establishing a new approach to improving outcomes through a National Improvement Programme for social care;
- Developing models of care;
- Commissioning for the public good through collaborative commissioning and a greater focus on people's needs;
- Developing fair work arrangements with national oversight;
- Improving investment with a focus on prevention rather than crisis response.

It is expected that the findings from the review will have significant impacts for the delivery of social care and wider supports moving forward. We will support any changes to policy/strategic approach that are adopted following the review and will look to include these in our strategic planning engagement for 2022 and beyond. During 2021-22 we will implement any recommendations or specific actions arising from the review as requested by Scottish Government.

## 5. Our strategic priorities

We have reviewed our performance in relation to the strategic priorities in our previous Strategic Plan, assessed our demographic profile and the lessons learned from the Covid-19 pandemic, and in consultation with key stakeholders we have reviewed our priorities for 2021-22. The majority of our high-level priorities remain unchanged but we have decided to widen our focus on mental health to include community wellbeing and have added a strategic priority relating to the wellbeing of our workforce.



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

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. Improving the mental and emotional wellbeing of children and young people will continue to be one of the highest priorities for East Renfrewshire Health and Social Care Partnership (HSCP) as we go forward in future years.

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. A co-production event which included children, young people and parents/carers supported relationship-based and nurturing approaches which bridge the gap between school and home. There was a shared view that in many instances help for a child or young person would be best placed in the context of the child's family network. From this it was agreed to develop a blended model of support which would incorporate new as well as existing approaches.

Over the past year the impact of the Covid-19 pandemic has exacerbated the circumstances of many children, young people and families, and we are now seeing a significant rise in the number of those experiencing challenges with their mental health and wellbeing. In response to this a multi-stakeholder Healthier Minds Service approach aligned to school communities has been developed to identify and ensure delivery of mental wellbeing support to promote children and families' recovery. This will work alongside our existing Family Wellbeing Service which links to GP practices and the CAMHS service.

In addition, our Healthier Minds Framework is an evidence-based guide for children, young people, families and practitioners, outlining ways to support mental wellbeing in a holistic way and provides information about service and resources that can help at different stages in time.

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". As outlined in the Children and Young People's Plan we will work in our role as Corporate Parents to ensure all care experienced children and young people have settled, secure, nurturing and permanent places to live, within a family setting.

| Our contributions to delivering this priority | Key activities during 2021-22 | How we will measure our progress |
|---|---|---|
| Improved support for vulnerable children<br><br>Increased confidence among parents most in need of support as a result of targeted interventions | Deliver family support to families that need it the most and that will enhance safe parenting, and reduce risks to children and young people<br><br>Support engagement and participation through East Renfrewshire Champions Board<br><br>Undertake scoping activity that quantifies the need for community resources for children and young people with additional support needs<br><br>Work in partnership with children, young people and their families to implement the recommendations of the Independent Review of Care Report (The Promise).<br><br>Offer Family Group Decision Making at the initial referral stage through Request for Assistance (s12 duties)<br><br>Embed the Signs of Safety practice principles across all child and family interventions<br><br>Fully implement new Scottish Child Interview Model (SCIM), alongside key partner agencies ensuring trauma informed support from referral to recovery. | % Looked After Children with more than one placement within the last year<br><br>% of children who are looked after away from home who have had a permanence recommendation within 6 months<br><br>% of children with child protection plans assessed as having an increase in their level of safety<br><br>% of children subject to child protection who are offered advocacy service |

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

We will continue to work together to ensure as many East Renfrewshire residents as possible can maintain their independence at home, during the pandemic and recovery period in 2021-22.

We are aware that many older people, shielding residents and those who live alone have become more isolated and had less opportunities for leisure, exercise and social activities. At the same time, the response to the pandemic has demonstrated the resilience of our community-based supports with teams of volunteers and staff keeping touch with the most vulnerable and isolated, notably through the Community Hub. We want to build on this joint working going forward 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. With our partners we will support digital inclusion and the roll out of the AskSARA web based assessment and advice on equipment and solutions to support daily activities. In line with the NHSGGC Remobilisation 3 Plan we will support the increased use of digital technology, telephone and Near Me technology to support remote consultations and enable services to continue seeing patients in new ways.

We will continue to review and embed our outcome-focused assessment tool and our new individual budget calculator and ensure that people who require support have as much choice and control as they wish in relation to their supports. We will work with our partner providers and in-house services to support them to develop their business/service plans to adapt to these new approaches. As we recover from the pandemic we 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.

As more people live longer with more complex conditions it is important that we work collaboratively with housing to support independent living in our communities. We have committed to work with colleagues in East Renfrewshire Housing Services and local housing providers to better understand local needs and discuss future models of housing, technology and support.

| Our contributions to delivering this priority | Key activities during 2012-22 | How we will measure our progress |
|---|---|---|
| Support more people to stay independent and avoid crisis though early intervention work<br><br>Ensure the people we work with have choice and control over their lives and the support they receive. | Promote the range of local supports and opportunities available through the Community Hub and Talking Points<br><br>Promote the use of AskSARA and other digital opportunities that support independence<br><br>Support use of digital technology, telephone and Near Me technology<br><br>Improve links and pathways between our rehabilitation and re-ablement services<br><br>Review and refresh our roll out of individual budget calculator and access to self-directed options<br><br>Commence work with local care providers in responding to National Social Care Review recommendations<br><br>Work with housing providers to refresh our housing need assessment and consider future housing opportunities | Number of people engaged though Talking Points events and support<br><br>Referrals to preventative support through Talking Point engagement<br><br>% of people whose care need has reduced following re-ablement/rehabilitation<br><br>Number of people self-directing their care through receiving direct payments and other forms of self-directed support.<br><br>Percentage of people reporting 'living where you want to live' needs fully met.<br><br>% of people aged 65+ with intensive needs receiving care at home<br><br>Percentage of people aged 65+ who live in housing rather than a care home or hospital |

## Working together to support mental health and wellbeing

Our previous strategic priority had a focus on recovery for people experiencing mental ill health. In response to the impact of the pandemic we are extending this priority to working together to support mental health and wellbeing across our communities.

The pandemic has tested everyone's emotional resilience, and will continue to do so. Many of us have been anxious or worried about our health, our family and friends, and changes to our way of life. Some individuals, families and communities have found the past few months really tough. During 2020/21 we want to see a continued focus 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.

Covid-19 has created many challenges. During the pandemic we developed new approaches and ways of working that we can build on to help meet the demands on us going forward as we support good mental health and wellbeing, help people manage their own mental health, and build their emotional resilience.

We will continue to work in partnership with people who use services, carers and staff to deliver the Greater Glasgow and Clyde Five Year Strategy for Adult Mental Health Services. 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 test and develop the impact of lived experience in the delivery of services such as peer support and its contribution to individual's recovery journeys, alongside formal services.

We have committed to working together with community planning partners on activities that support mental wellbeing and resilience across our communities, with Voluntary Action taking a leading role. As we recover during 2021-22, we will support the promotion of positive attitudes on mental health, reduce stigma and support targeted action to improve wellbeing among specific groups. Supporting the wellbeing and resilience of our staff and volunteers is critical to ensuring they can support residents effectively. We will continue our partnership working with primary care and Recovery Across Mental Health in which link workers in all of our GP practices offer social and psychological interventions to improve wellbeing.

| Our contributions to delivering this priority | Key activities during 2021-22 | How we will measure our progress |
|---|---|---|
| A range of supports for individuals on their journey to recovery from mental ill-health<br><br>A strong partnership approach to enhancing wellbeing through prevention and early intervention<br><br>Staff and volunteers with the skills, knowledge and resilience to support individuals and communities | Ensure appropriate access to primary mental health services<br><br>Develop and deliver the programme of activity supported by Action 15 funding<br><br>Implement the priorities set out in the Greater Glasgow and Clyde Mental Health Strategy in East Renfrewshire and the Coronavirus mental health - transition and recovery plan<br><br>Support holistic link worker service through all GP practices<br><br>Develop local peer support service<br><br>Reflect and build on innovative ways services have been delivered during the pandemic (including digital solutions)<br><br>Support mental health and wellbeing interventions delivered through local wellbeing partnership activity | Percentage of people waiting no longer than 18 weeks for access to psychological therapies<br><br>Mental health hospital admissions (age standardised rate per 1,000 population)<br><br>Positive outcomes for individuals supported through link worker interventions<br><br>Positive outcomes for individuals receiving peer support<br><br>*Wellbeing measures – to be agreed* |

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

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. This should allow local GPs to spend more time in clinically managing patients with complex care needs.

During the pandemic we have strengthened the partnership and opportunities for shared clinical conversations between the consultants and clinical leaders in hospitals and GP as the expert medical generalists in the community. The vision set out in NHSGGC Remobilisation 3 Plan 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.

We are working together with HSCPs across Glasgow, primary and acute services to support people in the community, and develop alternatives to hospital care. Over the next few months we will be finalising our joint strategic commissioning plan which outlines improvements for patients to be implemented over the next five years. For 2021/22 we have committed to a number of immediate actions that support this strategy and can be delivered a shorter timescale.

Our joint programme outlined is focused on three key themes:

- **early intervention and prevention** of admission to hospital to better support people in the community;
- **improving hospital discharge** and **better** supporting people to transfer from acute care to community supports;
- **improving the primary / secondary care interface** to better manage patient care in the most **appropriate** setting.

| Our contributions to delivering this priority | Key activities during 2012-22 | How we will measure our progress |
|---|---|---|
| Early intervention and prevention of admission to hospital to better support people in the community<br><br>Improved hospital discharge and better support for people to transfer from acute care to community supports<br><br>Improved primary / secondary care interface to better manage patient care in the most appropriate setting | Complete the implementation of the local Primary Care Improvement Plan<br><br>Improve quality and quantity of Anticipatory Care Plans and Emergency Care Information Summaries<br><br>Progress local out of hours response arrangements to support implementation of Urgent Care Resource Hub.<br><br>Implement discharge to assess protocol.<br><br>Improve process for AWI patents learning from mental welfare commission recommendations and GGC wider review<br><br>Develop and test enhanced community support and intermediate care models in partnership with HSCPs across Glasgow<br><br>Continue support to local care homes and other supported living providers through safety and professional assurance arrangements. | No. of A & E Attendances<br>Number of Emergency Admissions<br>A & E Attendances from Care Homes<br>Emergency Admissions from Care Homes<br>Occupied Bed Days (Adult – non-elective)<br><br>People waiting more than 3 days to be discharged from hospital<br><br>Bed days lost to delayed discharge<br><br>% of last six months of life spent in Community setting<br><br>*Percentage of people admitted to hospital from home during the year, who are discharged to a care home*<br>*Number of clients supported into intermediate care* |

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

We recognise that carers have been significantly impacted by the pandemic and changes to a range of supports. Unpaid carers have also taken on increased caring during this time and have faced additional pressures. Over 2021/22 we need to move to recovery and make sure that the right supports and services are in place for carers. The work of the Care Collective has demonstrated how we need to strengthen our approach to involving carers through the planning process and with identifying the outcomes that matter to them.

Our Carers Strategy maps how we will work together with partners to improve the lives of East Renfrewshire's carers. Through local engagement and discussion we know that we need to develop our workforce, pathways and supports for Carers. We had commenced work on this prior to the pandemic and will review and refresh this activity as part of our recovery work this year

We have committed to working together with East Renfrewshire Carers Centre to improve access to accurate, timely information. We will continue to encourage collaboration between providers of supports to carers ensuring local provision best meets carers needs and any infection control requirements. We will provide information and training to raise awareness of the impact of caring responsibilities. We will continue to support the expansion of personal 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.

Sadly, many people have lost loved ones as a result of Covid-19. Bereavement is amongst the most difficult challenges any of us will ever experience and the circumstances and restrictions of the pandemic have made this even harder. We will work with our partners to ensure relevant help and support is available to those who have experienced bereavement over the last year.

| Our contributions to delivering this priority | Key activities during 2021-22 | How we will measure our progress |
|---|---|---|
| Staff across the partnership are able to identify carers and value them as equal partners<br><br>Carers can access accurate information about carers' rights, eligibility criteria and supports<br><br>More carers have the opportunity to develop their own carer support plan | In partnership with Carers Centre provide information and training to raise awareness of the impact of caring and requirements of Carers Act.<br><br>Publicise our clear prioritisation framework (eligibility criteria) for support and implement consistently<br><br>Ensure that carers and support organisations are aware of the scope and different types of respite care and short-break provision available<br><br>Work with providers to review and modernise our approach to respite and short term breaks in light of Covid-19 requirements<br><br>Develop tools and supports to help carers identify the impact of their caring role during the pandemic and recovery and plan how best to meet their needs<br><br>Work with partners to ensure supports are available to carers to minimise the impact of financial hardship as a result of caring during the pandemic.<br><br>Implement carers' support planning including planning for emergencies with individual carers. | Percentage of carers who feel supported to continue in their caring role. (NI8)<br><br>People reporting 'quality of life for carers' needs fully met (%)<br><br>Carers supported to develop their own personal support plans |

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

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 criminal 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 identify and develop opportunities for the unpaid work element of community payback orders to meet the needs of the local community.

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 criminal justice system have access to the services they require, including welfare, health and wellbeing, housing and employability.

We are aware of the impact of lockdown on people experiencing domestic abuse. As part of our community planning work to protect people from harm and abuse, we have established and will continue to support a Multi-Agency Risk Assessment Conference (MARAC) in East Renfrewshire for high-risk domestic abuse victims. During the pandemic we have seen higher numbers of referrals to MARAC and greater levels of complexity in the cases being dealt with. We will ensure that all high-risk domestic abuse victims and children have multi agency action plans in place to reduce the risks posed to them by perpetrators. We will work together with East Renfrewshire Women's Aid Service to provide direct support for women and children who have experienced domestic abuse.

| Our contributions to delivering this priority | Key activities during 2021-22 | How we will measure our progress |
|---|---|---|
| People have improved access to through care and a comprehensive range of recovery services.<br><br>The risk of offending is reduced though high quality person centred interventions | Using appropriate assessment tools to identify risk and need<br><br>Delivering a whole systems approach to diverting both young people and women from custody<br><br>Delivering accredited programmes aimed at reducing reoffending<br><br>Working with local partners to ensure a range of beneficial unpaid work placements are taken up | % of people reporting community payback order helped to reduce their offending<br><br>Offenders completing unpaid work requirements<br><br>Positive employability and volunteering outcomes for people with convictions |
| Effective arrangements are in place to identify and manage risk<br><br>Effective interventions are in place to protect people from harm | Providing a range of services for women who experience domestic abuse<br><br>Working in partnership with people at risk of harm to assess their needs and provide appropriate support | Change in women's domestic abuse outcomes<br><br>People agreed to be at risk of harm have a protection plan in place |

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

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.

The significance of health inequalities has been brought into even sharper focus as a result of the Covid-19 pandemic. 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. We will support equalities activities being taken forward under NHSGGC Remobilisation 3 including mainstreaming of changes shown to be effective in reducing inequalities.

This priority also reflects our longer-term ambitions for East Renfrewshire. 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 contributions to delivering this priority | Key activities during 2021-22 | How we will measure our progress |
|---|---|---|
| Increase in activities which support prevention and early intervention, improve outcomes and reduce inequalities.<br><br>Health inequalities will be reduced by working with communities and through targeted interventions | Work to understand and address longer term impacts of Covid-19 on our communities and particular groups<br><br>Work in partnership to build the capacity of community organisations, groups and individuals to deliver their own solutions for recovery from the coronavirus pandemic<br><br>Deliver tailored health improvement programmes and activities in communities with greater health inequalities and disproportionate effects of Covid-19<br><br>Continue to support local activity to tackle Child Poverty and its effects<br><br>Work to ensure people in our most disadvantaged community are able to access digital opportunities that support independence and wellbeing<br><br>Working with our partners in Culture and Leisure to plan recovery of our Ageing Well programme where safe to do so<br><br>Implement the Maternal and Infant Nutrition Framework | Male life expectancy at birth in 15 per cent most deprived communities<br>Female life expectancy at birth in 15 per cent most deprived communities<br>Premature mortality rate per 100,000 persons aged under 75.<br><br>% increase in exclusive breastfeeding at 6-8 weeks in most deprived SIMD data zone |

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

In consultation with staff and stakeholders we have added support for resilience and staff wellbeing as a new strategic priority for 2021-22. Working together with staff and our partners we will develop and deliver a series of positive measures to promote staff wellbeing during the year.

Responding to Covid-19 has tested us in in ways we have never experienced before. The people who comprise the health and social care workforce have gone above and beyond to deliver much needed care to individuals under incredibly difficult circumstances. While these challenges are constantly evolving, we continue to rely on the workforce to support all aspects of health and social care and their wellbeing and resilience has never been more important.

The HSCP has identified a health and wellbeing champion who contributes to discussions at a national level. 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 drafted a wellbeing plan entitled 'You care….We care too.' The plan identifies four strategic objectives / outcomes and a supporting action plan. The objectives are given below. We will work to ensure that this priority is delivered across the wider partnership with advice, support and activities made available as widely as possible.

- Overview and Communication - Staff have access to resources and information that can improve their wellbeing;
- Resilience and connectedness - Build resilience across HSCP ensuring all employees feel connected to their team or service and embed health and wellbeing culture across HSCP;
- Promotion of physical activity, rest and relaxation - Opportunities for staff to take part in physical activity are promoted across the HSCP and opportunities for rest and relaxation are provided;
- Staff feel safe in their workplace - Appropriate measures are in place to ensure staff feel safe in the workplace.

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 contributions to delivering this priority** | **Key activities during 2021-22** | **How we will measure our progress** |
|---|---|---|
| Staff have access to resources and information that can improve their wellbeing<br><br>Staff feel connected to their team or service and we embed a health and wellbeing culture across the partnership<br><br>Opportunities are promoted for staff to take part in physical activity, rest and relaxation<br><br>Staff feel safe in the work place | Ensure that all staff have access to universal information with regard to health and wellbeing across the partnership's services, including staff working from home and shielding<br><br>Develop leadership competencies across management in order to focus on resilience across the partnership<br><br>Ensure regular wellbeing conversations with staff and teams<br><br>Promote relaxation and physical activity opportunities across the partnership<br><br>Ensure all physical environments are adapted to be Covid-19 compliant | Number of activities promoted<br><br>Participation rates in health and wellbeing activities for staff<br><br>*iMatter / pulse survey feedback from staff – ongoing development.* |

## 6. Long-term strategic planning

This Strategic Plan is a one-year 'bridging' plan covering the 12 month period that will see us moving through our emergency response to the Covid-19 pandemic. Due to the exceptional circumstances we have temporarily moved away from producing a longer-term 3 year plan but will return to this approach for 2022-25.

We wish to take a collaborative approach to our long-term strategic planning driven by our multi-agency Strategic Planning Group. This will mean that over the course of 2021 and into 2022 we want to engage in conversations about future priorities for change. We will also look to refresh the more detailed plans that support the implementation of our Strategic Plan including our Medium-Term Financial Plan, Strategic Commissioning and Market Shaping Plan, and a range of thematic and service-specific plans. Our engagement with residents and partners in developing this work will be in accordance with the principles and approaches set out in our recently revised Participation and Engagement Strategy.

# Appendix One - Financial context 2021/22

## Context

The context for setting the budget for 2021/22 is unique, possibly as far from a "normal" year as we have ever been. The baseline for activity and demand that we would normally work to is significantly different and we need to continue working to shape our services on our post Covid recovery; recognising we are not there yet and still have many unknowns to face.

The IJB has recognised we will need to adopt an evolutionary approach to financial planning and service delivery during 2021/22 and to support this we will need to move away from longer term planning to short term, scenario plans informed by our recovery and emerging issues, allowing for some capacity to adapt and react to an ever changing environment. A flexible transformation programme will be pivotal to provide a framework and governance structure to allow us to work through this in a controlled and informed manner.

Our workforce is an incredible asset and have clearly demonstrated not only their commitment but also their ability to flex and adapt to new ways of working with minimal notice. We will continue to build on the lessons learned through the pandemic and from our earlier recovery work.

We will continue to work closely with our partner care providers who are fundamental to many aspects of our service delivery. We intend to build on and strengthen the solid relationships we already have in place.

The Scottish Government Budget settlement for 2021/22 is for one year only and it is expected that from 2022/23 there will be a return to multi-year budget settlements. This will improve certainty for future medium term financial planning.

The recommendations made in the Independent Review of Adult Social Care may have further significant impact on our service delivery and financial position should this progress and we should be clearer on any intent following the Scottish Parliament elections in May 2021.

## Our Opening Budget and Financial Challenge

The IJB agreed the budget for 2021/22 on 17 March recognising a number of issues will be refined as outstanding elements are agreed and as we work through our post Covid recovery. The financial challenge is significant. The table below summarises our opening budget position:

| | Opening Budget<br><br>£m | Uplifts & Other Increases<br>£m | Savings & Other Deductions<br>£m | Proposed Budget<br><br>£m | Net Change<br><br>£m |
|---|---|---|---|---|---|
| NHSGGC Revenue Contribution | 72.813 | 0.730 | (0.039) | 73.504 | 0.691 |
| NHSGGC Set Aside | 32.160 | 0.482 | 0 | 32.642 | 0.482 |
| ERC Revenue Contribution | 51.313 | 4.186 | (1.794) | 53.705 | 2.392 |
| ERC Aids & Adaptations | 0.400 | 0 | 0 | 0.400 | 0 |

Note: Criminal Justice grant funded at £0.614m is an increase of £0.008m.

In addition to the new savings target included in the above at £1.794 million we also have legacy savings brought forward from 2020/21 of £2.394 million. We did not have capacity to work towards achieving all our savings in 2020/21 as our focus was on the pandemic response and the savings we were unable to work on were:

| | £m |
|---|---|
| Adult Care packages – reviews | 0.100 |
| Interim Income – based on nursing & residential activity in prior period | 0.100 |
| Inflation revision - potential gain from assumptions | 0.160 |
| Discretionary Spend Moratorium | 0.120 |
| Digital Efficiencies | 0.250 |
| Individual Budget Calculator – criteria and contribution | 1.664 |
| Total | 2.394 |

Unachieved savings are recognised in our Covid-19 funding from the Scottish Government through our mobilisation plans and we have received 100% support for this during 2020/21.
When we set the budget for 2020/21 we recognised we would not have plans in place from 1 April 2020 to deliver a full year effect of the savings and we would utilise our budget savings reserve to phase in the saving throughout the year; in line with our agreed strategy; determined by our approach to achieving the not insignificant savings in previous years.

That strategy still stands, albeit deferred for one year however other events have clearly overtaken us; the Covid-19 pandemic, the impact of further significant new savings and the implications that may result from the recommendations within the National Review of Adult Social Care that could effectively handcuff our previous approach to review criteria and implement a non-residential individual contribution.

Taking into account the cumulative savings challenge the table below sets out a summary of our cost pressures, the funding available to meet these pressures and the savings challenge to close the funding gap.

| Revenue Budget | ERC £'000 | NHS £'000 | TOTAL £'000 |
|---|---|---|---|
| **1. Cost Pressures:** | | | |
| Pay Award and Incremental Increases | 1,021 | 307 | 1,328 |
| Inflation, Contracts and Living Wage | 2,304 | 239 | 2,543 |
| Demographic and Demand Pressures | 803 | 100 | 903 |
| Prescribing based on a 1.5% pressure only | | 237 | 237 |
| Other | 58 | | 58 |
| 2021/22 New Savings | 1,794 | | 1,794 |
| 2020/21 Legacy Savings | 2,394 | | 2,394 |
| **Total Pressures** | **8,374** | **883** | **9,257** |
| | | | |
| **2. Funding available towards cost pressures** | **4,186** | **691** | **4,877** |
| | | | |
| **3. Unfunded Cost Pressures** | **4,188** | **192** | **4,380** |
| | | | |
| 4**. Proposals to Close Funding Gap:** | | | |
| Learning Disability Bed Model Framework | | 100 | 100 |
| Freeze uplift on non-pay – manage through efficiency | 150 | 61 | 211 |
| Property Savings – lease and other | 120 | | 120 |
| Travel and other running costs | 60 | 31 | 91 |
| Budget Saving – phasing in of reserves | | | |
| In year Pressures | | | |
| | | | |
| **Total of Identified Savings** | **330** | **192** | **522** |
| | | | |
| **5. Remaining Recurring Funding Gap** This will need to be met from Transformation Programme and potentially still consider care packages: revise individual budget calculator to reflect prioritisation based on national criteria. Mitigate in part on a non-recurring basis through reserves. | **3,858** | **0** | **3,858** |
| **Application of Budget Phasing and in Year Pressure Reserves** (balances expected as at January 2021) | **1,419** | **0** | **1,419** |
| **In year Gap to Fund** (subject to any further Covid-19 funding) | **2,439** | **0** | **2,439** |

There are a number of assumptions and provisions included above that will be refined as each issue crystallises and the associated cost implication refined. The post Covid-19 impact on the health and wellbeing of our population is still unclear and we will closely monitor the provision we have identified for demographic pressures not only to determine the application but also the sufficiency.

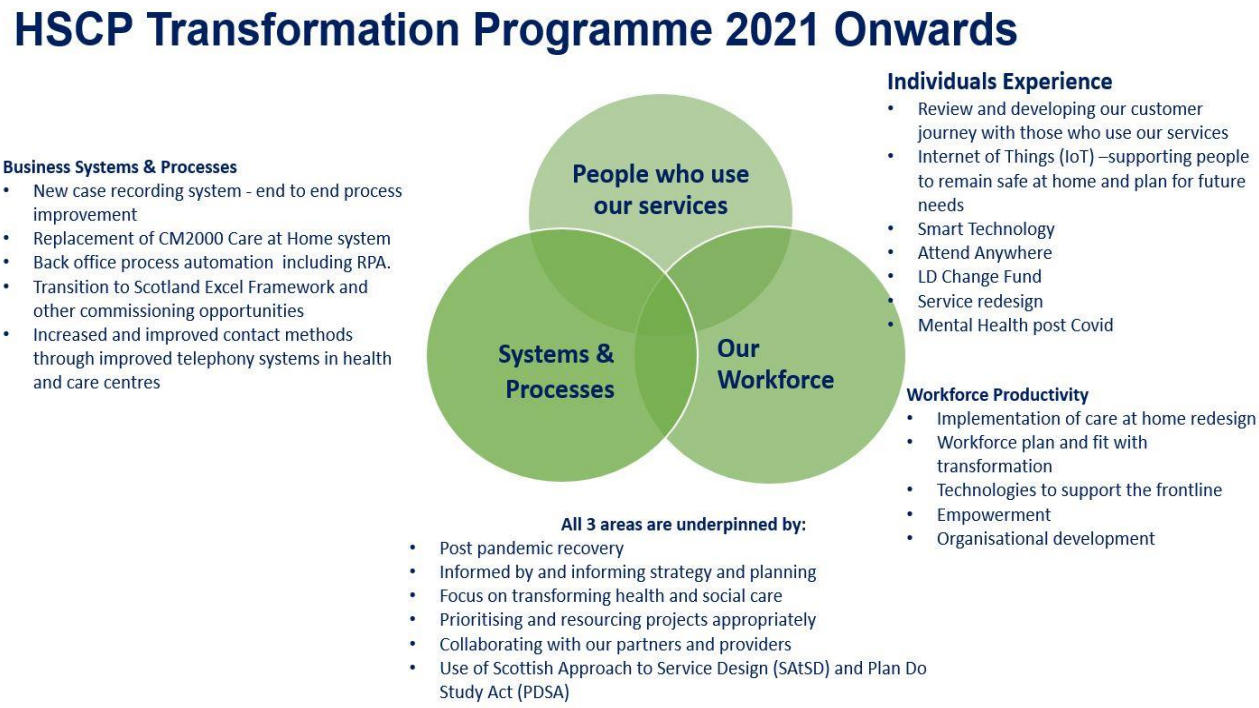
In addition to the earmarked reserves referred to above the IJB may also need to un-hypothecate other earmarked reserves and utilise our general reserve of £0.272 million to help get us through 2021/22.

We may receive additional Covid-19 funding during 2021/22 to support ongoing activity and if so it is hoped that this will extend to unachieved savings; on the same basis as 2020/21 we do not have the immediate capacity to work on this. The total COVID related activity for which we received support for in 2020/21 was c£9 million.

In the event we are unable to deliver the full savings required during the year through a combination of recurring and non-recurring actions or be in a position where we are unlikely to have full year effect savings in place by 31 March 2022 we may need to invoke the financial recovery process included within our Integration Scheme.

## Transformation

We will not deliver this magnitude of savings by "doing more of the same" and will undertake a radical transformation programme:




The programme will build on lessons learned during the pandemic as well as our earlier steps towards recovery and will take into account any policy decisions resulting from the Scottish Parliament election. The programme will need to align to, inform and be informed by our strategic plan as well as ensuring fit with system wide work.

There is little doubt that the proposed 2021/22 budget will be incredibly challenging to deliver and will leave us with little, if anything, in reserve for unforeseen circumstances or forward investment opportunity to develop our next strategic plan. However we do not know what the implications will be following the national election in May 2021 for the recommendations made in the National Review of Adult Social Care and given this

recognises the need for investment there could possibly be future changes to our financial position.

## Risk

The most significant risk to the IJB remains sustainability and delivering a balanced budget in 2021/22 and beyond. The IJB will most likely deplete reserves and this means we will be non-compliant with our policy on reserves. We may not meet our population's demand for services and may need to invoke the financial recovery process with our partners.

The post Covid-19 impact on our population and the impact on the demand for services and how these can be delivered is unclear. There may still be impact from Brexit. The implementation or otherwise of the National Review of Adult Social Care following the outcome of the Scottish Parliament elections in May 2021 is unknown.

We need to adequately resource our Transformation Programme if we are to achieve a successful plethora of changes and there is likely to be continued competing demand for fairly scarce resources, both internally within the HSCP and when trying to recruit to any vacancies.

There remains a cost pressure within the Learning Disability In-Patient Service from significant observation resource requirements.

## Equalities

We will complete full equalities impact assessments for all transformation work streams and savings proposals for the IJB to consider alongside proposals. This should ensure that no individual or groups are adversely impacted and that implementation of change is equitable.

There will need to be appropriate engagement and communication and we will need to be mindful of any "double hits" with potential for crossover within work streams or multiple impacts; this will require close scrutiny