East Renfrewshire Health and Social Care Partnership

Annual Performance Report

2020/21

Contents

Chief Officer's Foreword

In East Renfrewshire we have been leading the way in integrating health and care services since 2006, and our Health and Social Care Partnership (HSCP) continues to deliver a wide range of high quality services to local people. Along with community health and care services, we provide health and social care services for children and families and criminal justice social work.

2020-21 has been one of the most significant years in the 15 year history of the partnership as we worked to negotiate the challenges presented by the Covid-19 pandemic. Responding to the crisis has tested us in in ways we have never experienced before. Since lockdown restrictions were introduced in March 2020 our ways of working have changed significantly and as we work to build back better we are committed to taking forward new approaches that are delivering positive outcomes for local people.

In East Renfrewshire we have built a strong and lasting partnership with our communities and our third and independent sector partners. Our experiences over the Covid-19 pandemic have reinforced the benefits of working together as a broad and inclusive partnership. As we move beyond the pandemic the HSCP will work to further strengthen these supportive relationships and our commitment to this approach will be reflected in our next Strategic Plan.

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 the pandemic. As we take our partnership forward we must extend beyond traditional health and care services to a long-term meaningful partnership with local people and carers, volunteers and community organisations.

The bedrock of our partnership is the dedication, skills and creativity of our staff and these attributes have carried us through the pandemic ensuring that our most vulnerable residents have continued to receive safe and effective care and support over the year. I wish to once again thank all the staff, partners and individuals in the HSCP and in the community more widely, for the enormous effort that they have made to maintain services to the people we support during this challenging period.

This is our fifth Annual Performance Report. It gives a broad overview of the progress we have been making to deliver the priorities set out in our second Strategic Plan and highlights the many innovative approaches we have taken during the pandemic. While the report describes many exceptional areas of work undertaken in the past year, it can only partly do justice to the incredible effort we have seen from our teams and individual members of staff.

The HSCP is currently engaging with communities and stakeholders for the development of our Strategic Plan for 2021-24. Along with the development of our Recovery and Renewal Programme this is a great opportunity for us to reflect on our experiences during the pandemic and the best approaches for support East Renfrewshire residents in the future.

Julie Murray - Chief Officer, East Renfrewshire HSCP

1. Introduction

1.1 Purpose of Report

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

This is the fourth report for the East Renfrewshire Integration Joint Board. It sets out how we delivered on our vision and commitments over 2020-21. As required, we review our performance against agreed local and national performance indicators and against the commitments set out in our second Strategic Plan, which covers the period 2018-21. The report looks at our performance during an exceptional 12 months period that saw teams having to change approaches due to Covid-19 and reprioritise work to focus on our pandemic response and support residents with most urgent need. As such our performance outcomes for the period are different from those previously predicted. In our discussion of performance we seek to include as much information as possible on the additional activities undertaken, although we recognise the challenge in doing justice to the incredible efforts of individuals and teams during 2020-21.

The main elements of the report set out:

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

1.2 Our Covid-19 response

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

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

The HSCP provides care, support and protection for people of all ages, to enhance their wellbeing and improve outcomes for them as children, young people, families and adults. Over the course of 2020-21, our teams in collaboration with our partners and communities have continued to deliver this work in the most unprecedented and challenging times throughout the Covid-19 pandemic. This has involved responding to higher demands for support, supporting individuals with higher levels of emotional distress, complex needs and limited informal support networks. Out teams have responded compassionately, creatively and with an unwavering commitment to improve outcomes for the individuals and families we support.

Our strong local partnerships have responded with great innovation and greater collaborative working with and in support of our local communities. During the pandemic we established

and ran a local Community Assessment Centre for people with respiratory problems. We successfully distributed high volumes of essential PPE supplies and have delivered an enhanced flu vaccination programme and Covid-19 vaccination programme. We have developed and coordinated many services and supports to care homes, who have been caring for some of our most vulnerable residents.

To support the wider wellbeing needs of our residents we worked in partnership to support the development of a Community Hub which has supported residents to access information and signposted to local community supports as well as establishing new shopping and prescription delivery service. It also responded to the growing need for social contact by those who were reporting feeling isolated, especially those who were shielding. With our colleagues in education we set up the Healthier Minds service to respond to the mental wellbeing of our children and young people.

Our Covid-19 response activity has happened in addition to our planned operational priorities. Much of the performance data for 2020-21 reflects the direct impact of the pandemic on operational activity and changed behaviours among the population during lockdowns and the pandemic period more generally.

The data shows that despite the significant challenges of the Covid-19 pandemic we have continued to support our most vulnerable residents and have performed well against many of our outcome-focused performance indicators. We have seen some service areas more directly impacted by restrictions and areas where patterns of demand have shifted significantly during the reporting period. Through our recovery and renewal planning and the development of our next strategic plan we will ensure that our priorities and approaches meet the changing needs of our population.

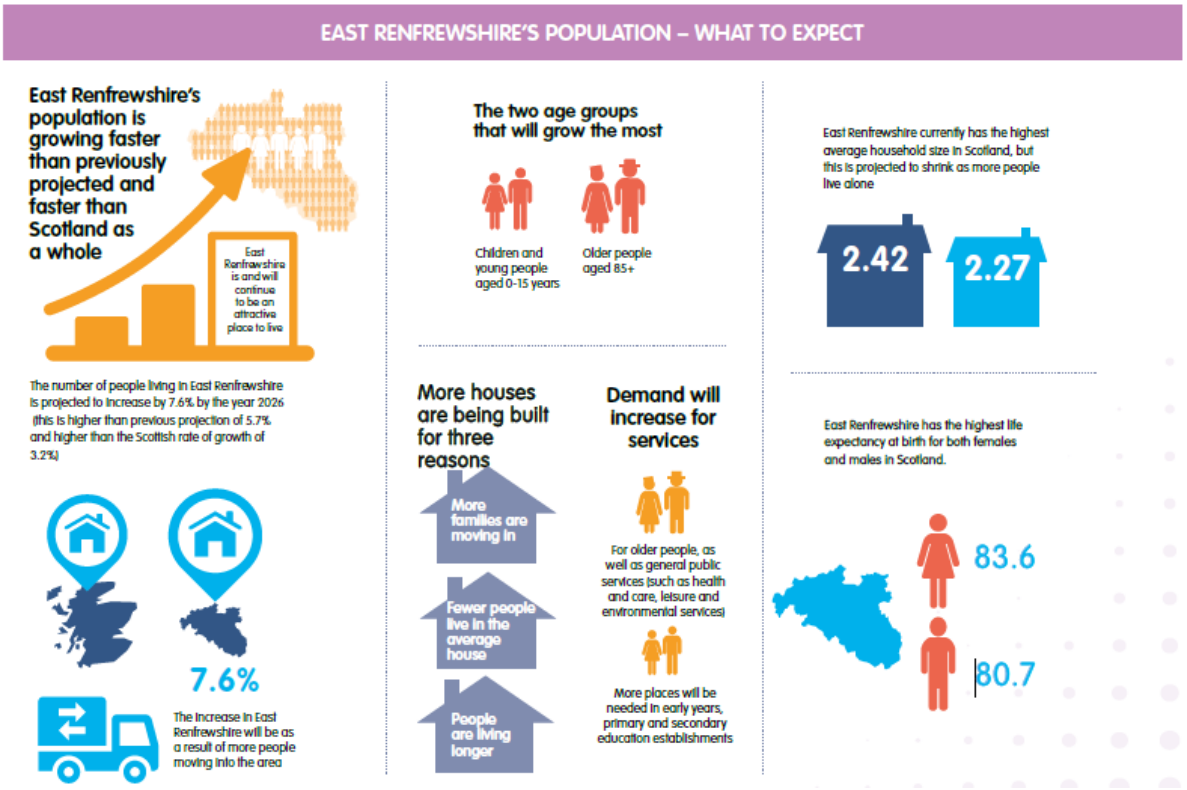
1.3 Local context

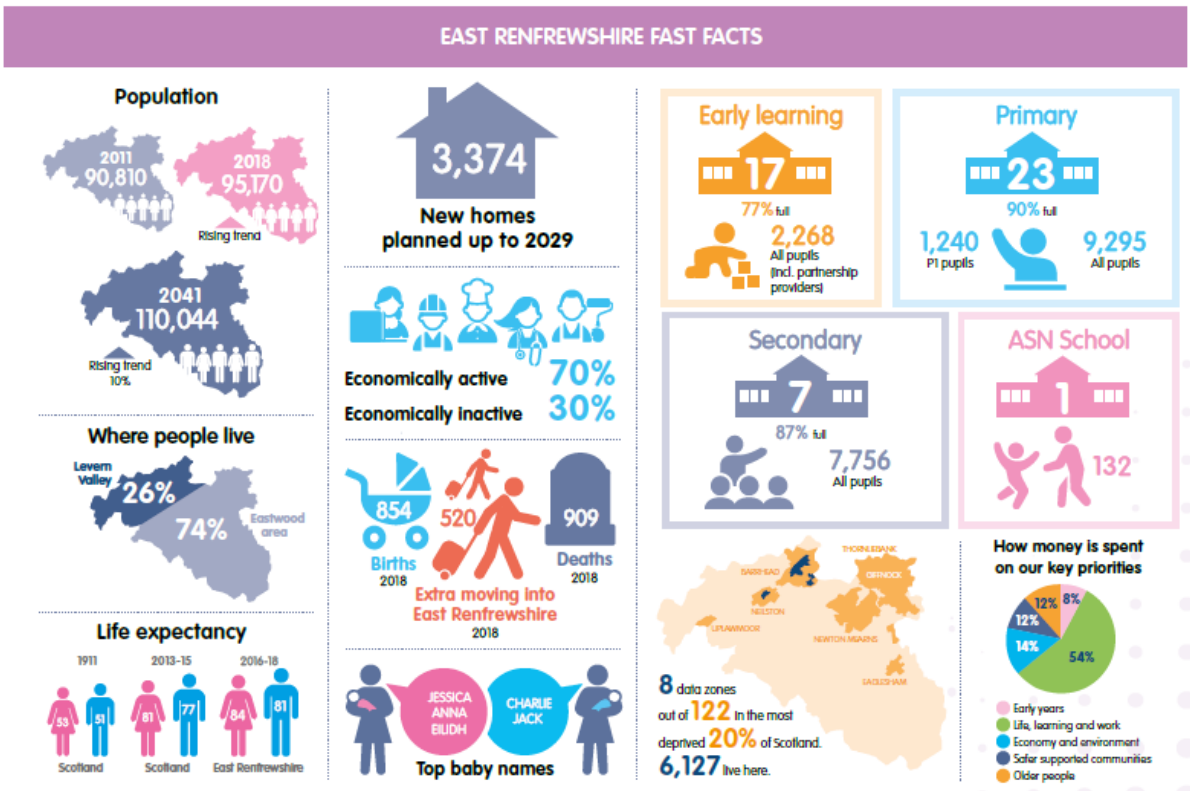
East Renfrewshire covers an area of 174 square kilometres and borders the city of Glasgow, East Ayrshire, North Ayrshire, Renfrewshire and South Lanarkshire.

Our population continues to grow and reached 96,060 in 2020. 74% of the population live in the Eastwood area (Busby, Clarkston and Williamwood, Eaglesham and Waterfoot,

Giffnock, Netherlee and Stamperland, Newton Mearns and Thornliebank) and 26% live in the Barrhead area (Barrhead, Neilston and Uplawmoor).

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





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

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

During the last 15 years our integrated health and social care management and staff teams have developed strong relationships with many different partner organisations. Our scale and continuity of approach have enabled these relationships to flourish. We have a history of co-production with our third sector partners and we are willing to test new and innovative approaches.

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

1.4 Our Strategic Approach

1.4.1 Our Strategic Vision and Priorities

In East Renfrewshire we have been leading the way in integrating health and care services. From the outset of the CHCP we have focused firmly on outcomes for the people of East Renfrewshire, improving health and wellbeing and reducing inequalities. Under the direction of East Renfrewshire's IJB, our new HSCP builds on this secure foundation. Throughout our integration journey during the last 15 years, we have developed strong relationships with many different partner organisations. Our longevity as an integrated partnership provides a strong foundation to continue to improve health and social care services.

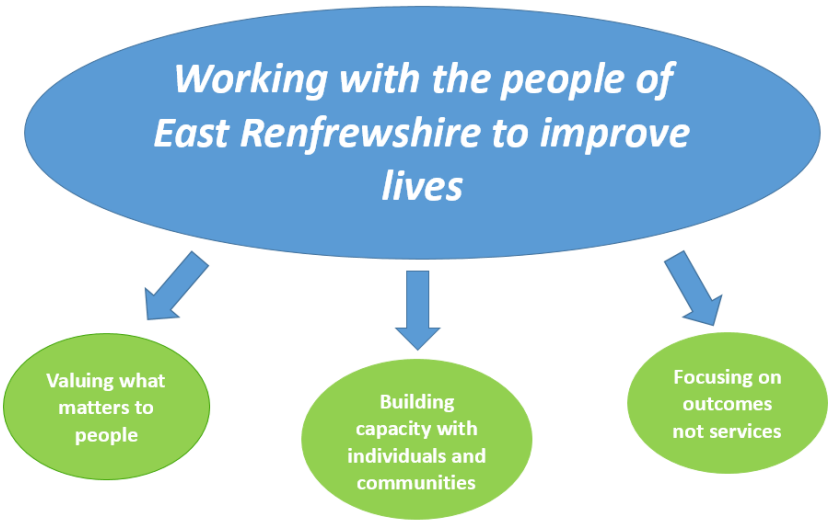
Our Vision

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

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

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

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



Our Strategic Plan

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

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

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

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

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

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

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

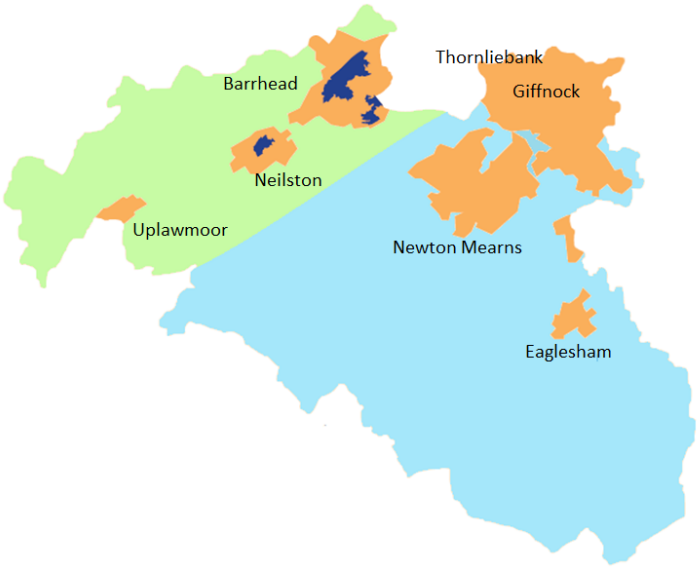
Recognising the ongoing pressures as we continue our response and recovery from the Covid-19 pandemic and the current level of dynamism in the health and social care sectors, the partnership has chosen to establish and interim one-year Strategic Plan for 2021-22. The interim plan builds on the seven priorities listed above and adds a further priority to support resilience and wellbeing among staff across the wider partnership. During the current financial year we are undertaking engagement and needs assessment work to support the development of our next three-year Strategic Plan for 2022-25. We plan to do this in collaboration with people who use our services, family carers and local partners. A draft plan will be produced for public consolation by December with the final plan published by April 2022.

1.4.1 Locality planning in East Renfrewshire

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

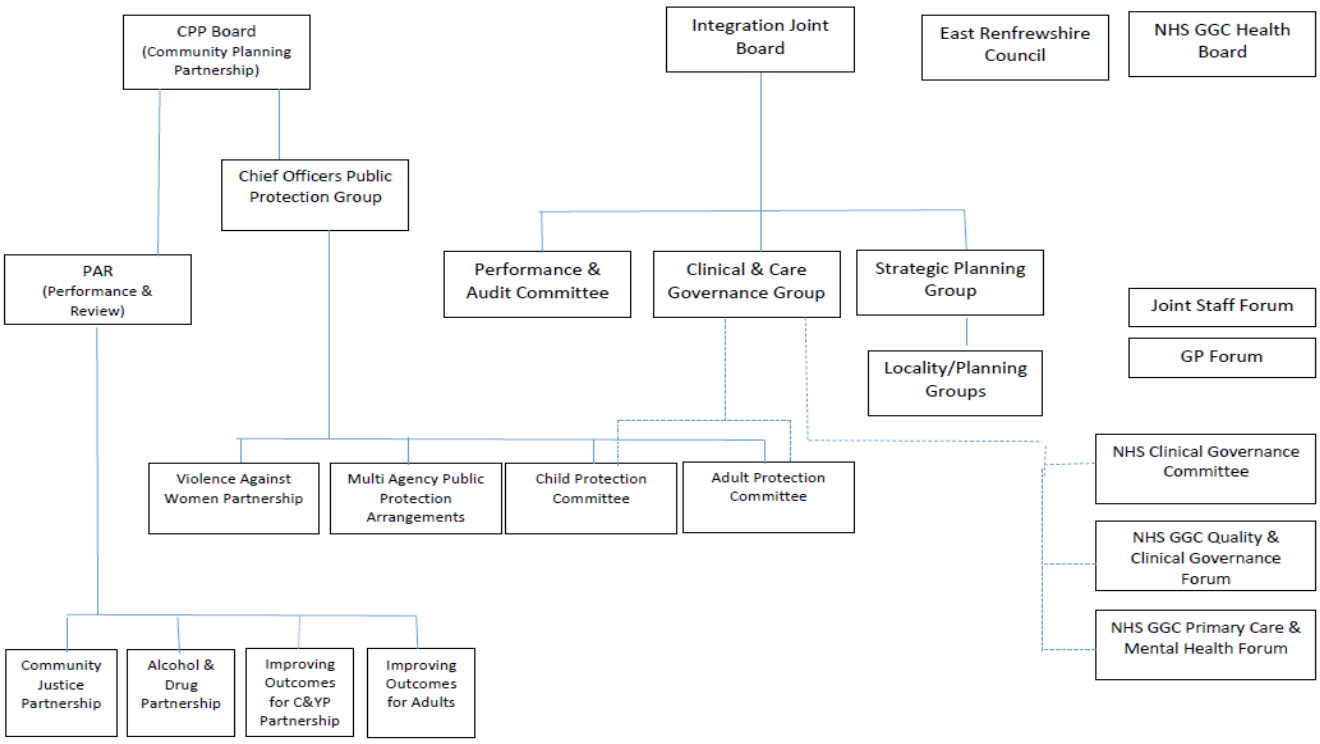
Our locality areas also reflect our hospital flows, with the Eastwood Locality linking to South Glasgow hospitals and the Barrhead Locality to the Royal Alexandra Hospital in Paisley. The Barrhead Locality and Eastwood Locality Managers came into post in 2018. They have responsibility for both locality-based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

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

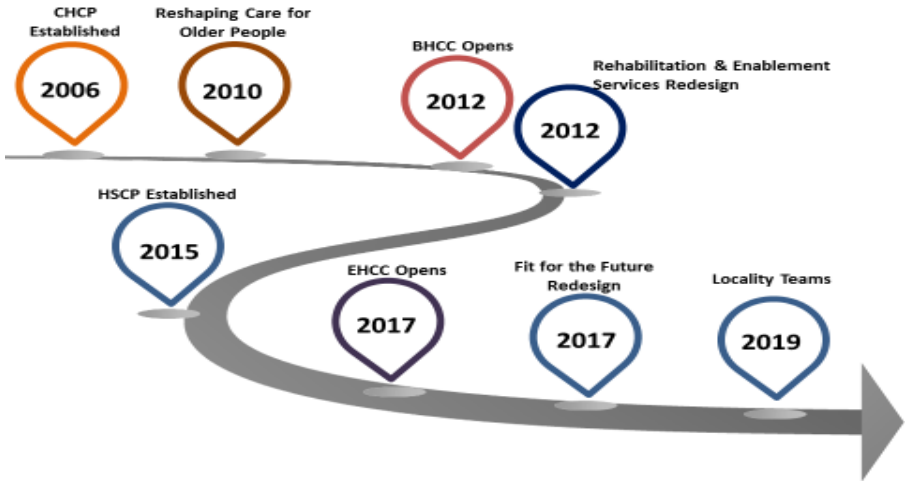


The IJB continues to build on the long standing delivery of integrated health and care services within East Renfrewshire and the continued and valued partnership working with our community, the third, voluntary and independent sectors, facilitating the successful operation of the HSCP.

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



1.4.2 Realising the strategy through operational delivery

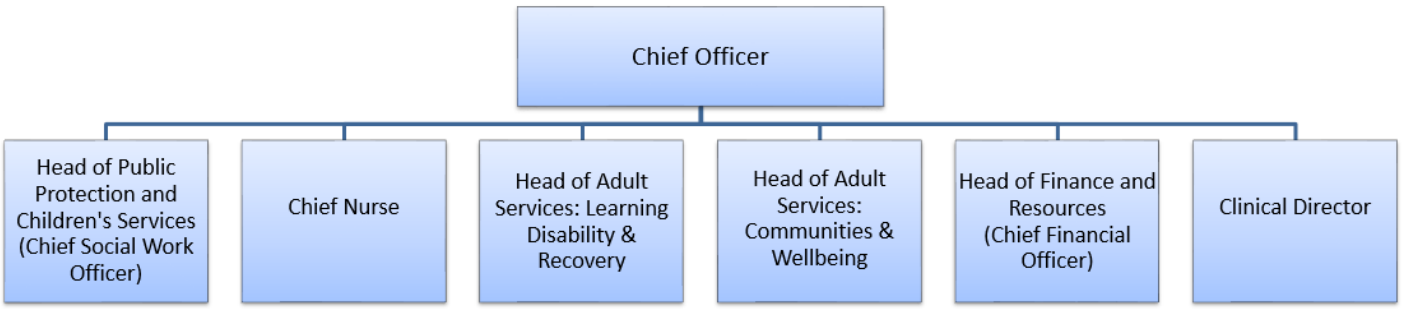


Developing our integrated Health and Care Centres at Barrhead and Eastwood has provided us with an ideal opportunity to facilitate a fundamental change in the operational delivery of health and social care for people in East Renfrewshire. Eastwood Health and Care Centre was designed to support the further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

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

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

This structure modelled through FFTF recognised the need to strengthen the link between strategy and operations, and to develop a stronger locality focus. Strategic planning, market facilitation and improvement capacity are being embedded in the locality structure. Our new teams have undertaken self-evaluation and planning activity to support the strategic direction. In 2020 we established a new Senior Manager role for Recovery Services to strengthen leadership around adult social work practice. The structure of our leadership team is shown below.



1.4.3 Our integrated performance management framework

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

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

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

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

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

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

2. Delivering our key priorities during the pandemic

2.1 Introduction

This section looks at the progress we made over 2019-20 to deliver the key priorities set out in our Strategic Plan and how we are performing in relation to the National Health and Wellbeing Outcomes. We also set out performance for cross-cutting areas that support our strategic priorities including public protection and staff engagement. For each area we present headline performance data showing progress against our key local and national performance indicators. In addition to an analysis of the data we provide qualitative evidence including case studies and experience from local people engaging with our services. Our intention is to illustrate the wide range of activity taking place across the partnership during the pandemic.

A full performance assessment covering the period 2016/17 to 2020/21 is given in Chapter 4 of the report.

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

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

2.2.1 Our strategic aims and priorities during 2020-21

We provide ongoing support to children who are described as vulnerable due to being looked after and in our care, or on the edges of care, who need targeted interventions to safeguard their wellbeing.[1] Our Strategic Plan established a targeted priority of improving mental wellbeing of children and young people. The plan emphasises the need to ensure appropriate supports to children and families to reduce the use of mental health inpatient beds, the number of GP consultations for mental wellbeing and alleviate pressures on Child and Adolescent Mental Health Services (CAMHS).

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

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

During the pandemic we have seen the following impacts that have refocused our operational priorities. These are areas that we will continue to focus on as we recover from the pandemic.

[1] Our main activities to support children and young people in partnership with other services and support organisations in East Renfrewshire are set out in "At Our Heart" East Renfrewshire's Children and Young People's Services Plan 2020-2023.

- The 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. This is a key priority in our new multi-agency Children and Young Peoples Services Plan 2020-2023.
- Teams are seeing increasing complexity particularly for children with diagnosed neurodevelopmental disorders and a higher prevalence of families in crisis leading to more of these children coming under child protection and an associated increase in numbers coming into care.
- There is a lack of foster care placements locally and externally and we are seeing additional pressures on the system due to the complexity of the needs of the children becoming looked after.
- Coronavirus (COVID-19) has brought particular challenges for disabled children and their families. This can be seen by the increase in numbers of disabled children in the child protection system and becoming looked after.
- The pandemic has highlighted that third and independent market place service provision for disabled children, young people and their families is limited and is an area for development.

2.2.2 The progress we made in 2020-21

Throughout the pandemic our Children and Families services have succeeded in maintaining high rates of contact with children (for example, Childs Plan contacts – av. 72%/week; Child Protection contacts – av. 100%/week; throughcare/aftercare – av. 90%/week) and have successfully managed to support the highest proportion of looked after children in school (57%).

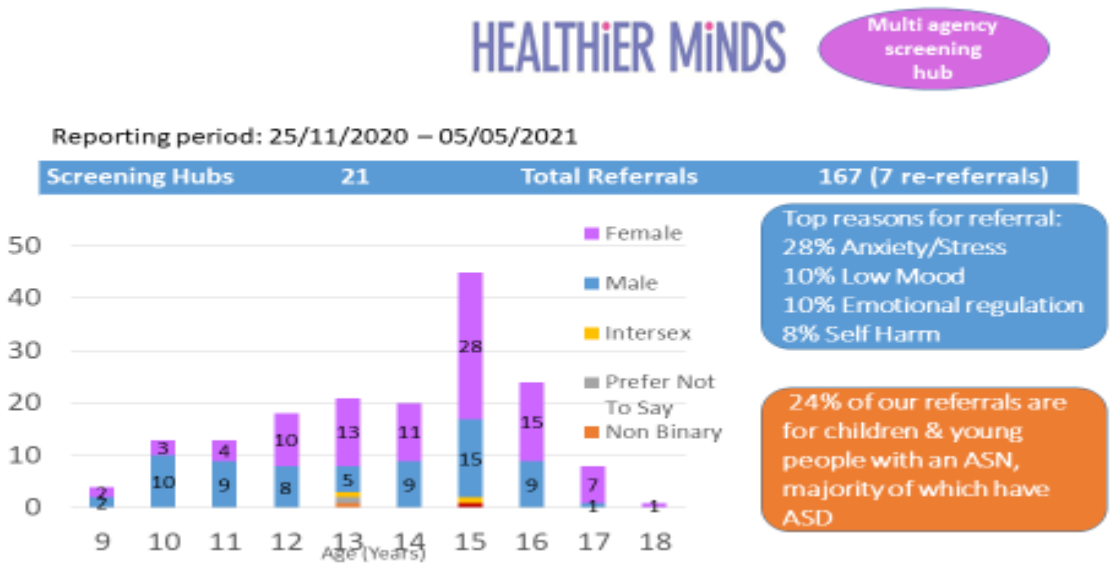
Headline performance data includes:

- % starting CAMHS treatment within 18 weeks – 61% down from 78%
- Care experienced children – positive performance on permanence – just one child with three or more placements
- 95% of care experienced children supported in community rather than an institutional setting – ranked 3rd best in Scotland (Local Government Benchmarking Framework (LGBF))
- Child protection - 88% child protection cases with increased safety
- Reduced % of children subject to child protection offered advocacy – 66%

2.2.3 The support we provided in 2020-21

As a local authority, East Renfrewshire has recognised the extent of mental health concerns among the children's population, and in our new Children and Young Peoples Services Plan 2020-2023 we have agreed mental and emotional wellbeing as a key priority. 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 and this also includes those who have a neuro developmental diagnosis.

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. Working with schools and young people prior to and following referral helps the team build a fuller picture of the support required and the young people are then assigned to the most appropriate support based on their needs. This is in addition to the existing Family Wellbeing Service which links to GP practices.



Healthier Minds – supporting our young people in the pandemic

As the pandemic took hold, it was identified that the needs of the majority of children and young people presenting with emotional distress were unlikely to meet the criteria for referral to existing clinical health services such as CAMHS. And traditional school counselling while highly valued, is less equipped to address the difficulties experienced due to social, home and family issues. Additional community and third sector family wellbeing provision (only accessible through GP services) was experiencing significant pressures. To address these issues it was felt that more flexible support which bridges counselling and systemic family intervention would be beneficial.

A new multi-stakeholder recovery team was developed known as Healthier Minds. This is aligned to school communities and has been developed to identify and ensure delivery of mental wellbeing support to promote children and families' recovery and renewal and reconfiguration of services. The three key elements are:

- Strategic mapping and support to maximise school community capacity to be trauma responsive;
- Provision of direct services to children and families to build on strengths and improve social, emotional and mental wellbeing;
- Strengthening of our existing school counselling model.

The team works alongside Secondary and Primary (with respect to P6/7) and takes a collaborative approach to identify opportunities to strengthen mental health and wellbeing. This includes developing a needs assessment for each school cluster, facilitating the implementation of targeted packages of support and the delivery of direct services to children, young people and their families where this is assessed as necessary. The team comprises a mixture of multi-agency professionals from health, education and third sector temporarily recruited, seconded or aligned to the recovery model.

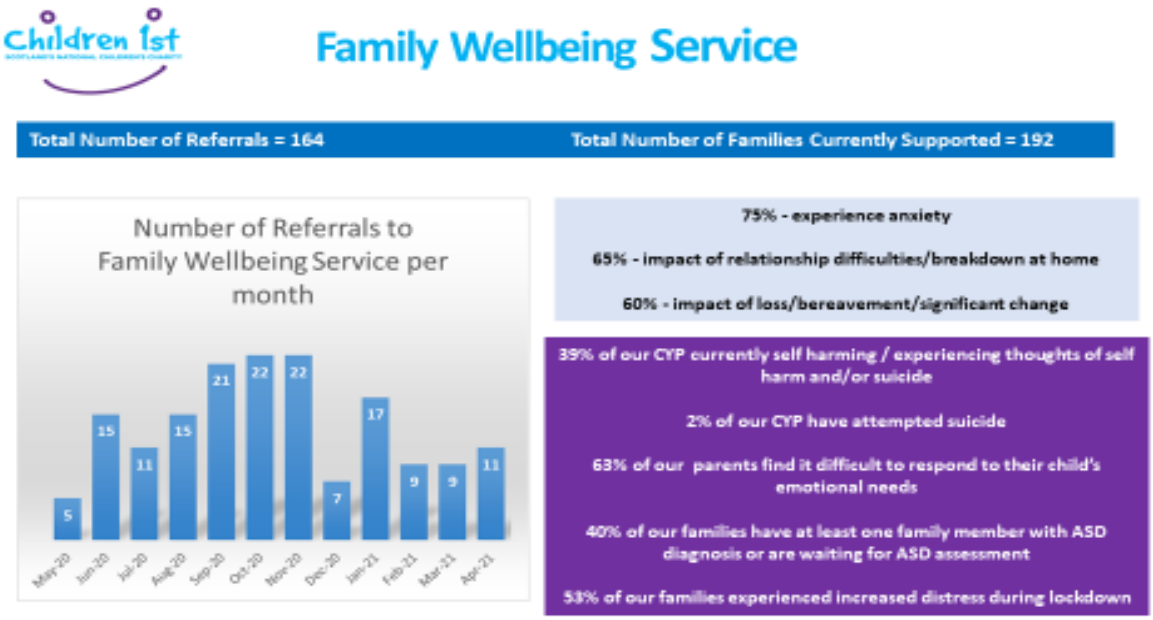
A screening hub model is in place to consider referrals for support, co-ordinated by the Recovery and Service Development Co-ordinator – Children and Young People's Emotional Wellbeing. The hub meets on a weekly basis, attended by regular representatives from CAMHS, social work, youth counselling, educational psychology and the Family Wellbeing Service. The hub discuss and agree the best possible support and route for provision, based on the needs of the child or young person (e.g. allocation to either Healthier Minds Team member or youth counselling service).

Through regular communication with children, young people, parents, carers, staff and stakeholders we have been able to proactively adapt and improve aspects of the service. Successes of the approach include:

- Help is available at the right place, at the right time, by the right person - new partnership models of support with schools and communities have established a 'no wrong door' approach during the recovery period.
- Our focus has prioritised early help and support.
- We are implementing actions and activities which will build on strengths, increasing good social connections, positive coping strategies, physical activity etc decreasing and mitigating the conditions in which poor mental wellbeing occur.
- There is strengthened capacity across schools and allied services - Gathering and share information on what's working well and what needs to change
- There is better co-ordination of wider mental health and well-being provision in East Renfrewshire.

East Renfrewshire's **Family Wellbeing Service** supports children and young people who present with a range of significant mental and emotional wellbeing concerns. The services works with the HSCP to deliver holistic support based in GP surgeries to:

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



Family Wellbeing Service

The last year has brought a unique set of challenges and demands for the local Family Wellbeing Service delivered by Children 1st. However, it has also brought opportunities for the service and working in partnership with families and colleagues in East Renfrewshire the service has been able to continue to build on successes and learning despite the pandemic.

The increase in the demand for the service is evidence of this. Although funded to accept a minimum of 178 referrals per year, this figure was exceeded significantly demonstrating the need for emotional wellbeing support from the children and families population. Moving into reporting period 2019-20 179 families were being supported with a further 159 referrals received during 2020-21. This amounts to a total of 338 children / young people and their families being offered support from the Family Wellbeing Service during this year.

Promotion of the service among GPs has been highly successful with almost all accessing the service when required for their patients. Programme evaluation indicates a significant improvement in the emotional wellbeing of the children and young people referred with fewer repeat presentations to GPs with distress. Thus demonstrating the efficacy of the family support and wellbeing intervention model deployed by the service.

Our **Inclusive Support Service (ISS)** continues to provide three distinct services: holiday provisions, out of school activity clubs and individualised support services. Providing a range of targeted supports for children and young people aged 5-18 years. All of the children and young people who access the service have either complex health or behavioural support needs, with a significant number having limited verbal communication.

Inclusive Support – adapting approaches

For some families the Inclusive Support Service is one of the few consistent supports throughout their children's lives. Supportive, long standing and positive relationships exist between families and the team. This has facilitated and enhanced the contribution the team have been able to make during the Covid-19 pandemic.

During the pandemic the team has refocused activity by working closely with partners in Education, Health and Adult Social Care Services to ensure support for our most vulnerable children and young people. In response to the unprecedented Covid-19 outbreak the team continued to support the 226 children, young people and their families through creative and innovative means. The team adapted service delivery as part of the multi-agency response to the changing and challenging demands placed upon the Health & Social Care Partnership. The team showed their compassion and commitment to the health and wellbeing of children, young people and their families through 308 personalised activity boxes, videos, calls, online chats, outdoor programmes and intensive supports at HUB provisions.

Over the year communication with our children, young people and the staff team was undertaken using some new and innovative practices including Microsoft teams, Skype, online social media platforms, including the HSCP twitter account, emails, newsletters, telephone calls, video calls and Covid-safe door step check-ins. The medium chosen was linked to family preference and the child's communication needs.

Families were empowered to engage with the team in relation to the delivery of the service over the pandemic. After receiving feedback from shielding families in relation to their children feeling isolated the team established an online weekly Glee club; an online crafts club and worked in partnership with an outdoor provider to support play sessions, improving the opportunities and outcomes for vulnerable children and hopefully assisting recovery for both the child and the family.

In response to a growing need for families the team organised and delivered in summer, October and December HUB provisions for 52 children and young people with complex support needs, who fell under the Key Worker and Critical Childcare category. The team also supported our colleagues within the adults with learning disabilities teams to provide

provisions to young people transitioning from children's services - further supporting the services ethos of providing the right support at the right time.

Over 2020-21 we have continued the implementation of the **Signs of Safety** model, led by the Chief Social Work Officer and the Head of Education Services (Equality and Equity). The model supports practice improvement, with a particular focus on developing relational interventions with children, young people, their families and carers in order to reduce risk and improve children's wellbeing. Although much of our implementation plan has had to be postponed due to the impact on services from the pandemic, we have continued to support practice improvement, with a particular focus on developing relational interventions with children, young people, their families and carers in order to reduce risk and improve children's wellbeing. This has been more important than ever during the pandemic. From analysing our data we have found that our approach and safety planning with families is having a positive impact with most new referrals coming to our Request for Assistance team being families who were not known to us previously.

Over the course of the pandemic there have been pressures on CAMHS and speech and language therapy services but waiting list initiatives are in place in these services as part of our remobilisation and recovery work and we continue to engage with families on best approaches moving forward.

Speech and Language Therapy – engaging with local families

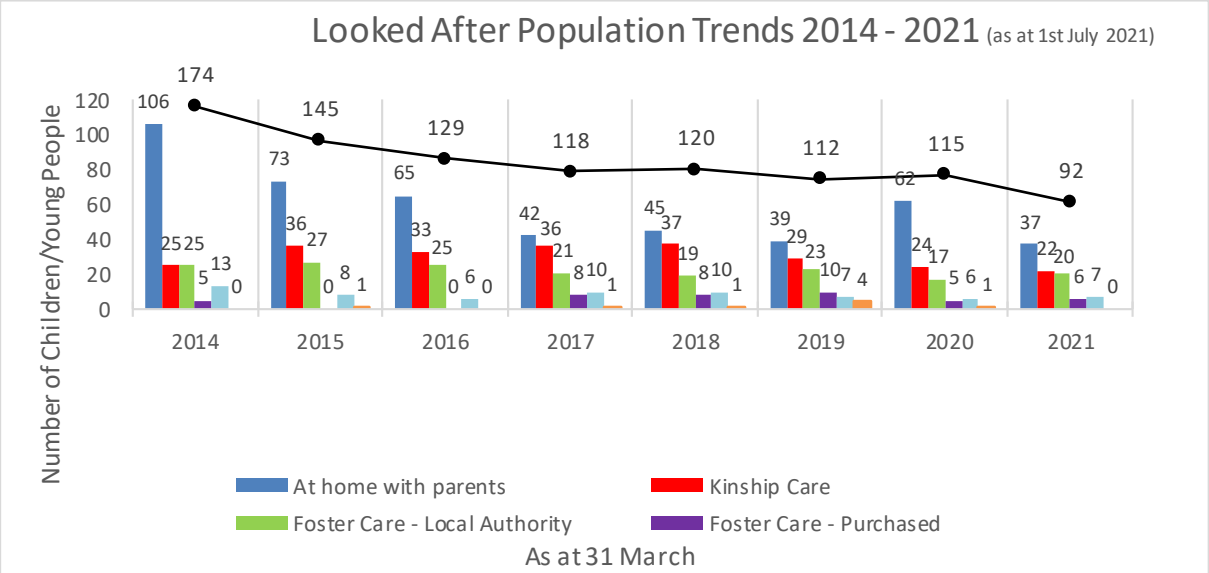
During 2020-21 the paediatric speech and language therapy team have been working together to focus on meaningful conversations with families about what really matters in their care. The team considered how to improve their own processes to support these conversation, what skills were needed as therapists to listen well to patients and how the issues that matter to families feeds into the care they receive. The What Matters To You event came along at a great time for the team to put all of this into practice. Outcomes from the event were shared on social media and they plan to develop posters to display in clinics and nurseries. Feedback is considered collaboratively as a team. Team members also talked about how it felt to be having these conversations and what they might learn and change for the future.

Themes emerging from the feedback include:

- Families appreciate relationships with therapists that they perceive to be genuine and honest. The quality of the relationship is important to families and something that they see as important in the care of their children.
- Families like to know that therapists know and understand their children well and have their best interests at heart. They like to know that our workforce is skilled and knowledgeable.
- Families told us that success in SLT was something beyond speech and language - it included how children feel about themselves and how they were valued for being themselves.
- Families want good outcomes for their children in education and in their future lives. Communication is seen as being part of broader life outcomes.
- Children told us in many ways that they like their contact with SLT to be fun. They like toys and stickers. They like the feeling of success.

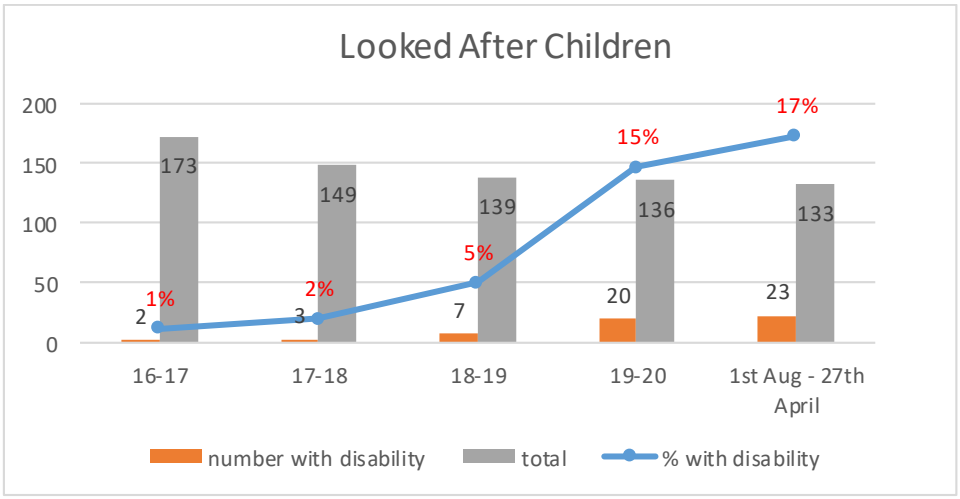
Support to our looked after children and young people has continued throughout the pandemic period. To support the wellbeing of our looked after children we work to ensure they access the most appropriate destinations possible. We are proud that 95% of our looked after children are supported in the community rather than institutional settings.

At the end of 2020-21, 92 children and young people in East Renfrewshire were looked after in a range of settings. This constitutes approximately 0.5% of the total children's population of the area and remains one of the smallest proportions in Scotland. The gender balance has been consistent in recent years with 60% boys and 40% girls. We have continued to work to improve outcomes for children by securing permanent destinations for them. In 2020-21 there was a decline in the number of children looked after at home while the number looked after away from home has remained consistent. The reduction in the number of children looked after at home correlates with a decrease in referrals to Scottish Children's Reporter Administration (SCRA) overall.



Over the course of 2020-21 the average amount of time children were looked after at home increased from fifteen months to twenty months. This can be attributed to the significant reduction in children's hearings taking place and the powers afforded by the Coronavirus Act to extend Compulsory Supervision Orders.

As a result of the pandemic there has been a significant increase in the number of children with complex and additional support needs who have become looked after. Currently 17% of looked after children have a disability evidencing that the pandemic has significantly affected families with children who have additional support needs.



Key successes in supporting our looked after children over the course of 2020-21 include:

- The number of children looked after away from home has continued to decrease.

- Improvement work in our multi-agency contribution to the Scottish Children's Reporter Administration to support effective decision making.
- Improvement work in Looked After Independent Chair role to ensure effective and consistent decision making for children.
- All staff have been trained in Signs of Wellbeing assessment approach.

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

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

In 2020-21, the service directly supported 155 young people and their families.

- 38 were care experienced young people in receipt of Continuing or After Care support.
- 45 of care experienced young people were supported through East Renfrewshire's Family Firm.
- 62 were assessed as of immediate risk of custody.

During the Covid pandemic the contact levels with young people remained very high, evidence of the success of our relationship based practice averaging at 81% of young people having contact at least once per fortnight.

East Renfrewshire Champions Board aims to improve life chances of looked after young people both within our community planning partnership and in the wider community. A central focus is on inclusion and participation allowing looked after young people a meaningful forum to directly influence and, through time, redesign services that affect them in a co-produced way by influencing their corporate parents. The Champions Board offers looked after young people leadership opportunities and the opportunity to change practice and policy. Our aim is to demystify and challenge misconceptions about looked after children and young people and strengthen awareness of the barriers that they face.

Support, participation and coproduction with young people during the pandemic

Despite the challenges of the pandemic the partnership continued to support participation and engagement with many of our vulnerable and harder to reach children and young people. Examples of Champions Board and wider participation activity during the pandemic include:

- Daily group video calls during initial lockdown period involving 10 young people
- Wellbeing bags given to 15 young people involved with Champions Board
- Online group which focused on wellbeing and exploring emotions during lockdown using art and photography, supported by Articulate Cultural Trust. This moved into a community setting when restrictions allowed. 12 sessions delivered.
- Creative consultation around a vision for the East Renfrewshire Children's Services Plan in August 2020. Articulate Cultural Trust were commissioned to consult with young people in a creative way to explore their views on what is important to them to help create a vision for the East Renfrewshire Children's Services plan. A care

experienced young person from East Renfrewshire was paid as a creative Consultant to support this. Consultation took place with 30/40 young people from Mini Champs, Champions Board, and young people attending the Education HUBs.

- Summer Programme 2021 - daily activities of Yoga, Fishing, Football, Drama, Graffiti and photography for young people run by YISS with support from other agencies. 100 opportunities offered. 30 young people attended in total, with most young people attending a number of the groups. This also included an under 12s group for graffiti and football.
- Mini champs film group and premier.
- Three of our care experienced young people have completed their Peer Mentor training with Move On (online). 3 YP attended 8 sessions.
- Two young people engaged with Children Hearing Scotland and completing relevant online training to be part of the interview process for new panel members.
- Four young people involved in a working group with officers from Education, discussing anxieties around returning to school post-Covid, mental health provision in schools and the PSHE (Personal, Social and Health Education) curriculum. This followed on from previous involvement from the Champions Board and Youth Voice in 2019 at a co-production event looking at mental health services and provision in schools. As a response to this engagement and the circumstances of the pandemic, there is a new Healthier Minds service within schools for young people.
- Young people have been involved in interviews for a service manager, Social Workers, Support Workers and Team Managers through online inputs and were paid for this work. 4 young people involved in 6 sessions.
- Two Young People were involved in a council wide planning group for PrideER which was led by an elected member. 1 session.
- Care Day - We made up 60 wellbeing bags for our care experience young people which included winter items such as fluffy socks and blankets, face masks and hot chocolate. We delivered this alongside a pizza for each young person and had a socially distanced blether on their doorstep.
- Individual consultations of school nursing service. 10 young people involved.
- Christmas - Event held in Eastwood Theatre for young people receiving a throughcare service. Turkey sandwiches, selection boxes a catch up and a Christmas movie. All the young people received Christmas gifts and hampers. 20 young people attended.
- 15 Champions Board young people were delivered a small gift and multiple Christmas cards with personal messages from their corporate parents/ adult champions.
- Our young people were supported to form small bubbles at Christmas and we booked some of our young people into local restaurants for dinner.

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

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

2.3.1 Our strategic aims and priorities during 2020-21

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

Over the course of our 2018-21 Strategic Plan the East Renfrewshire HSCP has strengthening links with other community services and programmes to provide greater access and support for people to prevent and reduce offending. We have worked to support people moving through the criminal justice system to have better access to the services they require, including welfare, health and wellbeing, addiction services, housing and employability.

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

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

Criminal justice services have been significantly impacted by the pandemic, notably with the suspension of Unpaid Work Orders on 23rd March 2020. The service has had to develop creative ways to support those with existing orders to complete work.

2.3.2 The progress we made in 2020-21

Despite the significant impact of the pandemic which saw unpaid work suspended at the start of the crisis, the Community Payback Team completed 2,417 hours of activity equating to £21,535 of unpaid work which directly benefited the local community. Whilst there has been an overall reduction in referrals for employability support, positive employment outcomes have been maintained at 65%. And there has been strong support for women and families affected by domestic abuse continued throughout the pandemic.

Headline performance data for the Criminal Justice service includes:

- Percentage of unpaid work placement completions within Court timescale – 75% up from 71% (although significant reduction in Community Payback Orders - 44 compared to 205 previous year)
- Positive employability outcomes for people with convictions – overall reduction in referrals but positive outcomes maintained - 66% up from 65% in 2019-20.
- 92% of people reported that their order had helped address their offending - 8% reduction
- Domestic abuse outcomes for women - 114 reviews completed with 84% of women assessed noting improvement in progress (5.5% improvement on previous year).

2.3.3 How we delivered in 2020-21

During the pandemic, there was a limited staff presence in offices with only essential services entering council buildings. Social workers continued to supervise people by phone whilst maintaining office contact with those offenders who were deemed as vulnerable or assessed as posing the highest risk of harm.

Strong partnership working was evident in planning support for people who were being released early from prison in May 2020. Throughout the Covid-19 restrictions, we ensured that people being released from custody, including those not subject to statutory supervision, were supported and that housing had been identified for them. Service users released from custody during lockdown necessitated close collaborative working with Housing, Health, Addictions and Police Scotland to ensure needs were met and risks were managed during a particularly challenging time.

As noted the issuing of Unpaid Work Orders was suspended on 23rd March 2020. This led to a significant backlog in Unpaid Work hours. The **Community Payback Team** had to creatively adapt their way of working, and used a blended approach in order to reduce the backlog of hours. They delivered working at home kits, utilised a learning pack that people could complete with the support of a social worker and ensured other activity hours were claimed appropriately. This has helped reduce the number of outstanding hours and ensured some people completed orders within timescales. Despite the significant disruption the team completed 2,417 hours of activity during 2020-21, equating to £21,535 of unpaid work which directly benefited the local community.

Legislation was introduced in March 2021 to reduce the number of hours originally imposed on Community Payback Orders (CPOs) by 35% (excluding CPOs imposed for domestic abuse, sexual offending or stalking). In East Renfrewshire the legislation has reduced the outstanding backlog of unpaid work by 2329 hours.

During the year we enhanced our Unpaid Work Service by securing **workshop premises**. We also recruited a full time supervisor and new sessional staff. We have used the period when the service was suspended to ensure the premises were upgraded and equipped with appropriate tools and machinery. This will enable people subject to Unpaid Work to develop new skills and allow us to address the backlog of unpaid work hours once restrictions ease.

STREET CONES

We commissioned the theatre group Street Cones to deliver an online 12 week Road to Change Programme. The ten service users who attended the interactive lived experience workshops, were credited with other activity hours for participation in this programme which ended with an online performance.

The criminal justice team began to facilitate the local delivery of the nationally accredited sex offender treatment programme, **Moving Forward Making Changes (MFMC)**. During the crisis the programme was suspended resulting in increased numbers of people requiring to complete the programme. To re-establish this area of work the team adapted their approach to ensure it was delivered on a one to one basis by practitioners and a treatment manager. As a result three people were able to complete the MFMC programme.

Throughout the year the Criminal Justice Team continued to ensure 100% attendance at scheduled Multi Agency Risk Assessment Conferences (MARAC) to complement the work undertaken by the service.

We provide a high level of support for women and children who have experienced **domestic abuse** and this has remained a key area of focus during the pandemic. During 2020-21 Women's Aid supported 805 women and children across the three core services (Refuge, Outreach and Child and Young People support) including helpline and drop in enquiries. This is a decrease of 17% compared to the previous year. Reports from survivors and specialist services during the pandemic has shown that lock down restrictions prevented women from seeking support especially where perpetrators remained in the family home. During the year, East Renfrewshire Women's Aid service reported significant change and improvement for women across all reported outcomes. 114 reviews were completed with 84% of women assessed noting improvement in progress in their outcomes overall. Reduction in risk is reflected in the significant increases in the areas of safety with 89% improvement, health & wellbeing 80%, and empowerment and self-esteem 80%.

Multi-Agency Risk Assessment Conferences (MARAC) are recognised nationally as best practice for addressing cases of domestic abuse that are categorised as high risk. In East Renfrewshire Multi-Agency Risk Assessment Conferences was first introduced in March 2019. Over the course of the last year Multi-Agency Risk Assessment Conferences in East Renfrewshire continued each month, switching to an online platform due to Coronavirus (Covid-19). This has worked very well and we have had 100% attendance from the range of agencies that attend. In this reporting year 120 high risk victims and 172 children were discussed at Multi-Agency Risk Assessment Conferences. This is an increase of 40% and 28% respectively in cases discussed compared to the previous year. A total of 592 actions have been agreed via MARAC in this reporting period (compared to 469 the previous year).

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

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

2.4.1 Our strategic aims and priorities during 2020-21

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

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

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

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

2.4.2 The progress we made in 2020-21

- Our premature mortality rate remains significantly below the national average at 295 per 100,000 (Scotland 426)
- 15.4% of infants in our most deprived areas (SIMD 1) were exclusively breastfed at the 6-8 weeks (19.1% Scotland wide) (2019-20 figure)
- 66 people in our most deprived areas (SIMD1) supported to successfully stop smoking
- Male life expectancy at birth in our 15% most deprived communities is 74.7 compared to 72.1 for Scotland.
- Female life expectancy at birth in our 15% most deprived communities is 79.8 compared to 77.5 for Scotland.

2.4.3 How we delivered in 2020-21

We have seen variation in the **breast feeding** rates over the preceding three years (data to 19/20). Throughout the pandemic the Children and Families team have continued to prioritise and fully support all breast feeding mothers with a focus on those living in our most deprived areas. To support this the team have developed a new antenatal pathway which is being delivered in 2021. The pathway enables early discussions with pregnant women particularly

around infant feeding with the aim of increasing interest in breast feeding particularly in SIMD 1 & 2 neighbourhoods.

Our **Health Improvement Team** have continued to promote self-help and information campaigns throughout the year using alternative communication methods. Information about self-help and community support is provided via the 'Your Voice' Bulletin which is sent directly to individuals on our database and online. As we moved beyond lockdown restrictions health and social care information was made available in public settings including our Health and Care Centres, libraries and other local public and community facilities.

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

The programme has been operational throughout the pandemic, adapting services continually to support existing and new clients to be physically active.

From April 2020 the programme:

- continued to receive and triage referrals online and support clients for 12 months.
- continued to provide evidenced based, client led, exercise advice to clients with complicated medical histories.
- continued to follow up and motivate clients to become more active, contacting them by phone, email and text on a regular basis.
- prescribed a variety of home exercise and free local activity to clients.
- provided in person 1 on 1 supervised sessions twice a week for BACPR clients and those members who needed support accessing services when the Leisure Centres reopened.
- continued to provide updates to referrers and clinical partners on our services and on specific client goals and their success towards meeting these goals.
- Signposted clients to other providers when necessary, partnering with Voluntary Action East Renfrewshire to ensure those most in need of support had access to community supports.
- recruited a new part time member of staff, who has a wealth of experience and is also our Macmillan physical activity specialist.

Live Active 2020-21 in numbers

- 137 first appointments
- 14 high risk clients medically screened
- 183 clients supported to be active for 6 months
- 181 clients supported to be active for 12 months

Feedback from Live Active service users:

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

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

2.5.1 Our strategic aims and priorities during 2020-21

A key strategic aim for our partnership is to ensure that people with support needs continue to enjoy a good quality of life in their own home and local community. We do this through a wide range of community-led supports and interventions to ensure that individuals have choice and control in the decisions that affect their life. We have established our 'front door' to support and new ways of engaging with people in their communities. Through our local 'Talking Points' people can talk to different health and care staff and community volunteers about what matters to them. Through this approach we ensure that people have access to the right conversation at the right time and have the right support to maintain their independence.

For those people who require support for their daily lives, we have moved to a model of "the right amount of support" and established a new individual budget calculator for self-directed support. This is helping to minimise the barriers for people looking to take on more 'choice and control' and providing a more simple and transparent approach.

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

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

The pandemic has impacted our approaches to supporting independence and the delivery of our preventative supports. Teams were required to establish and adjust to alternative ways of working in a short space of time. Across our services we have seen increased demand and higher levels of complexity among the people we support. And as a direct consequence of the pandemic restrictions we have seen increased frailty and social isolation particularly among older people.

The pandemic has changed some of the choices people make and disrupted pathways within the health and social care system. For example, our care at home services have seen additional pressures due to a desire from more people to be supported at home and we have been dealing earlier and more complex hospital discharges. 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.

2.5.2 The progress we made in 2020-21

Across services that support independence we have seen growing demand pressures during the pandemic and we are concerned about higher levels of frailty among the people we work with as a result of the lockdowns. These issues have impacted on many of our established performance measures. Our rehabilitation teams have experienced increased pressures in the absence of a number of specialist rehabilitation services and earlier discharges from hospital (average of 40–50 referral per week in 2019/early 2020; now 70-80 per week over past 10 months). The increased frailty and complexity of people referred to our services has seen a decrease in the percentage of people whose care need has reduced following re-ablement.

Headline performance data includes:

- Number of people self-directing their care through receiving direct payments and other forms of self-directed support – 556 up 7% from 518 in 19/20
- % of people 'living where you/as you want to live' needs met (%) – 91% up from 88%.
- % whose care need has reduced following re-ablement – 31% down from 67% (reflecting increased frailty, complexity of hospital discharge, pressure on service)

2.5.3 How we delivered in 2020-21

The HSCP remains committed to promoting Community Led Support which sees a move from traditional day service provision for older people to enabling access to more local, personalised and flexible services. The impact the pandemic has been wider the immediate effects of the coronavirus. Many people's wellbeing has been affected by the isolation and changes to routine.

Through strong local partnerships our teams have responded with great innovation and greater collaborative working in support of our communities. And with the aid of technology teams have been able to offer people ongoing support throughout the pandemic, and access to support and treatment has been maintained.

An East Renfrewshire community phoneline for local people and organisations looking for support, signposting and community information.

Support
Get in touch with The Community Hub if you or someone you know needs support.

In East Renfrewshire a local **Community Hub** was developed to coordinate the community response to the Covid-19 pandemic. The Community Hub is a partnership between Voluntary Action East Renfrewshire, HSCP Talking Points and East Renfrewshire Council Communities and Strategic teams. It has supported residents to access information and signposted to local community supports as well as establishing new shopping and prescription delivery service. It also responded to the growing need for social contact by those who were reporting feeling isolated, especially those who were shielding. **'Welfare Calls'** were conducted either weekly or fortnightly by newly recruited volunteers. The Community Hub has now formalised the partnership and will continue to co-produce new delivery models in response to community need.

Responding in partnership with our communities – Talking Points and the Community Hub

Talking Points hubs were established across East Renfrewshire as places where people can go to have a good conversation about their health and wellbeing within their own community. Here residents can be directed to services and support that best meet their needs. The Talking Point hubs are led by a single paid staff member and supported through the participation of third and independent sector organisations with support from social work services.

At an early stage in the pandemic, it became clear that Talking Points in its existing format, was unable to continue its community based work due to the lockdown restrictions (closures and support services, staff and potential attendees remaining at home).

It was decided at a very early stage that the Talking Points coordinator should be the link between the new Community Hub and the HSCP Initial Contact Team within Social Work and provide advice and support to Voluntary Action East Renfrewshire in the creation and delivery of new community supports. To facilitate this the Coordinator based himself within VAERs building in order to better respond to identified needs and when appropriate, provide support. It was also decided that, as Talking Points was unable to carry out its duties, we should concentrate on giving the message that if during the pandemic you needed help and support, that there were three conduits to access that support:

- The Community Hub
- The Initial Contact Team
- East Renfrewshire Council

This strategy strengthened the relationship between the organisations and allowed for new ways of working that previously did not exist. The benefits of a closer working model was clearly of benefit to the organisations and in turn the residents themselves.

Talking Points now has a membership of over 60 groups and organisations that provide advice and support for residents. This group continued to meet with its partners via Microsoft Teams and continued to link in with Talking Points when their particular expertise in their field was needed to give advice and support to residents either by phone or video call. During this period the Coordinator acted as a conduit for collating and sharing information between agencies and groups via fortnightly emails that ranged from online Mental Health support groups, changes in benefits, to dementia supports and everything in-between. This allowed partners to stay in touch and remain relevant to each other and culminated in the creation of a Directory detailing contact details, the roles of their organisation as well as their referral process.

Following discussions with partners it was decided that Talking Points should explore further how we could formalise and capitalise on the relationships forged during the pandemic within the Community Hub. Following discussions between the three Community Hub partners as well as HSCP management and Talking Point partners, it was agreed that we should formalise the relationship and in March of 2021, the message that “Talking Points has a new Home at the Community Hub”.

At this point we let our partners, HSCP staff and public know (via press our own Facebook page) that Talking Points was again open and that it could be contacted via the new number at the Community Hub. Since the relaunch we have been receiving referrals and have designed Postcards produced by the Community Hub which will be disseminated across the authority by HSCP and Third Sector partners. We are also redesigning HSCP leaflets and posters that will emphasise the Talking Point approach.

Talking Points continues to explore how, when and where we shall be engaging with our residents and partners and we move through the pandemic in collaboration our Culture and Leisure Trust regarding libraries and Community Centres, VAER regarding their Market Place events.

New Talking Point User Quotes:
"I first encountered (TP Coordinator) in Giffnock Library during an 'open-day' and found him to be so very approachable and knowledgeable."

"Recently I was very worried about a situation I find myself in and remembered about 'Talking Points'. I decided to ask 'Talking Points' if they could help me and they did! Therefore I am so appreciative of being able to source Talking Points and if I hadn't heard about this marvellous Organisation and met (TP Coordinator) in Giffnock Library I would still be floundering."

"I was feeling frustrated, anxious, and angry and didn't know where to turn to next. I phoned the community hub and within 15 minutes Talking Points had phoned and were on my case. (TP Coordinator) was a great listener, had a very calming manner and told me not to worry as he would find out the required information. This was last Thursday the back of 14.00. By Friday afternoon he had made contact with the department and gave me the superb news that I had been needing. I'd like to thank Talking Points so much for taking time to help me and resolving my problem so quickly. 5 star service!"

Whilst we had to close our day services during the pandemic, our **learning disability** staff worked with provider partners to develop outreach and wrap around support for individual and their families and our older people's Kirkton service staff were redeployed to support care at home supports.

Care at home has seen additional pressures due to a desire from more people to be supported at home and more complex discharges. At the start of the pandemic some families wanted to limit the number of people coming into their homes and asked for their services to be suspended but as more people have been vaccinated the majority have reinstated services.

At a glance – Supporting people at home in 2020-21

- 154,000 hours* of homecare provided by the HSCP's in-house Care at Home Service
- 424,000 hours* of homecare provided by partner providers
- 1,855 service users receiving homecare support
- 331 Community Care outcomes assessments completed by Adult and older people Social Work
- 84 Care at home staff trained in medication management on a socially distanced basis
- 166 Occupational Therapy assessments completed

*inc homecare elements from SDS packages

Our **Rehabilitation** teams have experienced increased pressures in the absence of a number of specialist rehabilitation services and earlier discharges from hospital. (Av. of 40–50 referral per week in 2019/early 2020 to now 70-80 per week over past 10 months.) The increased frailty and complexity of people referred to our services has seen a decrease in the percentage of people whose care need has reduced following re-ablement has 31% down from 67%.

Our partnership with local **care home** providers has developed and strengthened in response to the pandemic. In addition to testing and vaccination for residents, a multi-disciplinary Care Home Oversight Group continues meets twice weekly to provide co-ordinated support to care

homes. Care homes have been caring for some of our most vulnerable residents over the course of the pandemic. Care home liaison staff have supported homes to manage residents' care, with advice on pressure area care, food, fluids and nutrition and individual nursing issues. Along with NHSGGC colleagues, they have offered infection prevention control advice and supportive visits. Commissioning and contracts staff have supported homes with daily welfare calls, and arranged virtual meetings and workshops for managers, updating them on changes to guidance and providing a forum for peer support. The HSCP adult support and protection team has worked closely with homes advising and investigating to keep the most vulnerable individuals safe from harm. Bespoke support has been offered to care homes particularly affected by the pandemic and the wellbeing of staff and residents continues to be a high HSCP priority.

Ensuring the welfare of our care home residents – reviewing needs

During the pandemic the need to restrict the number of professional visitors to care homes and restrictions on family visiting meant that some people living in care homes had not been seen by anyone other than care home staff. Earlier this year Scottish Government asked Chief Social Work Officers to undertake additional work to ensure all residents residing within a care home had an up to date review of their care.

In response we created a temporary Review Team. The team consists of five Social Workers and two Team Managers with aligned business support and is overseen by one of the Locality Managers. The team undertook 268 reviews for individuals within the 12 East Renfrewshire care homes, including those placed by other authorities.

East Renfrewshire Chief Social Work Officer and Chief Nurse, supported by members of the Senior Leadership Team are carrying out support and assurance visits to all local care homes. The purpose of these visits is to provide HSCP support as care homes move into recovery phase and a level of assurance in relation to the quality of care provided to residents following the impact of the pandemic. Feedback from care homes is that the visits have been supportive and that our critical friend approach has been helpful. Excellent practice has been a key feature of these visits, particularly where staff in care homes have selflessly responded to ensure that the safety and risk to residents from transmission was paramount.

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

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

2.6.1 Our strategic aims and priorities during 2020-21

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

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

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

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

For many people experiencing and recovering from mental health and addiction the lockdown has been particularly challenging. Our teams have been dealing with a significant increase in demand across mental health and addiction services due to increased complexity in the cases we are working with and we expect this to increase going forward.

2.6.2 The progress we made in 2020-21

Headline performance data for mental health and recovery includes:

- % waiting no longer than 18 weeks for access to psychological therapies – 74% up from 65% in 19/20
- % accessing alcohol/drug recovery treatment within 3 weeks – 95% up from 89%
- % moving from treatment to recovery – 6% down from 14% due to focus on maintaining stability for service users and reduction in staffing in recovery team due to vacancies which are now being filled
- No significant increase in mental health acute admissions during pandemic – latest age standardised rate is 1.6 per 1,000 population. Psychiatric admissions (adult and older people) was 175 in 20/21 - up slightly from 169 for 19/20.

2.6.3 How we delivered in 2020-21

During 2020-21 our teams have been dealing with a significant increase in demand across mental health and addiction services due to increases in complexity. However, with the aid of

digital technology teams have been able to offer people ongoing support throughout pandemic, and access to treatment has been maintained. We will build on these new approaches and ways of working 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.

Despite the challenges of the pandemic we have continued to develop our recovery-focused approaches. During 2020-21 we have tested the impact of lived experience in the delivery of services and have developed a successful **peer support service** for mental health and addictions. Peer support is where people with similar life experiences offer each other support, especially as they move through difficult or challenging experiences. The service received its first referrals in early September 2020, initially offering opportunities to meet face-to-face, within the restrictions at that time. Peer support is also being offered via phone or video call, in line with individuals' preferences.

This type of approach is proving successful in supporting individual's recovery journeys, and complements other formal services that are available.

Peer support for mental health and addictions

In September 2020, East Renfrewshire Health and Social Care Partnership began testing a new service providing peer support to individuals recovering from mental health issues or alcohol or drug related issues. Peer support is based on the idea that working with someone with a similar experience can inspire hope and show that recovery is possible. The service is delivered by Penumbra, a leading organisation in employing people with lived experience of mental health and recovery to support others. The service has been well-received and two peer workers are supporting 28 individuals. Early feedback is extremely positive, from teams referring to the service, peer workers and individuals receiving support. The main differences for individuals at this early stage include building a positive relationship with a peer worker, feeling supported and able to think about their goals for recovery, and we are seeing increases in confidence and self-esteem. The HSCP is now investing further in peer support, with the addition of another peer worker, and ensuring that this is a key part of the service offered to individuals in recovery from alcohol or drugs, or mental health.

"It's been absolutely excellent. She's tried to guide me through - it's definitely working. She has shared her own experiences with me. Everything is so much better now, so much clearer. It's been invaluable to me." Peer support service user

"Seeing other people's lives and where they've made changes in their lives, I can look back at my own life and see where I can make changes." Peer support service user

During the year we also established a **peer research programme** in alcohol and drugs settings that will enhance the influence of people with lived experience on service delivery and design. We piloted a Buvidal clinic (a new, long-acting opiate substitution treatment and alternative to methadone and other substitutes).

Mental health services have delivered a **mental health and wellbeing remobilisation programme** with the third sector including a recovery college pilot, staff capacity building around bereavement, mental health and suicide prevention, and wellbeing support to carers.

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

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

2.7.1 Our strategic aims and priorities during 2020-21

We are committed to a programme of work with colleagues in acute services to ensure that only those people who require urgent or planned medical or surgical care go to hospital. Together we are looking at the most frequent preventable causes of admission and putting in place new services and pathways to support people in the community wherever possible, including at the end of life. Our aim will always be to return people home as quickly as possible and to support people at home wherever possible. However, sometimes people require additional supports and we continue to develop an appropriate range of intermediate facilities as well as end of life provision. Our model emphasises flexibility in terms of criteria to help support timely discharge from hospital.

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

We are working together with our colleagues in primary care to implement the new GP contract and Primary Care Improvement Plan. The new contract aims to support local GPs to spend more time in managing patients with complex care needs. Over the course of the 2018-21 strategy we have helped primary care teams to grow to support more patients in the community, with additional pharmacy, community treatment (e.g. phlebotomy), other health professionals and link workers.

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

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

2.7.2 The progress we made in 2020-21

Patterns of accident and emergency and unplanned hospital admissions were significantly altered by the pandemic. Overall bed days lost to delayed discharge are up 30% from 19/20, however the majority of these are due to delays in moving adults with incapacity, which has been impacted by court delays. Our performance for standard delays remains one of the best in Scotland.

Headline performance data includes:

- Adult bed days lost to delayed discharge – 2,342 – up from 1,788 in 2019/20
- Adult A&E attendances – 13,677 – down 32% from 20,159
- Adult Emergency admissions – 6,518 – down 13.5% from 7,532

2.7.3 How we delivered in 2020-21

During 2020-21 the HSCP has worked with other partnerships and acute services in the Glasgow area to develop new services and pathways that will continue as we move into recovery.

Our **Hospital to Home** team has worked throughout the pandemic using virtual technology to undertake assessments and communicate with patients, relatives and ward staff. East Renfrewshire continues to develop a model to support safe and early discharge from hospital by increasing the resource and skill mix within the Hospital to Home team. Delayed Discharge dashboard is being proactively used by the team along with Improvement activity to support earlier in-reach and effective discharge planning with individuals and their families. Despite this proactive activity the HSCP is still challenged with delays resulting from Adults with Incapacity (AWI) and family choice/indecision and delays due to Power of Attorney (PoA) not being in place.

Throughout Covid-19 crisis, **Community Rehabilitation** services continued delivering face to face urgent home visits to prevent admissions to hospital, facilitate hospital discharges and prevent deterioration of clients, in order to maximise safety and function in home environment. In addition, multiple innovative ideas have been embedded within the team. A Secondary Respiratory Response Team (Physio led) has been set up to respond to referrals from the GG&C Community Respiratory Team when required. A Rehab Nursing role was also developed to support Covid testing in home/care home environments when required and this will continue to be utilised when needed. The Rapid Access equipment service is now embedded within Rehab service and this has improved shared working, the responsiveness of Rapid Access OTAs, and reduced duplication.

The Community Rehabilitation service will require to continue to develop options for supporting the ongoing rehab needs of an increasingly frail client group in addition to those with complex long term health conditions, plus the potential impact of a prolonged timeframe for recovery for patients who have had Covid-19. There are also challenges due to other services not resuming their pre-Covid activity e.g. day hospitals/ community groups/ exercise classes/ falls classes.

There has been increased falls/ frailty presentations due to unintended consequences of Covid-19 lockdown restrictions on individuals' health including deconditioning, reduced social supports, implications of the pausing, ceased or phased remobilisation of NHS and community services and groups. There remains increased pressure on HSCP community assessment and rehabilitation teams to deliver assessment, intervention, and rehabilitation but without some of the wider supports previously available.

Providing Community Rehabilitation during the pandemic

During the past year, the Community Rehabilitation Team has continued to deliver face to face assessments and support to clients to avoid unnecessary conveyances to hospital; to help with discharge from hospital and to deliver ongoing rehabilitation for a variety of complex health conditions. While technology has been used to enhance triage, assessment and offer self-management information where possible, it was recognised that the majority of people referred to the Community Rehabilitation Service continue to require delivery of this in person, in their own home. We have done this safely and effectively for those who need it. We have worked closely with colleagues across the HSCP, and provided multidisciplinary assessment and rehabilitation to help individuals progress to the maximum of their abilities, while providing advice, support and encouragement to them and their families.

As a result of the changing demands and challenges of the Covid-19 pandemic, this past year has seen a significant increase in referrals to the Community Rehab Team. While managing this, we took on the additional responsibility of being a Community Respiratory Response Team to provide follow up to respiratory patients in the community. For many months, staff from the team also supported the Covid-19 testing and Covid-19 vaccination programmes for residents of Care Homes, and for those residents in East Renfrewshire who are housebound. Some of our staff were temporarily moved to other teams for a number of months to ensure the delivery of other essential services. Furthermore, two of the team were trained and undertook the Fit Testing for the specialist respiratory protective facemasks required for all staff across the HSCP providing care in higher risk situations.

It has been a year like no other, with so many individual stories and moments to reflect on…and with many, many positive outcomes despite the challenges faced by us all.

Over the past year unplanned acute presentations from care homes has dropped significantly due to Covid-19. Care homes had restrictions on who was able to go in and out of the facility and at the height of the pandemic ambulance service were not willing to take patients to the hospital unless patient's condition was life threatening. Staff within the care homes had to become more confident in managing their residents in such difficult times and pull together as a team. Care homes were closely monitored by the contracts team and support was provided by internal and external bodies.

Anticipatory Care Planning (ACP) is a person-centred, proactive approach, requiring services and professionals to work with individuals and their carers to set personal goals ensuring the right thing is done at the right time by the right person with the right outcome. ACP evolves reflecting the individual's situation and requires a supportive whole-system infrastructure to ensure delivery of positive outcomes. Over 2020-21 the partnership has continued to work to:

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

A Multi-disciplinary Team huddle has been implemented and has been working well based at Eastwood HSCP building. The aim is to improve communication between HSCP staff to prevent unnecessary admissions and proactively manage ACP, promoting seamless joint care.

The work responds to the challenge of providing care for an ageing population with increasing prevalence of long term conditions and multiple core morbidities and even more so now due to the pandemic. We now have ACP Champions and an ACP lead in place and we expect to see an increase in the number of ACPs in place.

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

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

2.8.1 Our strategic aims and priorities during 2020-21

As a partnership, the HSCP staff, the Carers Centre, Voluntary Action East Renfrewshire (VAER), the Care Collective and people with experience as carers have been working together to improve access to accurate, timely information that meets carers' needs and awareness of the range of supports for carers. Our approach encourages collaboration between providers of supports to carers ensuring local provision best meets carers' needs.

Through our work on self-directed support we will develop and implement a consistent and clear prioritisation framework and ensure that carers and support organisations are aware of the availability of suitable respite care and short-break provision. Working together with education we developed support systems that appreciate young carers and build resilience through opportunities for peer support.

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

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

As a direct consequence of the pandemic restrictions we have seen increased frailty and social isolation particularly among older people. The period has been especially challenging for our unpaid carers with impacts on health and wellbeing, increasing the difficulties that many carers face as they look after their loved ones. We recognise that unpaid carers have taken on increased caring during this time and have faced additional pressures.

2.8.2 The progress we made in 2020-21

Headline performance data includes:

- 91% of unpaid carers reporting 'quality of life for carers' needs fully met (154 respondents) – similar to 19/20 result (92%)
- 35% of carers who feel supported to continue in their caring role (19/20 data) – slight drop from previous national survey but above Scottish average

2.8.3 How we delivered in 2020-21

The pandemic has impacted significantly on carers, with potentially restricted access to support, resources and activities away from caring. The restrictions during the crisis have impacted on the health and wellbeing of carers and the people being cared for.

Throughout 2020-21 we have maintained our positive partnership working with the **East Renfrewshire Carers' Centre**, continuing to deliver community-based integrated support for

carers in East Renfrewshire including access to tailored advice, support, planning and community activities.

During the pandemic we have been working to ensure carers have access to required **guidance** and **PPE**. **Check-in calls** to carers were introduced by the Carers' Centre and carers were offered support to set up and manage a **peer support** Facebook Group.

Supporting carers during the pandemic – East Renfrewshire Carers' Centre

When Covid-19 restrictions first came into place, the Carers' Centre like most other organisations had to change the way they supported people.

The priority was working with the Health and Social Care Partnership to ensure that carers were aware of and, if required, had an Emergency Plan in place. This would detail support requirements in the event of the carer taking unwell and being unable to provide the care they normally do.

Any caring situations deemed to be at significant risk were shared with the HSCP and appropriate support would be offered if required. In addition to Emergency Planning, the Centre provided a focal point for carers needing personal, protective equipment (PPE).

Although referrals to the Centre dropped slightly compared to previous years, the Centre provided information to over 400 carers who were not known to the Centre but wanted information regarding Covid restrictions and priority access to the vaccination programme for carers.

The Centre tried to support as many carers as possible by moving all services to phone or online. All carers known to the Centre were contacted and made aware of what services the Centre was still able to provide.

Emotional and peer support as well as information and training sessions were moved online and the Centre continued to support carers and young carers in the most challenging of times.

The restrictions meant that carers and young carers had limited, if any, opportunity to get a break from their caring role. The Centre tried to address this by providing online social opportunities such as quizzes, concerts, comedy events and just the chance to catch up and have a chat. Some of these provided social opportunities for both the adult carer and the cared-for person simultaneously.

In addition to this, the Centre accessed funding made available through the Scottish Government, Carers Trust and other grant making organisations to provide financial grants to carers for activities and equipment that would make the caring role just that little bit easier during the Covid restrictions.

In total the Centre awarded almost £60,000 in grants for things like outdoor play equipment, bikes, laptops and tablets, take-out food vouchers and TV subscription services.

Together with the HSCP, the Centre supports a Carers Collective, a group of carers that can influence and shape services and support. The Collective is helping shape carers support as we emerge from the restrictions and has led on the development of new initiatives such as a Carers Card linked to the Respitality initiative and improving support for autistic people and their families.

As restrictions continue to ease, both the Centre and HSCP will continue to engage carers, improving support and ensuring that the support they need is available across East Renfrewshire.

"East Renfrewshire Carers' Centre have consistently supported me to continue to provide support for my loved one who has a long term disability, through numerous difficult situations. They often served as a sounding board so I could sort out exactly what approach I could take to issues troubling me and provided practical help and advice to help me navigate the health and care systems.

They have been exceptionally creative during Covid restrictions in thinking about new ways to include carers in service developments and providing new initiatives acting on the feedback they have received. I wish to thank their staff for their positive and compassionate support. I could not have continued caring for my loved one without them."

Carer (via Care Opinion)

The **Mental Health Carers Group** is a vital support for many of our local unpaid carers. The group has continued to run virtually throughout the pandemic.

During the year we worked collaboratively with carers and the Care Collective (East Renfrewshire Carers' Centre and Voluntary Action East Renfrewshire) to refresh the East Renfrewshire Carer's Strategy – **"I Care, You Care, We Care"**. During the engagement for the strategy, carers told us:

- Communication is an issue. Carers want more pro-active communication, to receive regular advice and updates on Covid-19 guidelines and on the practical support available.
- The pandemic has impacted on carers. The lack of resources and stimulation for the person they care for is impacting on the health and wellbeing of both the person being cared for and the carer.
- More support could be provided online for the person they care for and the introduction as restrictions allow of more health and wellbeing activities for carers such as stress management and community walking groups.
- There is a lack of choice and control over how they and the person they cared for are supported. Carers would like improved access to Self-Directed Support (SDS) options.

The strategy sets out a wide range of activities to deliver on the following four priorities for carers:

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

East Renfrewshire's **Short Breaks Statement** has also been updated during the year to ensure all advice and information is accurate and includes the development of creative, Covid-safe online breaks that meet the outcomes of the carer and the cared-for person. In collaboration with carers and other stakeholders we have established guiding principles for planning short breaks with carers and these remain key to short break provision. These are:

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

2.9 Public protection

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

2.9.1 Our strategic aims and priorities during 2020-21

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

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

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

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

During the challenge of the pandemic our focus remained the safety and reduction of harm for children and adults. We have seen an increase in child protection referrals in particular of children who have a diagnosis of autism and or complex needs. Despite the increase in referrals, registration numbers have been retained at a relatively low level, indicating that many of the families coming through the child protection referral route are in need of increased supports rather than child protection plans.

We maintained our Adult Support and Protection response throughout the pandemic and kept adult at the heart of what we do.

2.9.2 How we delivered in 2020-21

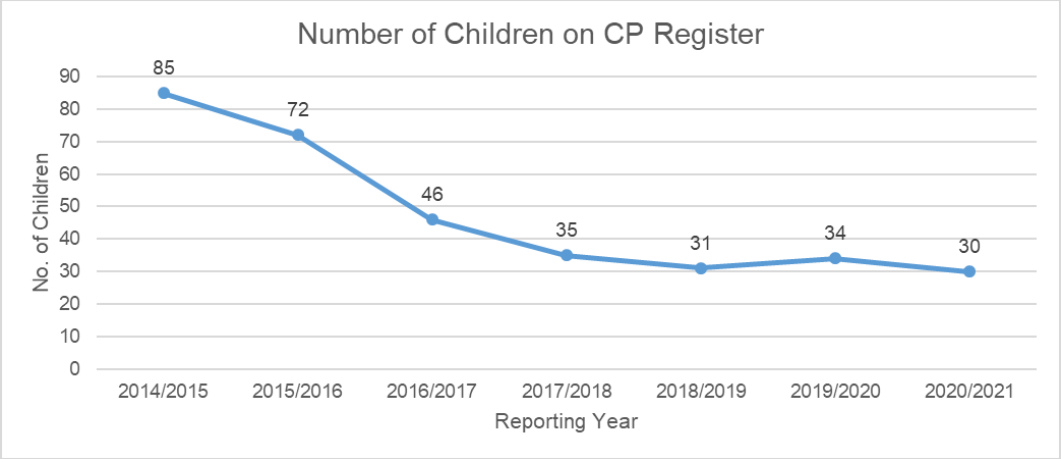
Supporting Children

The pandemic meant we had to adapt our approaches to overcome practical challenges. We ensured that staff provided with **Personal Protective Equipment (PPE)** equipment to enable them to safely respond to families in crisis and ensure critical services to protect vulnerable children and young people in their communities.

During the pandemic we provided **iPads** to children and their families to enable them to take part in virtual child protection case conferences / children's hearings.

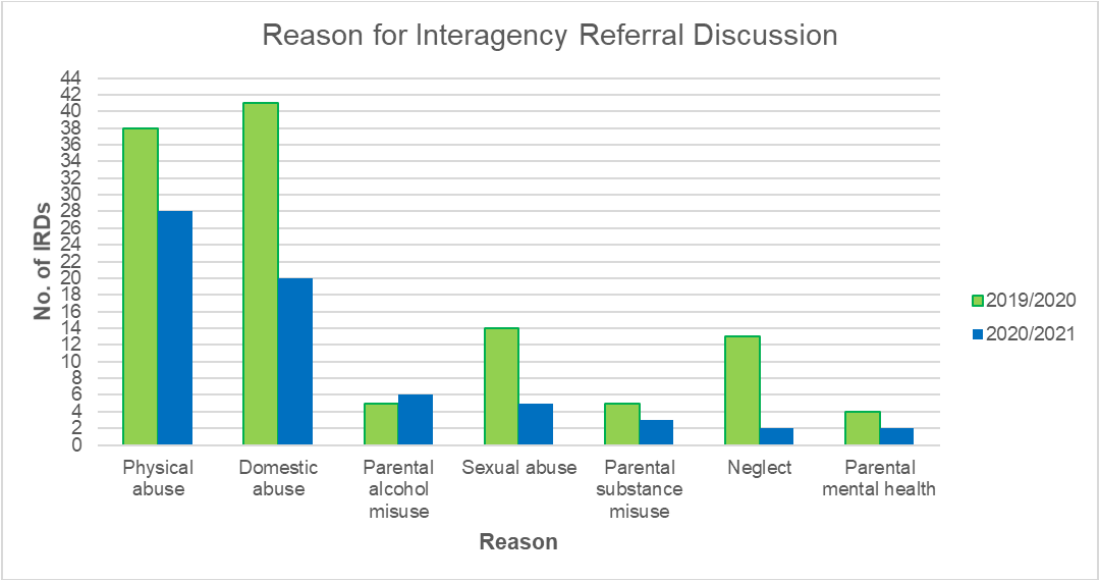
Early information sharing and decision making through the **Interagency Referral Discussion (IRD)** is well established and has been audited quarterly to provide quality assurance and management oversight. This has been an important process in maintaining relatively stable child protection registrations despite there being an increase in referrals.

In 2020-21, there were 30 children on East Renfrewshire's Child Protection Register. This is a decrease of four on the previous year. Although we had experienced variations in previous years higher than the national average, our registration rate appears to be stabilising at around 30 to 35 children each year. In addition to robust management and audit activity, we continue to benchmark against comparator authorities to ensure that the rate of registration activity is proportionate and necessary.



During 2020-21, we undertook 100 Interagency Referral Discussions (IRD) (between social work, police, health and where appropriate education services) in respect of 148 children.

The most common reasons for initiating an Interagency Referral Discussion (IRD) during 2020-21 are shown below. The highest reason for an IRD in the reporting period was physical abuse. There has been a significant decrease in IRDs in all reasons apart from parental alcohol misuse which increased slightly. Of the 148 children and young people subject to IRDs, half were subject to a child protection investigation.



During 2020-21 our programme of IRD audits reported significant strengths in our practice, including:

- Almost all (97%) IRDs reflected actual or potential risk to the child/young person.
- Almost all (93%) IRDs considered the historical information relevant to the concern being discussed.
- Most (83%) IRDs were able to reach a clear conclusion of risk.
- Almost all (94%) ensured the child / young person's safety throughout the process.
- The IRDs audited achieved an average rating of 'Very Good' in terms of overall quality.

Supporting Adults

During 2020-21 we established a new **Adult Support and Protection (ASP) team** responding to a 20% increase in referral numbers and a rise in referrals of a more complex nature. Revised adult support and protection processes and procedures were put in place in November 2020 and 239 staff have been trained across Adult Services, Children & Families, Mental Health, Addictions, Housing, Education, Health and our partner agencies in Safe and Together and MARAC.

We carried out two **Large Scale Investigations (LSI)** in line with our duties under The Adult Support and Protection (Scotland) Act 2007 in local care homes and moved 57 residents to new homes early in 2021.

During 2020-21 we adjusted our practice to incorporate **virtual communication** which has not only met the immediate necessity of the covid-19 pandemic, but also made many aspects of the Adult Support and Protection process more accessible for service users and carers. We have been able to engage with individuals in the way that work for them and overcome barriers such as mobility and distance.

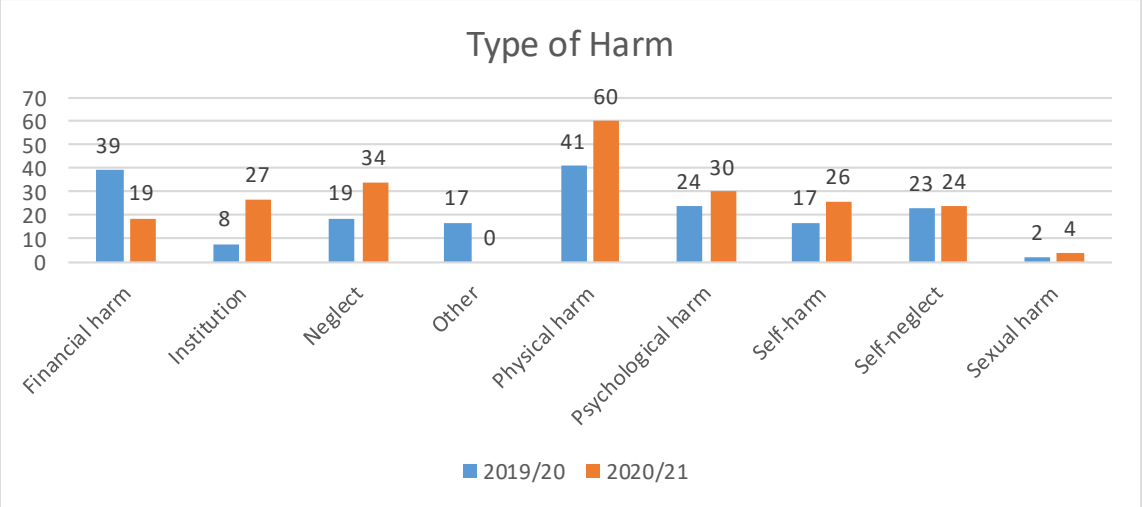
We have developed stronger **relationships** with partner agencies, promoting an approach that keeps all partners involved and included in discussions and planning particularly in the undertaking of LSIs. We have seen increased partnership working with a focus on keeping adults and their families and carers engaged and informed. As a partnership, we have developed a shared awareness of the complexity and multifaceted nature of risk, particularly in relation to violence against women, which has improved our joint working and understanding of the roles of other services and partners.

In 2020-21 there were a total of 857 **ASP inquiries** undertaken by Council Officers (Adult Service Social Workers) of which 224 progressed to investigations. Within the previous reporting period 2019-20 there were 697 inquiries carried out and 191 investigations. This demonstrates that there has been an increase of 23% (160) in the number of inquiries and of 17% (33) of the number of investigations undertaken compared to the previous period.

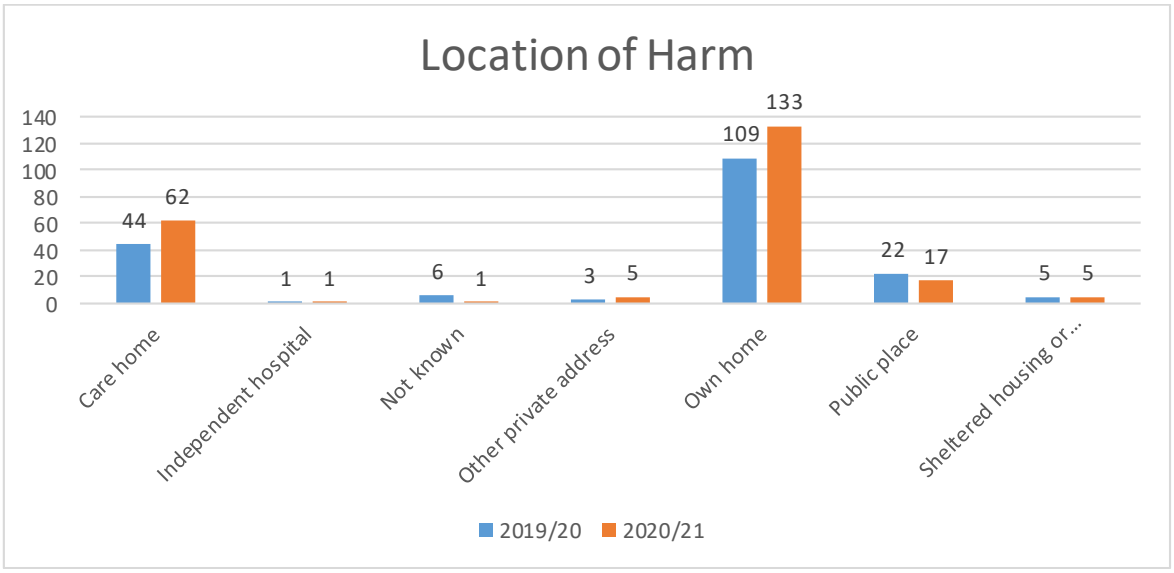
Of those inquiries carried out during 2020-21, 27% were received from third sector organisations delivering care and support to people in their own homes. This is the second year we have noted an increase in reporting of harm in people's own homes. This provides assurance that the identification of harm by providers is improving, which has been particularly of importance as adults have had limited contact outwith their homes during the Covid-19 pandemic.

For 2020-21 there was a 15% increase in **ASP investigations** carried out, rising from 190 in 2019-20 to 224. Consistent with this rise, we have seen an increase in almost all types of harm at investigation, with the exception of financial harm which has decreased by 51% by comparison to last year. Physical Harm remains the most common harm experienced by adults having increased to 27% of the investigations carried out in 2020-21, in 2019-20 this accounted for only 22% of investigations.

Institutional harm has seen a significant increase during this period, accounting for 12% of investigations, in 2019-20 this was only 4% of investigations. This increase is believed to be due to the two large scale investigations (LSIs) undertaken during this period. In order to promote more accurate recording the 'other' category of harm was removed, as such it is recorded as zero this year.



The primary location of harm in 2020-21 in 59% of investigations was within the adult's home. This is comparable to data from 2019-20. In 2020-21 care homes were the second highest location of harm in 28% of investigations. The increase in reported harm at care homes reflects the completion of two large scale investigation in the year.



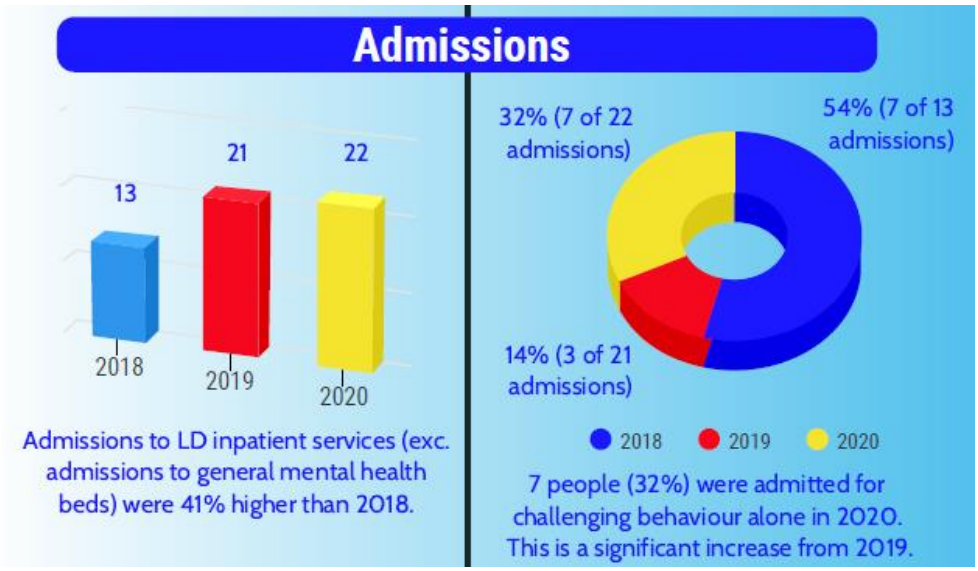
2.10 Hosted Services – Specialist Learning Disability Service

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

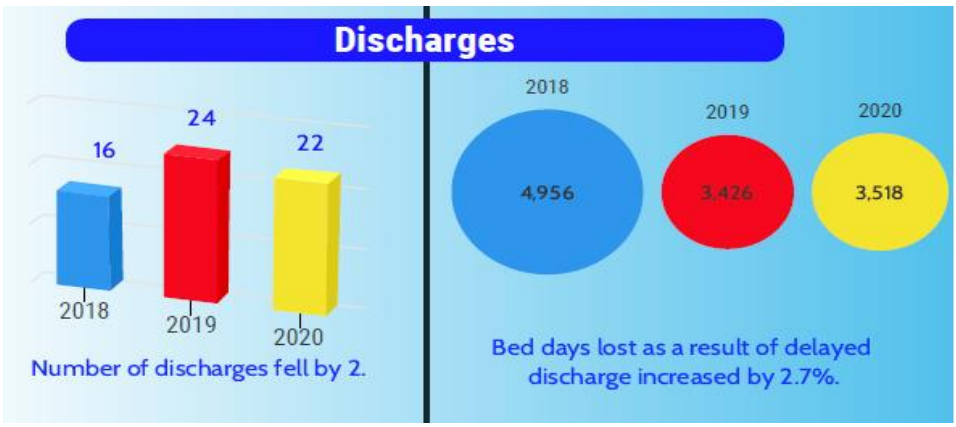
The service has operated at full capacity throughout the pandemic. We increased staffing levels and took a GGC wide approach to contingency through Board-wide collaboration. Over the year the service maintained good staff attendance and importantly achieved good infection control in challenging environments.

Over the year there has been a steady increase in request for admission as a result of distress. The team have worked very closely with community services to mitigate the effects of stress and limited community supports to maintain people at home.

Patient flow has been challenging with longer waits for admission or initial admission to mental health but everyone who requires the service has been successfully admitted. Despite the challenges of the pandemic, improvements seen in 2019 protected the service from a significant decrease in patient flow and more patients were admitted and discharged than the previous year.



Latest performance data for the service relates to Jan-Dec 2020. The pie chart above shows admissions relating to challenging behaviour. In 2020 admissions for challenging behaviour more than doubles from 2019.



Despite the challenges of the pandemic the service only saw a slight decrease in discharges. This was reflected in an increase of 2.7% in bed days lost due to delayed discharge. Although discharge planning improved, this did not translate to actual discharge. Placement breakdown remained stubbornly high - 59% of bed occupancy at the end of 2020. The majority of placement breakdowns originating from Glasgow City and Renfrewshire HSCPs.

Average waiting times to access the service increased significantly from 2019 but remained an improvement from 2018. The longest waiting time remained static. 65% of referrals were admitted directly to the service and were not diverted to general mental health services.

2.11 Supporting our staff

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

2.11.1 Our strategic aims and priorities during 2020-21

We recognise the enormity of the work of the partnership in responding to the Covid-19 pandemic and the potential effects of vicarious trauma across our workforce as they supporting citizen facing grief, loss and significant changes in their lives.

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.

In developing our interim strategic plan for 2021-22 and in consultation with staff and stakeholders we have added a new strategic priority to support staff across the partnership - *Working together with staff across the partnership to support resilience and wellbeing* .

2.11.2 How we delivered in 2020-21

To better understand the needs of staff at the HSCP during the pandemic we conducted a short 'pulse' survey across staff groups. We know from the HSCP **"Everyone matters Pulse Survey"** sent to NHS and Council staff that our staff's health and wellbeing has suffered as result of the first wave of the pandemic. As part of the survey when asked "*how anxious they felt yesterday*" 53% of respondents had high or medium levels of anxiety. Feedback from providers has highlighted similar issues. NHSGGC psychology services have been providing mental health check-ins across Acute and HSCP sectors and predict an increase in staff experiencing mental health conditions as a result of the pandemic.

Our local **East Renfrewshire HSCP Wellbeing Group** ran throughout the pandemic with links to both the National and NHSGGC wellbeing groups. The group developed a regular **newsletter** and cascaded information to ensure colleagues across the across the partnership, including colleagues within primary care, independent and third sector had access to **information and support** in order their workforces wellbeing and resilience was enhanced. We are continue to develop and refresh a series of positive measures to promote staff wellbeing throughout the year.

The HSCP Wellbeing Group is chaired by Head of Recovery and Intensive Services who also holds the national health and wellbeing **champion role** and contributes to discussions at a national level.

The group has developed a **Wellbeing Plan - 'YOU care…WE care too'** to support our workforce to cope with the emotional and physical impact of their overall health and wellbeing. The plan identifies four strategic objectives / outcomes and has a supporting action plan. The objectives are given below. We will work to ensure that advice, support and activities made available as widely as possible across the partnership.

- 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.

Within the wider partnership area Voluntary Action East Renfrewshire have established a **wellbeing network**. The aim of the network is to provide a space for likeminded people to share and act together to ensure East Renfrewshire residents can improve their physical and mental wellbeing. The need to come together, is even more important as we navigate through the many changes and priorities that are happening in society as a result of the pandemic. Wellbeing is a wide and varied topic, that touches all services, groups and social activities and the network is open to all who are interested in developing a positive collaborative approach to wellbeing.

3. Financial performance and Best Value

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

3.1 Introduction

Within this section of the report we aim to demonstrate our efficient and effective use of resources. Our Annual Report and Accounts 2020-21 is our statutory financial report for the year. We regularly report our financial position to the IJB throughout the year.

3.2 Financial Performance 2020-21

The annual report and accounts for the IJB covers the period 1st April 2020 to 31st March 2021 and provides a detailed financial overview of the year which ended with an operational underspend of £0.833 million. This position is per our unaudited annual report and accounts as at 23 June 2021 and the audited accounts are expected to be confirmed, subject to any adjustments, on 24 November 2021.

Service	Budget	Spend	Variance (Over) / Under	Variance (Over) / Under
	£ Million	£ Million	£ Million	%
Children & Families	12.823	12.413	0.410	3.20%
Older Peoples Services	20.158	18.087	2.071	10.27%
Physical / Sensory Disability	5.001	4.902	0.099	1.98%
Learning Disability – Community	13.411	13.678	(0.267)	(1.99%)
Learning Disability – Inpatients	8.691	8.691	0.000	0.00%
Augmentative and Alternative Communication	0.237	0.237	0.000	0.00%
Intensive Services	10.928	12.672	(1.744)	(15.96%)
Mental Health	5.305	5.113	0.192	3.62%
Addictions / Substance Misuse	1.799	1.747	0.052	2.89%
Family Health Services	26.036	26.036	0.000	0.00%
Prescribing	15.858	15.858	0.000	0.00%
Criminal Justice	0.009	(0.002)	0.011	122.22%
Planning & Health Improvement	0.207	0.142	0.065	31.40%
Finance and Resources	22.532	22.588	(0.056)	(0.25%)
Net Expenditure Health and Social Care	**142.995**	**142.162**	**0.833**	**0.58%**
Housing	0.174	0.174	-	-
Set Aside for Large Hospital Services	36.149	36.149	-	-
Total Integration Joint Board	**179.318**	**178.485**	**0.833**	**0.58%**

The £0.833 million underspend (0.58%) is marginally better than the reporting taken to the IJB during the year and the underspend will be added to our budget phasing reserves. We had expected to draw from reserves as we recognised we would not achieve all savings required during the year however we received Covid-19 funding to support us as we did not have capacity to progress the required work as a result of our focus on the Covid-19 response.

The impact of Covid-19 throughout the year meant that the focus of many of our services was on response and the variances against budget reflect this; the £9.1 million we spent on Covid-19 related costs was fully funded by the Scottish Government so has nil impact on each service

The main variances to the budget were:

- £0.410 million underspend within Children & Families and Public Protection from staff turnover and the costs of care packages.
- £2.071 million underspend in within Older Peoples Nursing, Residential and Daycare Services. This reflects the reduction in care home admissions but does offset the increase in community activity; predominantly Care at Home.
- £1.744 million overspend within Intensive Services as our Care at Home costs reflect that we were able to operate a near full service throughout the pandemic, in part as a result of a successful recruitment campaign early in the year.

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

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

2019/20 £000	SERVICES PROVIDED TO EAST RENFREWSHIRE IJB BY OTHER IJBs WITHIN NHS GREATER GLASGOW AND CLYDE	2020/21 £000
460	Physiotherapy	451
48	Retinal Screening	43
464	Podiatry	352
303	Primary Care Support	285
297	Continence	325
618	Sexual Health	594
906	Mental Health	1,168
868	Oral Health	867
348	Addictions	346
194	Prison Health Care	197
162	Health Care in Police Custody	158
4,211	Psychiatry	4,644
8,879	**NET EXPENDITURE ON SERVICES PROVIDED**	**9,430**

We also host the Specialist Learning Disability services and Augmentative and Alternative Communication services on behalf of the other NHS Greater Glasgow and Clyde HSCPs and this cost is met in full by East Renfrewshire HSCP; the use by all HSCPs is shown below for information:

2019/20 £000	LEARNING DISABILITY IN-PATIENTS SERVICES HOSTED BY EAST RENFREWSHIRE IJB	2020/21 £000
5,659	Glasgow	4,754
1,347	Renfrewshire	1,349
199	Inverclyde	612
846	West Dunbartonshire	653
196	East Dunbartonshire	0
8,247	Learning Disability In-Patients Services Provided to other IJBs	7,368
112	East Renfrewshire	1,926
8,359	**TOTAL LEARNING DISABILITY IN-PATIENTS SERVICES**	**9,294**

2019/20 £000	AUGMENTATIVE AND ALTERNATIVE COMMUNICATION HOSTED BY EAST RENFREWSHIRE IJB	2020/21 £000
72	Glasgow	89
7	Renfrewshire	33
-	Inverclyde	3
4	West Dunbartonshire	3
25	East Dunbartonshire	19
108	AAC Services Provided to other IJBs	147
11	East Renfrewshire	19
119	**TOTAL AAC SERVICES ***	**166**

3.3 Reserves

We used £0.831 million of reserves in year and we also invested £6.590 million into earmarked reserves, with much of this increase from Scottish Government ring-fenced funding. The year on year movement in reserves is set out in detail at Note 8 (Page 59) and is summarised:

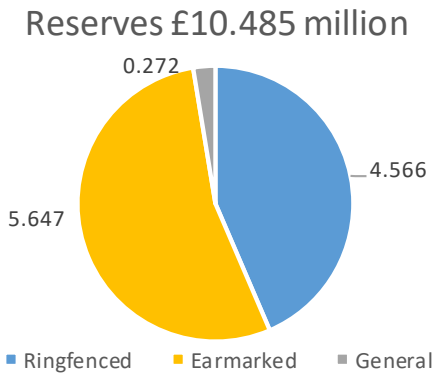
	£ Million	£ Million
Reserves at 31 March 2020		4.726
Planned use of existing reserves during the year	(0.831)	
Funds added to reserves during the year	6.590	
Net increase in reserves during the year		5.759
Reserves at 31 March 2021		10.485

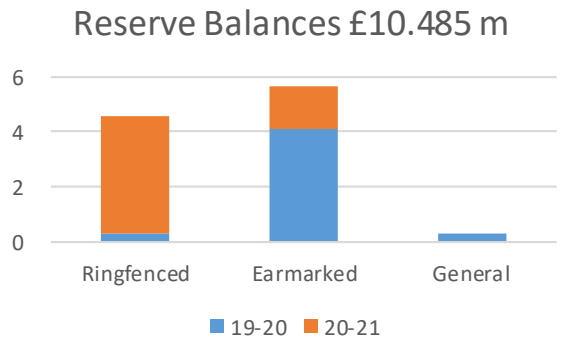
The purpose, use and categorisation of IJB reserves is supported by a Reserves Policy and Financial Regulations, both of which were reviewed in March 2020 in line with the statutory review of the Integration Scheme timescale.

The reserves of the IJB fall into three types:

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

The current balance of £10.485 million for all reserves falls in these three reserves types:





The majority of the increase in reserves relates to specific ring-fenced funding we have received from the Scottish Government during 2020-21 with £4.383 million added during the year. We can only spend this funding on those initiatives that the funding supports; the majority of this increase relates to Covid-19 funding of £3.165 million and this will support the ongoing response to the pandemic in 2021/22.

We spent £0.148 million of non Covid-19 ring-fenced reserves during the year and we are working on plans to utilise the balances within the scope of each area of activity during 2021/22 ensuring that we can support any ongoing activity from the one off investment of this funding.

The increase in ring-fenced funding during 2020-21 is not unique to East Renfrewshire and mirrors the national position.

Our earmarked reserves are in place to support a number of projects, provide transitional funding for service redesign, provide bridging finance for in year pressures, add capacity to support service initiatives and to support longer term cost smoothing and timing of spend across multiple years.

Within our earmarked reserves we spent £0.683 million, which is less than we planned given the prioritisation of services on the response to the pandemic. We had also planned to meet some refurbishment costs for work within our Learning Disability in-patient units, however this work was delayed at the start of the pandemic; this work is now on hold and will be incorporated as part of the work supported by the Community Living Change Fund. We have added £2.207 million to our earmarked reserves during the year.

Our general reserve remains unchanged at £0.272 million is well below the optimum level at a value of 2% of budget we would ideally hold. The general reserve is currently just under 0.2% of the 2020-21 revenue budget.

Given the scale of the financial challenge we have faced pre pandemic the IJB strategy to invest where possible in smoothing the impact of savings challenges has not allowed any investment into general reserves. We have recognised whilst this means we are below our policy level the prioritisation has been on long term sustainability and minimising the impact of savings over time on those services we provide. In the event we find ourselves unable to achieve sufficient savings delivery during 2021/22 we may need to un-hypothecate (i.e. un-earmark) reserves to meet operational costs.

The use of reserves is reported to the IJB within our routine revenue reporting.

3.4 Prior Year Financial Performance

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

	2020/21	2019/20	2018/19	2017/18	2016/17	2015/16
SERVICE	**(Over) / Under £ Million**	**(Over) / Under £ Million**	**(Over) / Under £ Million**	**(Over) / Under £ Million**	**(Over) / Under £ Million**	**(Over) / Under £ Million**
Children and Families	0.410	0.637	0.800	0.083	0.537	0.604
Older Peoples & Intensive Services	0.327	(0.866)	(0.228)	0.153	(0.046)	1.763
Physical / Sensory Disability	0.099	0.030	0.056	(0.167)	(0.280)	(0.345)
Learning Disability - Community	(0.267)	(0.095)	(0.047)	(0.214)	0.986	(1.801)
Learning Disability - Inpatients	0	0.002	0.123	0	0	0
Augmentative & Alternative Communication	0	0	N/A	N/A	N/A	N/A
Mental Health	0.192	0.189	0.419	0.409	0.393	0.354
Addictions / Substance Misuse	0.052	0.013	0.032	0.018	0.123	0.085
Family Health Services	0	-	0.008	0	0	0
Prescribing	0	(0.311)	(0.428)	0	0	0
Criminal Justice	0.011	-	0.039	0.011	0.013	0.027
Planning and Health Improvement	0.065	0.098	0.074	0.001	0.039	0.029
Management and Admin / Finance & Resources	(0.056)	0.238	(0.190)	0.483	(0.144)	(0.335)
Planned Contribution to / from Reserves	0		(0.398)	(0.600)	**	0
Net Expenditure Health and Social Care	**0.833**	**(0.065)**	**0.260**	**(0.177)**	**1.622**	**0.381**

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

3.5 Best Value

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

3.6 Future Challenges

The IJB continues to face a number of challenges, risks and uncertainties in the coming years and this is set out in our current Medium-Term Financial Plan for 2022/23 to 2026/27 which supports our strategic planning process and provides a financial context to support medium-term planning and decision making.

The funding gap in future years could range anywhere from £0 to £4.7 million per year, excluding unknown factors and any additional savings requirements in future years. The resulting funding gap will be dependent on the funding settlement for each year.

The 2021/22 budget settlement fell within the poor settlement range of scenario planning assumptions with cost pressures of just over £9.3 million and subsequent required savings of £3.9 million after all funding uplifts of £4.9 million and deduction of immediately achievable savings of £0.5 million.

The budget for the year 2021/22 was agreed by the IJB on 17th March 2021 and identifies a funding gap of £3.9 million which relates to the £2.4 million legacy savings from 2020/21 we did not achieve as a result of the pandemic response and the funding gap of £1.5 million relating to 2021/22.

In setting this budget the IJB recognised the scale of the challenge; that we were still in response mode; that there are still many unknowns as we work our way towards recovery and the impact and implications from the plans for a national care service are unknown.

Pre the pandemic we had identified that the majority of the 2020-21 savings would come from the introduction of a contribution from individuals towards the cost of non-residential care, the prioritisation of care package costs and that we would need to further consider prioritisation and eligibility criteria for future savings options. This is now potentially at odds with the recommendations included in the Independent Review of Adult Social Care and the timing of any local decisions will need to be balanced with the risk of implementing change that may require subsequent reversal.

The implications from this review will be reflected in our short and medium term financial planning and in our Recovery and Renewal Programme as 2021/22 progresses and the policy decisions and directions become clearer. 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.

The IJB have recognised that 2021/22 will require an iterative approach and we will need to adapt, respond and flex in a timely manner. As one of the smaller IJBs we are nimble and can react quickly however we do have a significant financial risk; our funding gap is £3.9 million, we have c£2 million in reserves to phase in those savings we can achieve, but we will only achieve savings by fully resourcing our Recovery and Renewal programme; and the only options to do this, at present are to divert existing resources and / or invest in the short term thus reducing the reserve available to phase in the savings.

The 2021/22 budget recognises that we may require to invoke financial recovery planning if we cannot close our funding gap on a recurring basis.

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

The consequences of Brexit have not manifested in any specific issues during 2020-21 however given this period is far from normal this will continue to be monitored and working groups with partners remain active.

We have successfully operated integrated services for over 15 years so we have already faced a number of challenges and opportunities open to newer partnerships. However our funding and savings challenge take no account of this history. Whilst we have agreed a population based approach for future (NHS) financial frameworks and models this does not address the base budget.

Prescribing Costs: The cost of drugs prescribed to the population of East Renfrewshire by GPs and other community prescribers is delegated to the IJB. This is a complex and volatile cost base of around £16 million per year. The post Covid-19 impact on prescribing in the medium to long term is unclear. During 2020-21 the volume of items prescribed reduced by 4.8% over the year as a result of the pandemic; the post Covid-19 implication is not yet clear in terms of complexity of need, population demand and mental health impacts.

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

Care Providers: The longer term impact on the sustainability of the care provider market following Covid-19 is unknown and we continue to work closely with all our partners to work through issues, support where we can and look to develop the best way of working building on our collaborative and ethical commissioning approach as we move forward. This will build on our work to date, including the move to national contractual frameworks along with the implications from the independent review of adult social care; this may impact on how we commission services.

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

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

- Our Recovery and Renewal Programme will be implemented throughout 2021/22 and beyond and regular reports will be taken to the IJB.
- We will update our Medium-Term Financial Plan on a regular basis reflecting the ongoing impact of Covid-19 and the independent review of adult social care as these become clearer. This will allow us to continue to use scenario-based financial planning and modelling to assess and refine the impact of different levels of activity, funding, pressures, possible savings and associated impacts.
- We will continue to monitor in detail the impacts of Covid-19, Brexit and operational issues through our financial and performance monitoring to allow us to take swift action where needed, respond flexibly to immediate situations and to inform longer term planning.
- We will continue to report our Covid-19 costs through the NHS Greater Glasgow and Clyde Mobilisation Plan and to the IJB. At this stage we do not know if we will receive any further support for non-delivery of savings.
- We will continue to work through our Care at Home action plan and service redesign, taking into account any issues that are identified once the follow up inspection has taken place.
- We will continue to progress and report on our Strategic Improvement Plan until fully complete; work on this was not a priority during the pandemic response.
- We will complete the review of our Integration Scheme; work had been undertaken pre the pandemic and was then put on hold.
- We will review and revise savings proposals for 2021/22 for our funding gap, reflecting our Recovery and Renewal Programme and the impact of any policy decisions around a national care service. Our individual budget calculator will continue to be used and we may still need to revise the funding parameters. We will continue to use our reserve through 2021/22 to phase in budget savings. It is possible we will deplete this reserve in 2021/22 so there is a significant risk associated with:
    - Ensuring savings are achieved on a recurring basis by the end of the financial year
    - Impact of not achieving full year savings on a recurring basis
    - A similar level of budget settlement in 2021/22
    - Unknown impact of Covid-19

- We will continue to monitor the costs and funding of Covid-19 related activity through the NHS Greater Glasgow and Clyde Mobilisation Plan.
- We have realigned our senior management structure to ensure we are best placed to meet the challenges over the next period and to ensure leadership continuity following the planned retiral of key colleagues.
- We routinely report our performance to the IJB with further scrutiny from our Performance and Audit Committee and our Clinical and Care Governance Group. The service user and carer representation on the IJB and its governance structures is drawn from Your Voice which includes representatives from community care groups, representatives from our localities and representatives from equality organisations including disability and faith groups.
- Workforce planning will support identifying our current and future requirements. Recruitment and retention of staff is key to all service delivery and we have mitigated as far as possible by minimising the use of temporary posts and developing our workforce and organisational learning and development plans. Given the overwhelming response to the pandemic our staff are tired both physically and mentally and the wellbeing of our workforce is paramount.
- Governance Code; we have robust governance arrangements supported by a Governance Code.

- The IJB continues to operate in a challenging environment and our financial, risk and performance reporting continue to be a key focus of each IJB agenda.

The future challenges detailed above and our associated response include the main areas of risk that the IJB is facing. The uncertainty of the impact of Covid-19 on our population and the capacity for the HSCP and its partners to deliver services and implement our Recovery and Renewal programme whilst maintaining financial sustainability are significant risks.

4. Performance summary

4.1 Introduction

In the previous chapters of this report we have focused on the key areas of work carried out by the HSCP over the course of 2020-21 including crucial activities as we responded to and have started to recover from the pandemic. In this final chapter we draw on a number of different data sources to give a more detailed picture of the progress the partnership has been able to make against our established performance indicators. Our quantitative performance for 2020-21 clearly reflects the challenging operating context during the Covid-19 pandemic.

The sections below set out how we have been performing in relation to our suite of Key Performance Indicators structured around the strategic priorities in our Strategic Plan 2018-21. We also provide performance data in relation to the National Integration Indicators and Ministerial Steering Group (MSG) Indicators. Finally, we provide a performance summary relating to recent inspections of our in-house services.

4.2 Performance indicators

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

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

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

Strategic Priority 1 - Working together with children, young people and their families to improve mental wellbeing							
Indicator	**2020/21**	**Current Target**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
Percentage of children looked after away from home who experience 3 or more placement moves *(DECREASE)*	**1.2%**	11%	0.0%	1.4%	1.2%	7.1%	↓
Children and young people starting treatment for specialist Child and Adolescent Mental Health Services within 18 weeks of referral *(INCREASE)*	**61%**	90%	78%	74%	89%	90%	↓
Child & Adolescent Mental Health - longest wait in weeks at month end *(DECREASE)*	**35**	18	33	34	35	31	↓
Accommodated children will wait no longer than 6 months for a Looked After Review meeting to make a permanence recommendation *(INCREASE)*	**74%**	80%	94%	83%	100%	n/a	↓
Balance of Care for looked after children: % of children being looked after in the Community (LGBF) *(INCREASE)*	n/a	Data only	**94.9%**	98.0%	93.6%	91.5%	↓
% Child Protection Re-Registrations within 18 months (LGBF) *(DECREASE)*	n/a	Data only	**15.8%**	7.7%	0%	9%	↓
% Looked After Children with more than one placement within the last year (Aug-Jul). (LGBF) *(DECREASE)*	n/a	Data only	**18.8%**	24.5%	29.1%	19.6%	↑

Strategic Priority 2 - Working together with our community planning partners on new community justice pathways that support people to prevent and reduce offending and rebuild lives							
Indicator	**2020/21**	**Current Target**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
Community Payback Orders - Percentage of unpaid work placement completions within Court timescale. *(INCREASE)*	**75%**	80%	71%	84%	92%	96%	↑
Criminal Justice Feedback Survey - Did your Order help you look at how to stop offending? *(INCREASE)*	**92%**	100%	100%	100%	100%	100%	↓
% Positive employability and volunteering outcomes for people with convictions. (INCREASE)	n/a	60%	**65%**	55%	n/a	n/a	↑
% Change in women's domestic abuse outcomes *(INCREASE)*	**84%**	70%	79%	64%	65%	66%	↑
People agreed to be at risk of harm and requiring a protection plan have one in place. *(INCREASE)*	**100%**	100%	100%	100%	n/a	n/a	–

Strategic Priority 3 - Working together with our communities that experience shorter life expectancy and poorer health to improve their wellbeing							
Indicator	**2020/21**	**Current Target**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
Increase the number of smokers supported to successfully stop smoking in the 40% most deprived SIMD areas. (This measure captures quits at three months and is reported 12 weeks in arrears.) *(INCREASE)*	**66**	16	74	6	20	27	↓

Strategic Priority 3 - Working together with our communities that experience shorter life expectancy and poorer health to improve their wellbeing							
Indicator	**2020/21**	**Current Target**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
Premature mortality rate per 100,000 persons aged under 75. (European age-standardised mortality rate) *(DECREASE)* NI-11	n/a	Data Only	**295**	308	301	297	↑
Breastfeeding at 6-8 weeks most deprived SIMD data zones *(INCREASE)*	n/a	25%	**15.4%**	22.9	27.3	17.2	↓
Percentage of adults able to look after their health very well or quite well *(INCREASE)* NI-1	n/a	Data Only	**94%**	n/a	94%	n/a	-

Strategic Priority 4 - Working together with people to maintain their independence at home and in their local community							
Indicator	**2020/21**	**Current Target**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
Number of people self directing their care through receiving direct payments and other forms of self-directed support. *(INCREASE)*	**551**	600	575	514	491	364	↓
Percentage of people aged 65+ who live in housing rather than a care home or hospital *(INCREASE)*	n/a	97%	**97%**	95.9%	96.6%	96.8%	↑
The number of adults (18+) receiving personal care at home or direct payments for personal care, as a percentage of the total number of adults needing care. *(INCREASE)* NI-18	n/a	62%	**57%**	64%	64%	63%	↓
People reporting 'living where you/as you want to live' needs met (%) *(INCREASE)*	**91%**	90%	88%	92%	84%	79%	↑

Strategic Priority 4 - Working together with people to maintain their independence at home and in their local community							
Indicator	**2020/21**	**Current Target**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
SDS (Options 1 and 2) spend as a % of total social work spend on adults 18+ (LGBF) *(INCREASE)*	n/a	Data Only	**8.44%**	8.15%	7.5%	6.6%	↑
Percentage of people aged 65+ with intensive needs receiving care at home. (LGBF) *(INCREASE)*	n/a	62%	**57.6%**	57.5%	62.5%	61.1%	↓
Percentage of those whose care need has reduced following re-ablement *(INCREASE)*	**31%**	60%	67	68	62	64	↓

Strategic Priority 5 - Working together with people who experience mental ill-health to support them on their journey to recovery							
Indicator	**2020/21**	**Current Target**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
Mental health hospital admissions (age standardised rate per 1,000 population) *(DECREASE)*	n/a	2.3	**1.6**	1.5	1.5	1.5	–
Percentage of people waiting no longer than 18 weeks for access to psychological therapies *(INCREASE)*	**74%**	90%	65%	54%	80%	56%	↑
% of service users moving from drug treatment to recovery service *(INCREASE)*	**6%**	10%	16%	22%	12%	9%	↓
Achieve agreed number of screenings using the setting-appropriate screening tool and appropriate alcohol brief intervention, in line with SIGN 74 guidelines. *(INCREASE)*	**5**	419	33	93	331	468	↓

Strategic Priority 5 - Working together with people who experience mental ill-health to support them on their journey to recovery							
Indicator	**2020/21**	**Current Target**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
Percentage of people with alcohol and/or drug problems accessing recovery-focused treatment within three weeks. *(INCREASE)*	**95%**	90%	89%	95%	87%	96%	↑

Strategic Priority 6 - Working together with our colleagues in primary and acute care to care for people to reduce unplanned admissions to hospital							
Indicator	**2020/21**	**Current Target**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
People (18+) waiting more than 3 days to be discharged from hospital into a more appropriate care setting including AWI *(DECREASE)* (NHSGGC data)	**2**	0	2	4	4	4	–
Acute Bed Days Lost to Delayed Discharge (Aged 18+ including Adults with Incapacity) *(DECREASE)* (MSG data)	**2,342**	1,893	1,788	2,284	1,860	2,704	↓
No. of A & E Attendances (adults) *(DECREASE)* (NHSGGC data)	**9,854**	Data only	12,748	12,943	12,587	12,503	↑
Number of Emergency Admissions: Adults *(DECREASE)* (NHSGGC data)	**6,217**	Data only	6,859	6,801	6,916	6,908	↑
No. of A & E Attendances (adults) *(DECREASE)* (MSG data)	**13,677**	18,335	20,159	20,234	19,344	18,747	↑
Number of Emergency Admissions: Adults *(DECREASE)* MSG	**6,663***	7,130	7,538	7,264	7,432	8,032	↑

Strategic Priority 6 - Working together with our colleagues in primary and acute care to care for people to reduce unplanned admissions to hospital							
Indicator	**2020/21**	**Current Target**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
Emergency admission rate (per 100,000 population) for adults *(DECREASE)* NI-12	**9,324***	11,492	10,438	10,345	10,495	11,427	↑
Emergency bed day rate (per 100,000 population) for adults *(DECREASE)* NI-13	**96,295***	117,000	105,480	110,558	119,234	121,601	↑
Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges) *(DECREASE)* NI-14	**94**	100	78	79	79	83	↓
A & E Attendances from Care Homes (NHSGGC data) *(DECREASE)*	**236**	400	394	429	541	n/a	↑
Emergency Admissions from Care Homes (NHSGGC data) *(DECREASE)*	**154**	240	233	261	338	166	↑
% of last six months of life spent in Community setting *(INCREASE)* MSG	**89.9%****	86%	88.3%	86.2%	85.0%	85.8%	↑

* Full year data not available for 2020/21. Figure relates to 12 months Jan-Dec 2020. Data from PHS release, 10 June 2021
**Provisional figure for 2020/21

Strategic Priority 7 - Working together with people who care for someone ensuring they are able to exercise choice and control in relation to their caring activities							
Indicator	**2020/21**	**Current Target**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
People reporting 'quality of life for carers' needs fully met (%) *(INCREASE)*	**91%**	72%	92%	78%	72%	70%	–

Strategic Priority 7 - Working together with people who care for someone ensuring they are able to exercise choice and control in relation to their caring activities							
Indicator	**2020/21**	**Current Target**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
Total combined % carers who feel supported to continue in their caring role *(INCREASE)* NI 8	n/a	Data only	**35.3%**	n/a	37.5%	n/a	

Organisational measures							
Indicator	**2020/21**	**Current Target**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
Percentage of days lost to sickness absence for HSCP NHS staff *(DECREASE)*	**5.5%**	4.0%	7.3%	6.8%	8.5%	7.2%	
Sickness absence days per employee - HSCP (LA staff) *(DECREASE)*	**13.6**	12.4	19.1	16.4	13.0	13.6	
Percentage of HSCP (NHS) complaints received and responded to within timescale (5 working days Frontline, 20 days Investigation) *(INCREASE)*	**100%**	70%	56%	67%	100%	63%	
Percentage of HSCP (local authority) complaints received and responded to within timescale (5 working days Frontline; 20 days Investigation) *(INCREASE)*	**65%**	100%	72%	72%	81%	68%	

4.3 National Integration Indicators

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

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

4.3.1 Scottish Health and Care Experience Survey (2019-20)

Information on nine of the National Integration Indicators are derived from the biennial Scottish Health and Care Experience survey (HACE) which provides feedback in relation to people's experiences of their health and care services. The most recent survey results for East Renfrewshire relate to 2019-20 and are summarised below.

National indicator	2019/20	Scotland 2019/20	2017/18	2015/16	East Ren trend from previous survey	Scotland trend from previous survey
NI-1: Percentage of adults able to look after their health very well or quite well	**94%**	93%	94%	96%	-	-
NI-2: Percentage of adults supported at home who agreed that they are supported to live as independently as possible	**78%**	81%	74%	80%	↑	-
NI-3: Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	**75%**	75%	64%	77%	↑	↓
NI-4: Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	**62%**	74%	60%	69%	-	-
NI-5: Total % of adults receiving any care or support who rated it as excellent or good	**70%**	80%	77%	82%	↓	-
NI-6: Percentage of people with positive experience of the care provided by their GP practice	**85%**	79%	84%	88%	↑	↓
NI-7: Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	**78%**	80%	76%	79%	↑	-
NI-8: Total combined % carers who feel supported to continue in their caring role	**35%**	34%	37%	45%	↓	↓
NI-9: Percentage of adults supported at home who agreed they felt safe	**81%**	83%	82%	82%	-	-

Data from PHS release, 10 June 2021

4.3.2 Operational performance indicators

National indicator	2020/21	Scotland 2020/21	2019/20	2018/19	2017/18	2016/17	Trend from previous year
NI-11: Premature mortality rate per 100,000 persons	**n/a**	426* (2019)	**295***	308*	301*	297*	↑
NI-12: Emergency admission rate (per 100,000 population) for adults	**9,324****	11,100**	10,438	10,345	10,495	11,427	↑
NI-13: Emergency bed day rate (per 100,000 population) for adults	**96,295****	101,852**	105,480	110,558	119,234	121,601	↑
NI-14: Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges)	**94****	114**	78	79	79	83	↓
NI-15: Proportion of last 6 months of life spent at home or in a community setting	**90%****	90%**	88%	86%	85%	86%	↑
NI-16: Falls rate per 1,000 population aged 65+	**21.4****	21.7**	22.6	23.4	22.4	21.2	↑
NI-17: Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	**84%**	83%	84%	84%	88%	88%	-
NI-18: Percentage of adults with intensive care needs receiving care at home	n/a	63%* (2019)	**57%***	64%*	63%*	58%*	↓
NI-19: Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	**191**	488	156	170	117	228	↓
NI-20: Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	**19%****	21%**	21%	21%	22%	22%	↑

Data from PHS release, 10 June 2021. *Calendar years. **Full year data not available for 2020/21. Figure relates to 12 months Jan-Dec 2020. N.b. Scotland fig is Jan-Dec 2020 for comparison.

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

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

4.4 Ministerial Strategic Group Indicators

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

MSG Indicator	2020/21	Target 20/21	2019/20	2018/19	2017/18	2016/17	2015/16	Trend from 2019/20
Number of emergency admissions (adults)	**6,663***	7,130	7,538	7,264	7,432	8,032	7,922	↑
Number of emergency admissions (all ages)	**7,487***	8,331	8,645	8,246	8,513	9,199	9,123	↑
Number of unscheduled hospital bed days (acute specialties) (adults)	**58,400***	57,106	62,861	60,953	62,967	62,901	58,271	↑
Number of unscheduled hospital bed days (acute specialties) (all ages)	**59,676***	58,899	59,764	64,407	64,769	64,455	60,064	↑
A&E attendances (adults)	**13,677**	18,335	20,159	20,234	19,344	18,747	18,332	↑
A&E attendances (all ages)	**17,798**	25,299	27,567	27,850	27,011	25,888	25,300	↑
Acute Bed Days Lost to Delayed Discharge (Aged 18+ including Adults with Incapacity)	**2,342**	1,893	1,788	2,284	1,860	2,704	2,366	↓
% of last six months of life spent in Community setting (all ages)**	**89.9%****	86%	88.3%	86.2%	85.0%	85.8%	85.6%	↑
Balance of care: Percentage of population at home (supported and unsupported) (65+)	n/a	Data only	**96.5%**	95.9%	95.8%	95.7%	95.6%	↑
Balance of care: Percentage of population at home (supported and unsupported) (all ages)	n/a	Data only	**99.2%**	99.0%	99.0%	99.0%	99.0%	↑

Data from PHS release, 4 August 2021. (MSG Indicators)

*Full year data not available for 2020/21. Figure relates to 12 months Jan-Dec 2020.

**Provisional figure for 2020/21

4.5 Inspection performance

East Renfrewshire HSCP delivers a number of in-house services that are inspected by the Care Inspectorate. The following table show the most up to date grades as of 31 August 2021.

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

Service	Date of Last Inspection	Quality of Care and Support	Quality of Environment	Quality of Staffing	Quality of Management & Leadership
Adoption Service	11/10/2019	5	Not assessed	5	Not assessed
Barrhead Centre	23/02/2018	6	Not assessed	Not assessed	6
Fostering Service	11/10/2019	5	Not assessed	5	Not assessed
Care at Home	25/06/2021	4	Not assessed	Not assessed	Not assessed
HSCP Holiday Programme	21/07/2017	6	Not assessed	Not assessed	5
Thornliebank Resource Centre	07/04/2016	4	Not assessed	Not assessed	4
HSCP Adult Placement Centre	25/10/2019	5	Not assessed	5	5

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

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

Appendix One - National Outcomes

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

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

The National Outcomes for Children are:

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

The National Outcomes for Criminal Justice are:

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