



# **Working Together for East Renfrewshire – A Three Year Strategic Plan for Health and Social Care 2022-25**

**East Renfrewshire  
Health and Social Care  
Partnership**



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## **1. Introduction**

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Welcome to the third Strategic Plan for East Renfrewshire Health and Social Care Partnership (HSCP). The plan sets out the shared ambitions and strategic priorities of our partnership; and how we will focus our activity to deliver high quality health and social care to the people of East Renfrewshire. The plan covers the period 2022-25 and builds on our one-year 2021-22 'bridging plan' that was developed to support planning during our pandemic response phase.

Our response to the pandemic has seen incredible resilience, commitment and creativity from staff at the HSCP, our partner providers and community groups in East Renfrewshire. Our teams have established and adapted to new ways of working and have continued to maintain and deliver safe and effective services to our residents. During the pandemic period there has been innovation and collaborative working across the health and care system building on and strengthening local partnerships. This positive response is informing current and future approaches and we will continue to build on innovation and best practice over the course of this strategic plan.

While the plan sets out fundamental strategic priorities for health and social care such as supporting people to living independently and well at home, supporting better mental health and wellbeing, and ensuring access to high quality local health care services we continue to operate in the context of the pandemic. Our plan will be reviewed annually, building on the experiences and new learning as we continue our recovery.

This plan is based on strong evidence of local needs and despite practical challenges has been developed through a highly participative process drawing in voices from our partners in the community, third and independent sectors as well as people with lived experience and unpaid carers. As an inclusive partnership we will continue to engage widely as we review the delivery of our commitments in this plan and work to bring in fresh and innovative ideas as we move forward.



## **2. Our ambition, vision and priorities**

## **2.1 Our ambition**

This is a pivotal time for health and social care in Scotland and it is the ambition of East Renfrewshire HSCP to meet the challenges we face and embrace new opportunities with a renewed commitment to innovation and high quality services and supports, designed and delivered in partnership with local people and partners.

We want to ensure that health and care supports available in East Renfrewshire meet the needs, values and personal ambitions of the people who live here. We want supports to be truly person-centred, focused on human rights and empowering people to thrive at whatever stage they are at in life.

Building the health and social care system we want to see requires strong collaboration and over the life of this plan we will work to further strengthen collaborative practices, building on examples such as our digital partnership and local delivery of the Communities Mental Health and Wellbeing Fund.

Our focus is on prevention and early intervention, with a range of supports in place to meet health and care needs early, preventing deterioration and helping people avoid crisis situations. As a broad and inclusive partnership our ambition is to maximise the supports and opportunities that are available for local people in the community, supporting prevention and working to tackle health inequalities across our communities. We recognise the wider determinants of health and wellbeing including education, employment and income, and the importance of good quality, affordable and appropriate housing. Through collaborative and ethical commissioning we will work with communities, third sector organisations and our independent sector providers, championing the most innovative and effective ideas and approaches.

Everyone has the right to live in safety and be protected from neglect, abuse and harm. Our partnership has a key role in helping to keep vulnerable people in our communities safe; and in preventing harm and supporting people at risk of harm. Over the life of this plan we will continue to develop our responses to new risks and vulnerabilities as these emerge.

Our health and care system depends on those that provide care and support, both paid and unpaid. Our ambition in East Renfrewshire is to increase recognition of the role that unpaid carers play, and ensure that the supports needed by carers are in

place. As a partnership our workforce are our greatest asset. We want to ensure that those providing invaluable health and care services are happy and motivated; and feel respected and fulfilled in their role for years to come.

## 2.2 Listening to the experiences of people in East Renfrewshire

To support the development of this Strategic Plan we carried out a highly participative engagement process during 2021 designed and delivered in partnership with our third and independent sector partners. A wide range of views were shared with us by people with lived experience, unpaid carers, staff and management at support providers, HSCP staff and officers from internal and external partner organisations. Some of the most prominent issues raised in relation to our strategic themes are given below along with the response we take as a partnership.



<b>Supporting people to maintain independence</b>	
<b>What people told us</b>	<b>How we respond as a partnership</b>
<ul style="list-style-type: none"> <li>• We need to move beyond the mindset of traditional services – look at innovative options for support.</li> <li>• We need to be serious about prevention and stopping people reaching crisis. We need to expand what's available in the community – and communicate what's available to those that need support.</li> <li>• We need to make sure that services are 'joined-up' and support providers are talking to each other.</li> <li>• We need to make sure we're making the best use of digital technology.</li> <li>• We need to fulfil our commitment to expanding choice and control. We need a more effective framework needed around Self-directed Support – clarity on supports and criteria.</li> <li>• We need more collaborative working between support providers and with other partners – e.g. training, finance, and approaches to recruitment.</li> </ul>	<ul style="list-style-type: none"> <li>• We are committed to the principles and priorities set out in the Independent Review of Adult Social Care and the initial proposals for a National Care Service including: the commitment to person-centred, right-based approaches; more collaborative working and 'joined-up' approaches that focus on the experiences of individuals; and expanding choice and control through full delivery of self-directed support.</li> <li>• We will develop and delivery our Commissioning and Market-shaping Plan to support this strategy. Through collaborative practices we will develop and expand local market provision.</li> <li>• In partnership with our local providers' forum we will explore practical steps for more collaborative working between local support providers.</li> <li>• We will promote and support the expanded use of digital communication technology for access to health and care supports; and promote use of health monitoring systems to support self-management of conditions.</li> </ul>
<b>Supporting better mental health and wellbeing</b>	
<b>What people told us</b>	<b>How we respond as a partnership</b>
<ul style="list-style-type: none"> <li>• Essential that we support and promote resilience and self-management – across a range of groups – e.g. elderly, disabled, men, young people, shielding group, carers.</li> <li>• More strengths based support – building on people's lived experiences.</li> <li>• We need to ensure peer to peer support continues and is built on going forward.</li> <li>• Encourage prevention – self-awareness and understanding around mental wellbeing.</li> </ul>	<ul style="list-style-type: none"> <li>• Working collaboratively with our wider community planning partners we are focused on supporting better mental wellbeing and resilience across our communities. Led by the third sector, innovative approaches are being supported through the Communities Mental Health and Wellbeing Fund.</li> <li>• We are focused on preventative approaches and will build on the strengths of approaches such as community link workers in GP practices and our peer support programme.</li> </ul>

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| <ul style="list-style-type: none"> <li>• We need to make sure we are giving individuals time/space – listening and directing to most appropriate support.</li> <li>• We need to tackle stigma – getting messages across; embed with managers and staff.</li> <li>• Communication and awareness of services before crisis; sharing resources across our partnership and more widely. There is an increasing group of people not connected to services – they need to know what to do when they require support.</li> <li>• Some people have benefited from greater community connectedness during the pandemic – we should build on positive experiences.</li> </ul> | <ul style="list-style-type: none"> <li>• Through information and advice provision, digital communications, and greater awareness across services we will work to ensure access to the right mental health supports at the right time.</li> <li>• Through collaborative practices we will develop and expand local market provision for mental health and addiction supports.</li> <li>• Learning from our experiences during the pandemic, we will take full advantage of opportunities from digital technology to increase contact and improve access to mental health and addiction services.</li> </ul> |
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#### **Meeting local healthcare needs – and addressing health inequalities**

<b>What people told us</b>	<b>How we respond as a partnership</b>
<ul style="list-style-type: none"> <li>• Better information and access to support – raising awareness of what is available.</li> <li>• Need choice and flexibility for health and wellbeing - Services must fit people rather than people fitting services.</li> <li>• We need to see services coming together and working collaboratively.</li> <li>• We need to refocus our efforts on wider health improvement activity. Need to return to pre-pandemic screening programmes</li> <li>• We must promote the prevention agenda through interventions such as Talking Points, community link workers, support for self-management. And recognise that loneliness / isolation is a massive issues for health and wellbeing.</li> <li>• Need to improve support for learning disabilities post pandemic – and return to collaborative practices.</li> </ul>	<ul style="list-style-type: none"> <li>• We are committed to working collaboratively to improve the health and wellbeing of our population. We are focused on delivering targeted health improvement interventions in communities experiencing greater health inequalities. With our community planning partners we are working to tackle the root causes of health inequalities including child poverty, housing and employment; working to promote health literacy and self-management; and working to strengthen community resilience and capacity.</li> <li>• We are focused on preventative approaches and will continue to develop the support provided by Talking Points, community link workers, and physical health interventions delivered in partnership with the Culture and Leisure Trust.</li> <li>• In collaboration with NHS Greater Glasgow and Clyde we work to improve person-centred pathways for those accessing healthcare supports.</li> </ul>

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| <ul style="list-style-type: none"> <li>Health inequalities – need to look at wider issues of poverty and housing. Significant health inequalities for people with physical and learning disabilities – exacerbated during the pandemic – delays, disruption to clinics.</li> <li>There needs to be a focus on how we organise as communities to support health and wellbeing.</li> </ul> | <ul style="list-style-type: none"> <li>We are committed to early intervention and prevention for people with long-term conditions; minimising unplanned hospital use; and improving support in the community for people leaving hospital.</li> </ul> |
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### **Supporting unpaid carers**

<b>What people told us</b>	<b>How we respond as a partnership</b>
<ul style="list-style-type: none"> <li>We need to be creative – shift from traditional approaches and shift thinking on what's possible for families.</li> <li>Collaborative working between organisations and better engagement / communication with unpaid carers is imperative.</li> <li>We need to develop the availability of regular short breaks – many families at breaking point following the pandemic.</li> <li>We need to build clarity/understanding on definition of breaks – wide ranging in length and nature – supporting carers as individuals.</li> <li>We need to help people recognise their role and identify as carers – and overcome any barriers/stigma.</li> <li>We need to return to face-to-face peer support for unpaid – this has important social aspect.</li> </ul>	<ul style="list-style-type: none"> <li>In partnership with East Renfrewshire Carers Centre, we will work collaboratively with local carers in designing new, more flexible approaches to support.</li> <li>We are committed to developing the range of short-break options and increasing availability for carers to allow them to continue in their caring role. Listening to the needs and experiences of carers, we will work collaboratively with providers to expand the range of options available.</li> <li>We will work to widen understanding of caring, and the challenges faced by unpaid carers in East Renfrewshire through information and training.</li> <li>As we move beyond the pandemic, we will ensure that vital informal supports are re-established and strengthened as appropriate to the needs of local carers.</li> </ul>

### **Supporting staff wellbeing**

<b>What people told us</b>	<b>How we respond as a partnership</b>
<ul style="list-style-type: none"> <li>We need to recognise and reward the incredible contribution of our staff and the pressures they are under - before, during and after the pandemic.</li> <li>Important to recognise the wider mental health issues among staff (across our wider partnership).</li> </ul>	<ul style="list-style-type: none"> <li>Across the partnership our workforce has gone above and beyond to continue delivering vital support to local people during extremely challenging circumstances. We are entirely focused on supporting the wellbeing of our staff – and committed to embedding successful approaches as normal practice.</li> </ul>

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| <ul style="list-style-type: none"> <li>• We need to support our staff with new ways of working and adapting to a new landscape following the pandemic.</li> <li>• There is a need for flexibility and balance - providing staff autonomy.</li> <li>• We need to embed and sustain new meaningful supports for staff without stigma.</li> <li>• We need to focus on the wellbeing of staff e.g. through wellness sessions and 'champions' to take forward wellbeing issues alongside our management structures.</li> <li>• There should be better communication and sharing of resources across partnership – tapping into available supports.</li> <li>• We need to build on the raised profile and wider recognition of staff in care sector as a result of the pandemic.</li> <li>• We need to develop the skills of our managers to provide support – and have appropriate open conversations with staff.</li> <li>• We need to ensure we keep people connected where they are still working remotely.</li> </ul> | <ul style="list-style-type: none"> <li>• We have put in place new structures and new channels for communication and we will review and develop these approaches moving forward.</li> <li>• In the context of the pandemic, we are supporting managers to ensure team members feel connected and can access different levels of support for mental and emotional wellbeing.</li> <li>• Opportunities for physical activity, rest and relaxation will continue to be developed and promoted and will be available for staff across the wider partnership.</li> </ul> |
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### **Listening to children and young people**

In accordance with the Children and Young People's (Scotland) Act 2014 local and national partners have been working together to identify the needs of children, young people and families across East Renfrewshire. This work culminated in the publication of the **East Renfrewshire Children and Young People's Services Plan 2020-2023**. Based on a wide ranging assessment of local needs carried out in 2020-2021 East Renfrewshire HSCP and partners agreed a set of priorities to drive change and improve the wellbeing of children and their families.

This activity has included extensive engagement with children, young people, parents/carers in a range of settings including early learning centres, youth facilities, parents and carers groups, and summer holiday programmes. Furthermore, an emphasis has been placed on the need to specifically ensure the participation of vulnerable children and families including those care experienced and those with complex needs. The range of information gathered from this engagement activity has also informed the development of this Strategic Plan.

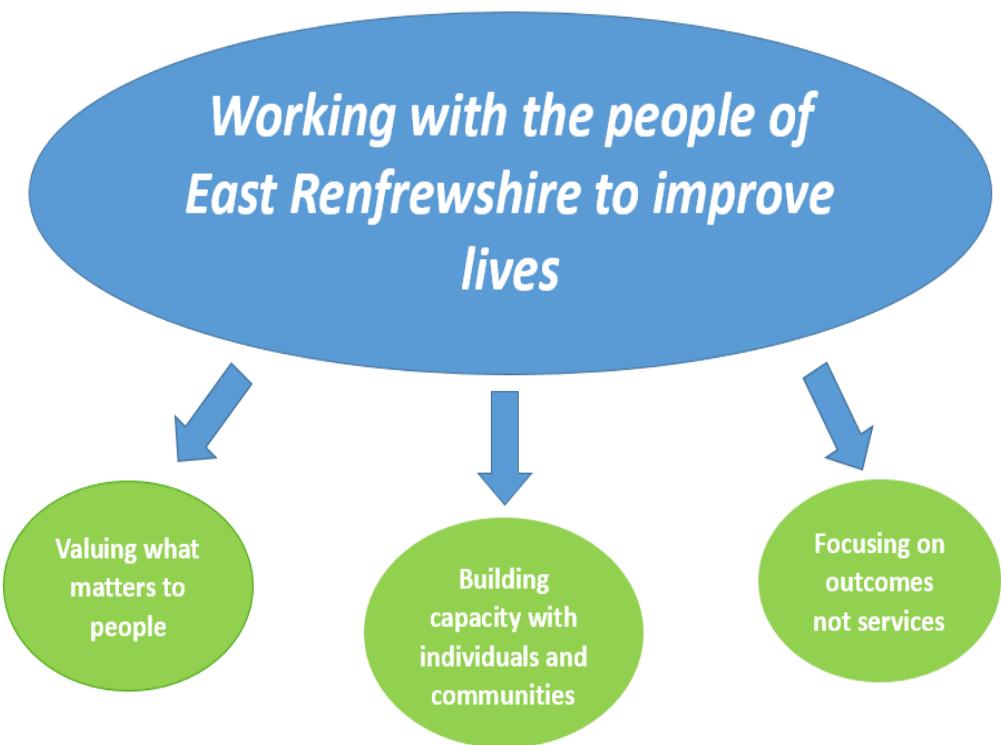
## 2.3 Our partnership

Under the direction of East Renfrewshire's Integration Joint Board (IJB), our HSCP builds on a secure footing of a 16 year commitment to health and social care partnership in East Renfrewshire. Our experiences throughout the Covid-19 pandemic have reinforced the benefits of working together as a broad and inclusive partnership. Moving forward we will further strengthen our supportive relationships with independent and third sector partners. It is also essential that we recognise the increased levels of participation in our communities and informal support within neighbourhoods that have developed in response to Covid-19. Our partnership must extend beyond traditional health and care services to a long-term meaningful partnership with local people and carers, volunteers and community organisations.

## 2.4 Our long-term vision

Our vision statement, "*Working together with the people of East Renfrewshire to improve lives*", was developed in partnership with our workforce and wider partners, carers and members of the community. This vision sets our overarching direction and remains unchanged for this iteration of our Strategic Plan.

We developed integration touchstones to progress this vision. The vision includes three touchstones which guide everything we do as a partnership.



## **2.5 Our strategic priorities**

In line with our vision and the wider priorities for our partnership, we have reviewed our strategic priorities. While our high-level strategic focus remains unchanged and the majority of our priorities from our previous 3-year (2018-21) plan will continue, we are building a wider focus on mental health to include community wellbeing. We have also added a strategic priority relating to the wellbeing of our workforce. Our strategic priorities are discussed in more detail at Section 4 and our operational planning will reflect how these priorities will be pursued as we recovery from the pandemic.

## **2.6 Delivering our strategy as we move beyond the Covid-19 pandemic**

The plan covers 2022-25, a period in which we will continue to respond to the impacts of the pandemic as well as building our recovery based on learning and understanding of the shifting needs and priorities our East Renfrewshire residents.

As a broad and inclusive partnership we will continue to meet the needs of those directly impacted by Covid-19, including those receiving care and support and their carers. The continuing delivery of the local Covid-19 and flu vaccination programme is of particular importance to residents and will remain a significant focus for our resources in the short and medium term. We will also continue to support NHS Greater Glasgow and Clyde (NHSGGC) to deliver vaccination programmes as efficiently as possible for East Renfrewshire residents.

New models and delivery approaches established in response to the challenges of the pandemic will continue as we deliver on the commitments in this plan. As a partnership we will take forward our approach to collaborative and ethical

commissioning; and draw in wider opportunities including in relation to housing options and technology solutions in our market shaping strategy.

At the same time, we will take forward our Recovery and Renewal Programme. The programme seeks to ensure that the lessons learned during the pandemic are used to inform our recovery as well as bring transformational change to the delivery of services in the future.

### **Recovery and Renewal Programme – aims and objectives**

- To establish a comprehensive programme of recovery and renewal to support key areas of change and development across the HSCP
- Support the operational challenges faced by the partnership as a result of the pandemic
- Focus on wellbeing and support of staff and those who use our services
- Build on the lessons learned and new ways of working during the response and initial recovery phase
- Work with those who use our services and our partners to develop and enhance services
- Delivery of financial efficiencies and savings and potential realignment of resource
- Be informed by and inform the delivery of current and future HSCP strategic plans

## 2.7 Our engagement process

To support the development of this Strategic Plan we carried out a highly participative engagement process designed and delivered in partnership with our third and independent sector partners. Our 'Festival of Engagement' ran between August and October 2021 and in spite of the practical challenges of the pandemic drew in the voices of people with lived experience, unpaid carers, staff and management at support providers, HSCP staff and officers from internal and external partner organisations. Full details of the engagement and learning coming from it can be viewed in our supporting Summary of Engagement document.



The engagement process was led by our multi-agency Participation and Engagement Network, delivered in line with the principles set out in the East Renfrewshire Health and Social Care Participation and Engagement Strategy 2020-23. Partner organisations supported facilitation of engagement events and over the three months we conducted 20 focus groups and workshops (principally

delivered online with some face-to-face groups) involving nearly 200 participants. Workshops focused on key themes and were designed to be fun and participative using tools such as instant online polls (via mobile phones). Those unable to attend events or wishing to give individual views had the opportunity to complete short online surveys in relation to the engagement themes.

Following development of a draft strategic plan a full public consultation exercise was carried out between November 2021 and February 2022. During the consultation period the draft plan was shared with our partners at East Renfrewshire Council and NHSGGC, considered in an IJB seminar event and promoted through social media and other communication channels. The engagement process has provided the partnership with a wealth of knowledge on the experiences and challenges being faced by those receiving support, unpaid carers and those delivering support in East Renfrewshire. This knowledge informs the priorities set out in this high-level strategy and will inform the operational plans that support it as well as our other thematic strategic plans.

Ongoing engagement with our communities is an essential part of our work. Through the Participation and Engagement Network we will continue to ensure that our engagement processes are robust, well-coordinated and reflect best practice. In East Renfrewshire engagement is recognised as a shared responsibility across our wider partnership and we will continue to ensure that as many voices as possible inform our planning and delivery.





### 3. Our plan on a page

## Working Together for East Renfrewshire - Our plan on a page

<b><i>The context for our Strategic Plan includes...</i></b>											
East Renfrewshire's population, demographics and patterns of needs	Our recovery from the Covid-19 pandemic		The Independent Review of Adult Social Care and National Care Service		<b>National Health and Wellbeing Outcomes</b> National legislation, policies and strategies Local plans, strategies and improvement/change programmes						
<b><i>Our vision is...</i></b>				<b><i>Our touchstones are...</i></b>							
Working together with the people of East Renfrewshire to improve lives				<ul style="list-style-type: none"> <li>• Valuing what matters to people</li> <li>• Building capacity with individuals and communities</li> <li>• Focusing on outcomes, not services</li> </ul>							
<b><i>Our strategic priorities are... Working together...</i></b>											
...with children, young people and their families to improve mental and emotional wellbeing	...with people to maintain their independence at home and in their local community	...to support mental health and wellbeing	...to meet people's healthcare needs by providing support in the right way, by the right person at the right time	...with people who care for someone ensuring they are able to exercise choice and control	...on effective community justice pathways that support people to stop offending and rebuild lives	...with individuals and communities to tackle health inequalities and improve life chances	...with staff across the partnership to support resilience and wellbeing				
<b><i>and... Protecting people from harm</i></b>											
<b><i>Our strategic enablers are...</i></b>											
Workforce and organisational development	Medium-term Financial and Strategic Planning	Collaborative, ethical commissioning	Communication and Engagement	Data and intelligence	Digital technology and Infrastructure						
<b><i>We will deliver this strategy through supporting plans and programmes, including...</i></b>											
HSCP Delivery and Improvement Plans	Commissioning and Market-shaping Plan	Medium-term Financial Plan	ER HSCP Workforce Plan	NHS Greater Glasgow and Clyde and ERC Improvement Plans	East Renfrewshire Children and Young People's Services Plan	East Renfrewshire Carers Strategy	Public Protection Improvement Plans	ER HSCP Participation & Engagement Strategy			

## 4. Delivering our priorities



## 4.1 Our strategic priorities

We have reviewed our performance in relation to the strategic priorities in our previous Strategic Plan (see Section 6), assessed our demographic profile and the lessons learned from the Covid-19 pandemic, and in consultation with key stakeholders and communities we have reviewed our strategic priorities and areas of focus within these. The majority of our high-level priorities remain unchanged from our previous three-year plan but we agreed in 2020 to widen our focus on mental health to include community wellbeing and have added a strategic priority relating to the wellbeing of our workforce. We also include a section looking at our cross-cutting, multi-agency work to protect people from harm. This activity underpins and enables the delivery of our other strategic priorities.



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

Our multi-agency approach to supporting the needs of children and young people in East Renfrewshire is set out in “*At Our Heart*” our Children and Young People’s Services Plan 2020-2023. Improving the mental and emotional wellbeing of children and young people will continue to be one of the highest priorities for East Renfrewshire Health and Social Care Partnership (HSCP) as we go forward in future years.

Together all partners in East Renfrewshire are building an approach to mental health support for children, young people and families that will ensure they receive the right care and interventions at the right time and in the right place. A co-production event which included children, young people and parents/carers supported relationship-based and nurturing approaches which bridge the gap between school and home. There was a shared view that in many instances help for a child or young person would be best placed in the context of the child's family network. From this it was agreed to develop a blended model of support which would incorporate new as well as existing approaches.

The Covid-19 pandemic has exacerbated the circumstances of many children, young people and families, and we are now seeing a significant rise in the number of those experiencing challenges with their mental health and wellbeing. In response to this a multi-stakeholder Healthier Minds Service approach aligned to school communities has been developed to identify and ensure delivery of mental wellbeing support to promote children and families' recovery. This will work alongside our existing suite of support for families including the Family Wellbeing Service which links to GP practices and the CAMHS service. In addition, our Healthier Minds Framework is an evidence-based guide for children, young people, families and practitioners, outlining ways to support mental wellbeing in a holistic way and provides information about service and resources that can help at different stages in time.

An emerging area of increasing need is from children and young people with a neurodevelopmental diagnosis (including autism) or suspected diagnosis. In partnership with the Council and other partners we will ensure service responses are effective and the workforce is sufficiently equipped to help children and their families in the right way.

We continue to support our care experienced children and young people and are committed to fully implementing the findings of the national Independent Care Review report “The Promise”. As outlined in the Children and Young People’s Plan we will work in our role as Corporate Parents to ensure all care experienced children and young people have settled, secure, nurturing and permanent places to live, within a family setting.

<b>Mental and emotional wellbeing is improved among children, young people and their families</b>	
<b>Our contributions to delivering this outcome</b>	<b>How we will measure our progress</b>
<p>Protect our most vulnerable children, young people and families</p> <p>Deliver on our corporate parenting responsibilities to our care experienced children and young people by fully implementing The Promise</p> <p>Respond to the mental and emotional health and wellbeing needs of children and young people</p> <p>Ensure children and young people with complex needs are supported to overcome barriers to inclusion at home and in their communities</p>	<p>% of children with child protection plans assessed as having an increase in their level of safety</p> <p>% of children subject to child protection who are offered advocacy service</p> <p>% Looked After Children with more than one placement within the last year</p> <p>% of young people in transition to young adulthood with a transition plan by age of 16</p>
<p><b>Key activities during 2022-25</b></p> <ul style="list-style-type: none"> <li>• Implementing the new Healthier Minds service linked to schools and communities</li> <li>• Support engagement and participation through East Renfrewshire Champions Board and Mini Champs</li> <li>• Work in partnership with children, young people and their families to implement the recommendations of the Independent Review of Care Report (The Promise).</li> <li>• Offer Family Group Decision Making at the initial referral stage through Request for Assistance (s12 duties)</li> <li>• Embed the Signs of Safety practice principles across all child and family interventions</li> <li>• Fully implement new Scottish Child Interview Model (SCIM), alongside key partner agencies ensuring trauma informed support from referral to recovery</li> </ul>	

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

Ensuring as many East Renfrewshire residents as possible can maintain their independence at home remains a priority of the partnership and a key area of focus as we move through and beyond the Covid-19 pandemic. Our approaches are person-centred and focused on the rights of individuals to exercise choice and control. We are able to deliver on this priority thanks to the enthusiasm and commitment of our partner providers and community support organisations and will continue to promote collaborative approaches.

We are aware that many older people, people with disabilities, residents who were required to shield during the pandemic 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 in East Renfrewshire has demonstrated the resilience of our community-based supports with teams of volunteers and staff keeping touch with the most vulnerable and isolated, notably through the Community Hub. We work to minimise isolation and engage with those in need through approaches such as befriending, peer support and the work of our Kindness Collaborative and Talking Points, linking people to local supports. We will continue to build on this collaborative working going forward to increase the community supports and opportunities available. Recognising the impacts of the pandemic on individuals, we will ensure that the people we support receive timely review and reassessments as we move through the pandemic.

We will make best use of technology and health monitoring systems to support independence and self-management. With our partners we will support digital inclusion and the roll out of the AskSARA web based assessment and advice on equipment and solutions to support daily activities. We will support the increased use of digital technology, telephone and Near Me technology to support remote consultations and enable services to continue seeing patients in new ways. To support this we have linked with the Scottish Government's Connecting Scotland programme and we are working alongside partners in the third sector and our Culture and Leisure Trust to minimise digital exclusion. We will ensure that digital technology is used only as appropriate to the needs of the people we work with and that a range of options are available to people.

We are committed to increasing choice and control and delivering the full potential of Self-directed Support. We will continue to review and embed our outcome-focused assessment tool and our individual budget calculator and ensure that people who require support have as much choice and control as they wish in relation to their supports. We will work collaboratively to ensure that we have an effective delivery framework in relation to supporting individuals and enabling innovative approaches. We will support our partner providers and in-house services to develop their business/service plans

*"We need to focus on how we work together as a whole partnership under the 'umbrella' of the HSCP" Support staff*

*"It's about feeling respected and trusting the support that's there - not just 'going along with things'. It's about being understood and support providers seeing beyond 'the mask'" Unpaid carer*

to adapt to these new approaches. As we recover from the pandemic we will build on our strong local partnerships and social enterprise approach, encouraging innovation that supports people to live independently in the community and offers alternatives to residential care.

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

## **People are supported to maintain their independence at home and in their local community**

<b>Our contributions to delivering this priority</b>	<b>How we will measure our progress</b>
<p>More people stay independent and avoid crisis through early intervention work</p> <p>The people we work with have choice and control over their lives and the support they receive.</p>	<p>Number of people engaged though Talking Points events and support</p> <p>Referrals to preventative support through Talking Point engagement</p> <p>% of people whose care need has reduced following re-ablement/rehabilitation</p> <p>Number of people self-directing their care through receiving direct payments and other forms of self-directed support.</p> <p>Percentage of people reporting 'living where you want to live' needs fully met.</p> <p>% of people aged 65+ with intensive needs receiving care at home</p> <p>Percentage of people aged 65+ who live in housing rather than a care home or hospital</p>
<b>Key activities during 2022-25</b> <ul style="list-style-type: none"> <li>• Promote the range of local supports and opportunities available through the Community Hub and Talking Points</li> <li>• Establishing greater choice and innovation by developing the local market for provision</li> <li>• Review and refresh our roll out of individual budget calculator and access to self-directed options</li> <li>• Promote the use of AskSARA and other digital opportunities that support independence</li> <li>• Support use of digital technology, telephone and Near Me technology</li> <li>• Improve links and pathways between our rehabilitation and re-ablement services</li> <li>• Work with housing providers to refresh our housing need assessment and consider future housing opportunities</li> </ul>	

#### **4.4 Working together to support mental health and wellbeing**

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

The experience of the Covid-19 pandemic has impacted on emotional wellbeing for people in all walks of life, and will continue to do so. Many of us have been anxious or worried about our health, our family and friends, and changes to our way of life.

Some individuals, families and communities have struggled significantly over the period. During the pandemic we have adapted our approaches across services to support the mental wellbeing of the people we work with. As we move forward we will continue to focus on good mental wellbeing, and on ensuring that the right help and support is available whenever it is needed. We recognise that different types of mental health need will continue to emerge as time passes and that we will need to continually adapt our approach to reflect this. We are focused on close collaboration with primary care, and further enhancing the mental health and wellbeing supports within primary care settings. We will work with GPs, third sector partners and people with lived experience to develop our approach to ensure people get the right service, in the right place at the right time.

***“One approach won’t fit for everyone – it’s about being open minded and flexible and treating everyone as an individual.”***  
Support provider

We are enhancing our approach to minimising drug-related harms and deaths and improving overall wellbeing amongst people with harmful drug or alcohol use and their families. This includes implementation of the Medication Assisted Treatment standards to ensure low barrier, person centred service provision, increasing access to residential rehabilitation and enhancing community based recovery supports. We recognise that there are often close links between individuals' mental health and substance use. Therefore, it is important that alcohol and drugs services have close connections with our mental health services in East Renfrewshire.

We will continue to work in partnership with people who use services, carers and staff to influence the Greater Glasgow and Clyde Five Year Strategy for Adult Mental Health Services and contribute to its delivery to ensure the needs of East Renfrewshire residents are met. We will ensure a particular focus on prevention, early intervention and harm reduction; high quality evidence-based care; and compassionate, recovery-oriented care recognising the importance of trauma and adversity and their influence on well-being. We are working on improving access to psychological therapies to ensure individuals receive the right support at the right time. We will continue to test and develop the impact of lived experience in the delivery of services such as peer support and its contribution to individual's recovery journeys, alongside formal services.

Over the life of this plan we will continue to support the promotion of positive attitudes to mental health, reduce stigma and support targeted action to improve wellbeing among specific groups. Suicide prevention is a key focus, raising awareness, reducing stigma and ensuring effective responses to distress and crisis.

We have committed to working together with community planning partners on activities that support mental wellbeing and resilience across our communities, with Voluntary Action taking a leading role. The rollout of the Scottish Government's Community Mental Health and Wellbeing Fund in East Renfrewshire is enabling grassroots community organisations to provide vital supports and activities to local communities with £238,000 already distributed – ranging from community food, cooking and exercise initiatives, mindfulness courses, social activities to reduce loneliness and isolation, a recovery college and dementia support services. We will work closely with Voluntary Action and wider partners to assure the success and sustainability of funded programmes.

***"Promoting self-management doesn't mean you are on your own." Local resident***

Over the life of this plan we will continue to support the promotion of positive attitudes on mental health, reduce stigma and support targeted action to improve wellbeing among specific groups. Supporting the wellbeing and resilience of our staff and volunteers is critical to ensuring they can support residents effectively. We will continue our partnership working with primary care and Recovery Across Mental Health (RAMH) in which link workers in all of our GP practices offer social and psychological interventions to improve wellbeing.

***"Helping people have resilience isn't always about services - often it's recognising small things we can do for ourselves and for one another."** Local resident*

<b>People are supported to look after and improve their own mental health and wellbeing</b>	
<b>Our contributions to delivering this priority</b>	<b>How we will measure our progress</b>
<p>Individuals can access a range of supports on their journey to recovery from mental health and alcohol and drugs harms</p> <p>Wellbeing is enhanced through a strong partnership approach to prevention and early intervention</p> <p>Staff and volunteers have the skills, knowledge and resilience to support individuals and communities</p>	<p>Percentage of people waiting no longer than 18 weeks for access to psychological therapies</p> <p>Percentage of people waiting no longer than three weeks from referral to alcohol / drug treatment</p> <p>Mental health hospital admissions (age standardised rate per 1,000 population)</p> <p>Positive outcomes for individuals supported through link worker interventions</p> <p>Positive outcomes for individuals receiving peer support</p> <p><i>Wellbeing measures being developed with CP partners</i></p>
<p><b>Key activities during 2022-25</b></p> <ul style="list-style-type: none"> <li>• Work with our communities to promote positive mental health and wellbeing</li> <li>• Support mental health and wellbeing interventions delivered through third sector and community-led activity</li> <li>• Enhance access to primary care mental health services</li> <li>• Continue to increase the mental health workforce through Action 15 funding, including occupational therapy provision in care homes and peer support for recovery</li> <li>• Implement the priorities set out in the Greater Glasgow and Clyde Mental Health Strategy in East Renfrewshire and the Coronavirus mental health transition and recovery plan</li> <li>• Enhance alcohol/drugs frontline staffing and service design to implement the Medication Assisted Treatment Standards and ensure fast, appropriate access to treatment.</li> <li>• Develop and deliver local action plan for suicide prevention with key partners.</li> <li>• Reflect and build on innovative ways services have been delivered during the pandemic (including digital solutions)</li> <li>• Enhancing alcohol/drugs service provision to support Rights, Respect and Recovery and the Drugs Mission to prevent drug-related deaths</li> <li>• Maximise opportunities for skills development in relation to mental health across services and the wider partnership</li> </ul>	

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

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

During the pandemic we have strengthened our partnership working and opportunities for shared clinical conversations between the consultants and clinical leaders in hospitals and the GP as the expert medical generalists in the community. The vision set out by NHSGGC in its recovery and remobilisation planning is to have in place a whole system of health and social care enabled by the delivery of key primary care and community health and social care services. HSCPs are working in partnership to ensure effective communications, a consistent approach, shared information and the alignment of planning processes.

*"Better and quicker access to specialist services can help deal with problems early and result in an appropriate action plan"*

Local resident

Significant investment in winter 2022 has helped add resilience to our health and care response. We have strengthened the capacity of our Care at Home Responder Service, Community Nursing and Community Rehabilitation teams and have established an intensive support service at our in-house care home for a multidisciplinary 'step-up', 'step-down' approach. This is supporting rehabilitation and reablement and timely discharge to home/homely settings. Additional resources are being used to address the accelerated demand pressures we have seen for Care at Home services, with increased frontline staff as well as management and support, and increased capacity for the Home First model and Technology Enabled Care. We are also building the capacity of our multi-disciplinary teams across the HSCP including: developing our multi-disciplinary Front Door model and leadership arrangements; additional capacity for social work and our Care Home and Community Review Team; support for the wider GGC frailty hubs; and increased capacity for frailty practitioners. We will continue to build on the collaborative working which has been further developed in response to the pandemic in order to support our care home community in maintaining residents in the community, and avoiding hospital admissions.

We have seen increasing use of digital communication as people interact with healthcare providers including, for example, extensive use of Near Me video appointments. We will take an evidence-based and inclusive approach to supporting the anticipated change in the way our communities access healthcare. This means ensuring wider access to digital

communication technologies, keeping pace with new approaches and opportunities and making sure a suite of options are available for those requiring alternatives.

We continue to work together with HSCPs across Glasgow, primary and acute services to support people in the community, and develop alternatives to hospital care. We will support the delivery of NHSGGC board-wide initiatives to help those experiencing frailty including the frailty pathway, Home First and other approaches supporting older people to stay well at home. In partnership we will support the national development of capacity for resilience and recovery, through the prioritisation of: the Covid Remote Health Monitoring Pathway; the Hospital@Home Pathway; the Community Respiratory Response Pathway; and, Out-patient Parental Antibiotic Therapy (OPAT).

In partnership we support the development and delivery of the joint strategic commissioning plan which outlines improvements for patients to be implemented over the next five years.

Our joint programme is focused on three key themes:

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

**People's healthcare needs are met with support provided in the right way, by the right person at the right time.**

Our contributions to delivering this priority	How we will measure our progress
Early intervention and prevention of admission to hospital to better support people in the community	No. of A & E Attendances Number of Emergency Admissions A & E Attendances from Care Homes Emergency Admissions from Care Homes Occupied Bed Days (Adult – non-elective)
Improved hospital discharge and better support for people to transfer from acute care to community supports	People waiting more than 3 days to be discharged from hospital Bed days lost to delayed discharge % of last six months of life spent in Community setting
Improved primary / secondary care interface to better manage patient care in the most appropriate setting	Percentage of people admitted to hospital from home during the year, who are discharged to a care home Number of clients supported into intermediate care
<b>Key activities during 2022-25</b> <ul style="list-style-type: none"> <li>• Improve quality and quantity of Anticipatory Care Plans and Emergency Care Information Summaries</li> <li>• Progress local out of hours response arrangements to support implementation of Urgent Care Resource Hub.</li> <li>• Implement discharge to assess protocol.</li> <li>• Implement frailty pathway and initiatives to address frailty</li> <li>• Improve process for AWI patients learning from mental welfare commission recommendations and GGC wider review</li> <li>• Develop and test enhanced community support and intermediate care models in partnership with HSCPs across Glasgow</li> <li>• Continue support to local care homes and other supported living providers through safety and professional assurance arrangements.</li> </ul>	

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

The contribution of unpaid carers to our social care system is beyond measure and the daily efforts of families and loved ones to those needing support is fully recognised by the partnership. Carers have been significantly impacted by the pandemic and changes to a range of supports available to those providing care. Unpaid carers have also taken on increased caring during this time and have faced additional pressures. As we move beyond the pandemic we must ensure that the right supports and services are in place for carers. The ongoing work of the Carers Collective has demonstrated the need to maintain and strengthen our approach to involving carers throughout the planning process in identifying the outcomes that matter to them and by ensuring carers voices are valued and reflected within our strategic planning work.

***"It's important to know there are people out there, who can, will and want to help you"***  
Carer

self-directed support options are offered to all adult carers who have been identified as eligible for support.

Our engagement for this plan reemphasised the importance of flexible and innovative approaches to the provision of breaks from caring. This will remain a focus for the partnership over the life of this plan. We will work collaboratively with providers to develop the range of options available; and we will make sure that carers are aware of and have access to appropriate breaks.

Peer support and having the opportunity to share experiences is highly valued by our carers but has been disrupted during the pandemic. As a wider partnership we will ensure that these informal supports that enable people to continue in their caring role are re-established and strengthened going forward.

***Having the opportunity to hear from other carers is great, and although problems and situations may be different the message you take home is "you are not alone". Carer***

<b>People who care for someone are able to exercise choice and control in relation to their caring activities</b>	
<b>Our contributions to delivering this priority</b>	<b>How we will measure our progress</b>
<p>Staff across the partnership are able to identify carers and value them as equal partners</p> <p>Carers can access accurate information about carers' rights, eligibility criteria and supports</p> <p>More carers have the opportunity to develop their own carer support plan</p> <p>More carers are being involved in planning the services that affect them and in strategic planning</p>	<p>Percentage of carers who feel supported to continue in their caring role. (NI8)</p> <p>People reporting 'quality of life for carers' needs fully met (%)</p> <p>Carers offered support to develop their own personal support plans</p> <p>Services involving carers in their design and planning process</p>
<p><b>Key activities during 2022-25</b></p> <ul style="list-style-type: none"> <li>• In partnership with Carers Centre provide information and training to raise awareness of the impact of caring and requirements of Carers Act.</li> <li>• Publicise our clear prioritisation framework for support and implement consistently</li> <li>• Work with providers to review and modernise our approach to breaks in light of Covid-19 requirements</li> <li>• Ensure that carers and support organisations are aware of the scope and different types of replacement care and short-break provision available.</li> <li>• Develop tools and supports to help carers identify the impact of their caring role and plan how best to meet their needs</li> <li>• Work with partners to ensure supports are available to carers to minimise the impact of financial hardship as a result of caring.</li> <li>• Implement carers' support planning including planning for emergencies with individual carers.</li> <li>• Work together with partners to ensure carers are being involved in planning the services that affect them</li> </ul>	

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

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

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

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

<b>People are supported to stop offending and rebuild their lives through effective community justice pathways</b>	
<b>Our contributions to delivering this priority</b>	<b>How we will measure our progress</b>
<p>People have improved access to through-care</p> <p>People have access to a comprehensive range of recovery services</p> <p>Trauma-informed practice is embedded across justice services</p> <p>Structured deferred sentence and bail supervision is implemented</p> <p>The risk of offending is reduced through high quality person centred interventions</p>	<p>% of people reporting community payback order helped to reduce their offending</p> <p>% of people completing unpaid work requirements</p> <p>Positive employability and volunteering outcomes for people with convictions</p>
<p><b>Key activities during 2022-25</b></p> <ul style="list-style-type: none"> <li>• Use appropriate risk assessment tools to identify need and reduce the risk of further offending.</li> <li>• Delivering a whole systems approach to diverting both young people and women from custody</li> <li>• Delivering accredited programmes aimed at reducing reoffending</li> <li>• Working with local partners to ensure a range of beneficial unpaid work placements are taken up</li> <li>• Enhance skills and knowledge in trauma informed practice across justice services</li> <li>• Increase effective use of structured deferred sentence, bail supervision electronic monitoring.</li> <li>• Actively participate in the East Renfrewshire Employability Partnership to develop pathway and employability support</li> <li>• Ensure people subject to statutory and voluntary supervision including licence have early access to community mental health, alcohol and drug recovery services</li> <li>• Deliver multi-agency public protection arrangements with police, health and prisons which assess and manage sex offenders, serious and violent offenders</li> </ul>	

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

We are committed to the local implementation of Greater Glasgow and Clyde's Public Health Strategy: Turning the Tide through Prevention which requires a clear and effective focus on the prevention of ill-health and on the improvement of wellbeing in order to increase the healthy life expectancy of the whole population and reduce health inequalities. This includes a commitment to reduce the burden of disease through health improvement programmes and a measurable shift to prevention and reducing health inequalities through advocacy and community planning. We will work to ensure that the health improvement activities we support are accessible, well communicated, and flexible; driven by the needs of local people. We will coproduce targeted interventions recognising diversity and addressing the specific needs of people with protected characteristics<sup>1</sup>.

**"Prevention work is key, now more than ever. The decline in general health following the pandemic is noticeable for many."**  
Support provider

The significance of health inequalities has been brought into even sharper focus as a result of the Covid-19 pandemic. We will continue to work together with community planning partners to improve health and wellbeing outcomes for our most disadvantaged localities and those who have been disproportionately impacted by the pandemic. We will also work collaboratively with local and regional partners to develop our understanding of health inequalities in East Renfrewshire and changing patterns of need as we recover from the pandemic. We will support equalities activities being taken forward under NHSGGC recovery and remobilisation planning including mainstreaming of changes shown to be effective in reducing inequalities.

**"We need to highlight inequalities and redress the current gaps for some of our most vulnerable individuals and families; to support families affected by poverty, mental health issues and addictions."**  
Support provider

This priority also reflects our longer-term ambitions for East Renfrewshire. The HSCP will continue to support community planning activity that aims to tackle the root causes of health inequalities as reflected in our Community Plan (Fairer EastRen). This includes activity to address child poverty, promote health literacy and strengthen community resilience. We will continue to promote digital inclusion with a particular focus on supporting people to live well independently; and play a proactive role in managing their health and wellbeing.

Through local delivery of the Universal Pathway we will ensure our children and young people have the best start in life with access to early support and help, and improved health and wellbeing with opportunities to maximise their growth, development and learning. The Universal Pathway will ensure all 0–5 year olds receive core universal provision including through antenatal supports.

<sup>1</sup> Protected characteristics are the nine groups described under the Equality Act 2010. They are: age; disability; gender reassignment; marriage and civil partnership; pregnancy and maternity; and, race.

## **Minimise health inequalities and improve life chances working in collaboration with our communities**

<b>Our contributions to delivering this priority</b>	<b>How we will measure our progress</b>
<p>Increase in activities delivered in partnership which support prevention and early intervention, improve outcomes and reduce inequalities.</p> <p>Health inequalities will be reduced by working with communities and through co-produced targeted interventions</p>	Male life expectancy at birth in 15 per cent most deprived communities Female life expectancy at birth in 15 per cent most deprived communities Premature mortality rate per 100,000 persons aged under 75. % increase in exclusive breastfeeding at 6-8 weeks in most deprived SIMD data zones Smokers supported to successfully stop smoking in most deprived SIMD data zones Cancer screening uptake in most deprived SIMD data zones Alcohol brief interventions delivered
<b>Key activities during 2022-25</b> <ul style="list-style-type: none"> <li>• Work to understand the needs of the population and address longer term impacts of Covid-19 on our communities and protected characteristic groups</li> <li>• Work in partnership to build the capacity of community organisations, groups and individuals to deliver their own solutions for recovery from the coronavirus pandemic</li> <li>• Deliver tailored health improvement programmes and activities in communities with greater health inequalities and disproportionate effects of Covid-19</li> <li>• Continue to explore additional funding opportunities to support targeted health improvement interventions</li> <li>• Continue to support local activity to tackle Child Poverty and mitigate its effects</li> <li>• Work to ensure people in our most disadvantaged community are able to access digital opportunities that support independence and wellbeing</li> <li>• Work with our partners to tackle inequalities and support residents with a number of long term conditions such respiratory illness, cardiovascular disease and obesity to provide physical and psychological health benefits</li> <li>• Implement the Women's Health Plan and Maternal and Infant Nutrition Framework</li> <li>• Lead on the development of the HSCP's Wellbeing Strategy for health and social care staff and implement staff wellbeing activities.</li> </ul>	

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

In consultation with staff and stakeholders we added support for resilience and staff wellbeing as a new strategic priority during the pandemic, and this remains a key area of focus for our new 3-year plan. Working together with staff and our partners we will continue to develop and embed positive practices and interventions to promote staff wellbeing over the life of the plan. We will work to ensure that this priority is delivered across the wider partnership with advice, support and activities made available as widely as possible.

*"It's important that we continue to support flexibility in the ongoing situation - as home life has been disrupted for staff as well as work life."*  
Support provider

During the pandemic 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 still evolving, we continue to rely on the workforce to support all aspects of health and social care and their wellbeing and resilience has never been more important.

The HSCP has established a health and wellbeing 'champion' who contributes to discussions at a national level and we have appointed a dedicated Health and Wellbeing Lead Officer for the wider partnership. A local Health and Wellbeing Group has been established to support the workforce across the partnership. The group is chaired by Head of Recovery and Intensive Services who also holds the national champion role. The group have put in place a wellbeing plan entitled 'You care....We care too.'

The plan identifies four strategic objectives / outcomes and a supporting action plan:

- 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.

*"A key challenge is sustaining things going forward; especially low level interventions that can help with prevention"* Support provider

Our activity aligns to the NHSGGC Mental Health and Wellbeing Action Plan and national objectives. We will continue to input at a national level to the health and wellbeing conversation and to the development and delivery of the NHSGGC vision to support the mental health and wellbeing of staff. This includes ensuring rest and recuperation, peer

support, helping staff fully utilise their leave allowance, and ensuring working arrangements are sustainable in light of continuing constraints and reflect ongoing changes to services and pathways.

<b>Staff resilience and wellbeing in supported across the partnership</b>	
<b>Our contributions to delivering this priority</b>	<b>How we will measure our progress</b>
<p>Staff have access to resources and information that can improve their wellbeing</p> <p>Staff feel connected to their team or service and we embed a health and wellbeing culture across the partnership</p> <p>Opportunities are promoted for staff to take part in physical activity, rest and relaxation</p> <p>Staff feel safe in the work place</p>	<p>Number of activities promoted</p> <p>Participation rates in health and wellbeing activities for staff</p> <p>iMatter feedback from staff, including:</p> <p><i>"My manager cares about my health and well-being"</i></p> <p><i>"I am given the time and resources to support my learning growth"</i></p> <p><i>"I feel involved in decisions in relation to my job"</i></p>
<b>Key activities during 2022-25</b>	
<ul style="list-style-type: none"> <li>• Ensure that all staff have access to universal information with regard to health and wellbeing across the partnership's services, including staff working from home</li> <li>• Develop leadership competencies across management in order to focus on resilience across the partnership</li> <li>• Ensure regular wellbeing conversations with staff and teams</li> <li>• Promote relaxation and physical activity opportunities across the partnership</li> <li>• Ensure all physical environments are adapted to be Covid-19 compliant</li> </ul>	

#### **4.10 Protecting people from harm**

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

In our work to protect adults at risk from harm we will continue to respond to the changing needs that have arisen as a result of the pandemic and our learning from our experiences will help us to deal more effectively with ongoing challenges and ensure the right supports are in place. Through the delivery of our multi-agency **Adult Protection Improvement Plan 2021-23** we are focused on: ensuring that adults at risk, their families and carers views are heard and help shape the way we deliver services; making best use of all our opportunities for the prevention and identification of harm; and ensuring that we offer supports and services which meet the needs of Adults at risk of harm and those who support them. Over the life of this plan we will continue to strengthen the consistency and robustness of our processes and continue to develop awareness of Adult Support and Protection with our partners, providers and the public.

Through the delivery of our **Child Protection Business/Improvement Plan 2020-23** we are supporting a range of multi-agency activity to minimise harm to our children and young people. Through the plan we are focused on recovery from the Covid-19 pandemic, working to mitigate the impacts from the pandemic and minimising disruption to the provision of services to children, young people and their families. We are focused on ensuring that children, young people and their families are actively part of safety planning and these plans are accurately recorded and shared with them. Our multi-agency approach sees partners working together to ensure oversight and timely responses to child protection concerns.

East Renfrewshire is leading the way in supporting children and young people impacted by abuse either as a victim or witness, with the establishment in 2022 of Scotland's first **barnahus** – or bairns' house. The barnahus model brings together all agencies involved in a case in one setting appropriate to the child. Key to the idea is that the child only has to tell their story once, minimising the time between a child disclosing abuse and being interviewed, so that they can move on to recovery as soon as possible, with all the specialist expertise for supporting children through the criminal process and therapies for recovery under one roof.

## **Violence Against Women and Girls (VAW&G)**

Evidence overwhelmingly indicates that domestic abuse is a widespread, chronic and damaging social problem. There is no doubt that the impact of the pandemic on women, children and young people who are victim-survivors of domestic abuse has been severe. The pandemic has put a spotlight on an existing crisis which has and continues to have a significant negative impact on survivors and children.

In East Renfrewshire, we have witnessed the devastating impact on women and children first hand through the increase in volume and complexity of domestic abuse referrals to our services. Domestic abuse continues to be the predominant reason for referral to our children's services and features as one of the most common concerns within child protection interagency referral discussions. In line with trends seen across Scotland we have seen a significant increase in referrals to our Multi Agency Risk Assessment Conference (MARAC) and to our specialist advocacy and support services provided by Women's Aid and ASSIST. It is expected that domestic abuse referrals will continue to increase longer term and recovering from the social and economic effects of Covid-19, and mitigating the long-term effects of trauma and abuse experienced by women, children and young people will require specific action to strengthen the capacity of our services and action across the whole system to ensure their recovery needs are recognised and addressed.

Our multi-agency approach to responding to all forms of violence against women and girls is set out in **The East Renfrewshire Equally Safe Improvement Plan 2020-2023**. The plan is underpinned with a clear focus on recovery and sets out how we will work collaboratively to achieve these aims and identifies the range of actions we will take to mitigate the impact of Covid-19. In the longer term it will ensure an effective and sustainable approach to preventing, reducing and responding effectively to all forms of violence against women and girls.

Our key priorities are:

- Ensure robust processes and pathways are in place to identify, protect and respond effectively to women, children and young people affected by domestic abuse and all forms of gender-based violence
- Strengthen the capacity of our services and action across the whole system to address the long-term effects of trauma and abuse experienced by women, children and young people
- Implementation of Routine Sensitive Enquiry, Multi Agency Risk Assessment Conference and Safe and Together practice to ensure a perpetrator pattern based, child centred, survivor strengths approach to working with domestic abuse.

<b>Key performance indicators</b>	
<u>Adult Support and Protection</u> People agreed to be at risk of harm have a protection plan in place Number of ASP inquiries completed within our reporting period % of ASP inquiries progressed to investigation Type and locations of harm	<u>VAWG</u> Change in women's domestic abuse outcomes (safety and wellbeing) Change in children's domestic abuse outcomes (safety and wellbeing) Number of referrals/number of new referrals to VAWG support services Number of referrals/re-referrals to MARAC
<u>Child Protection</u> % of children with multi-agency plans who have had contact with a professional % of referrals to Request for Assistance referred for allocation % of children and young people subject to child protection processes referred to the children's reporter	

## 5. East Renfrewshire's current context

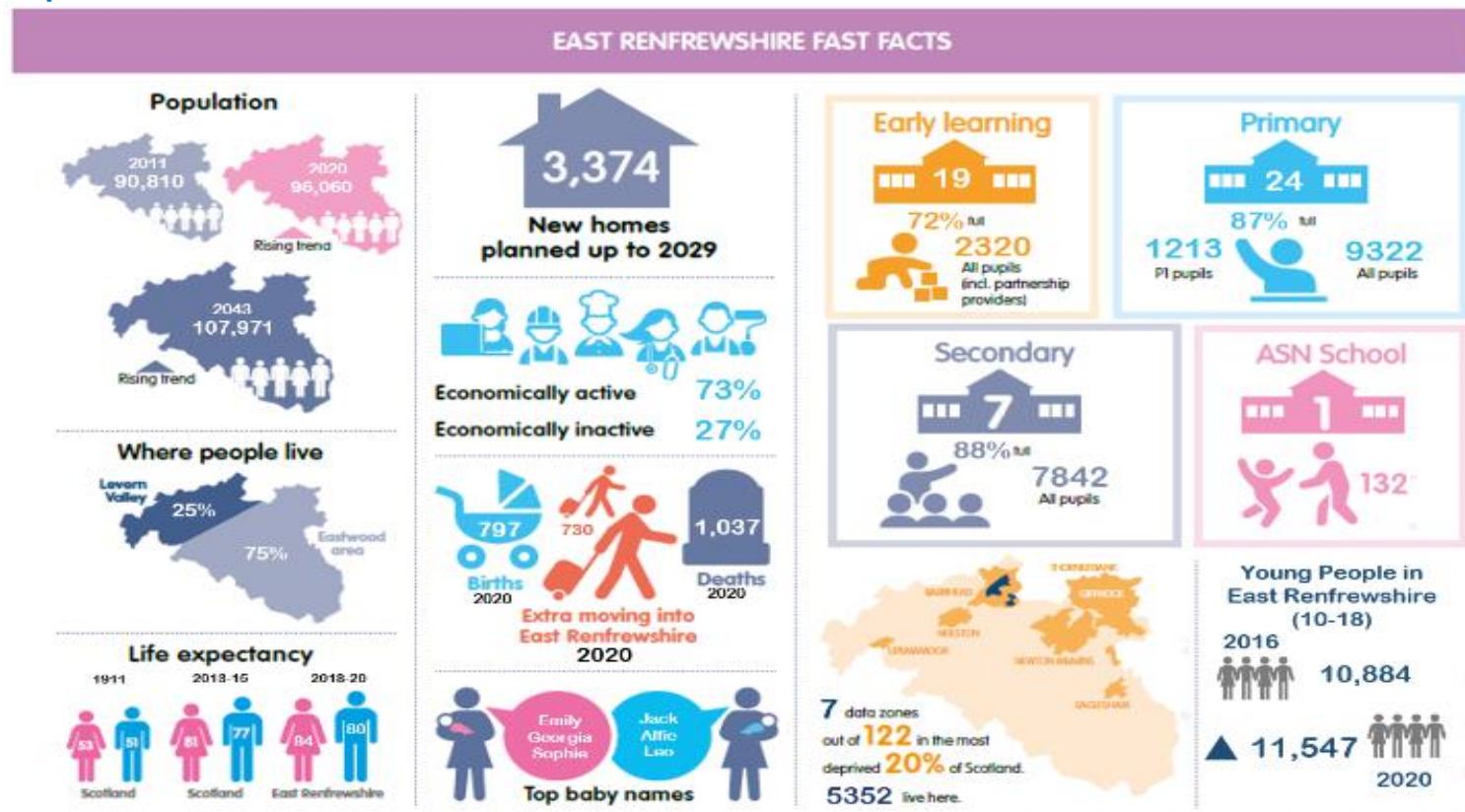


This section summarises our current context in relation to East Renfrewshire's demographic and health profile, future challenges and the impacts we are seeing from the Covid-19 pandemic, and our wider planning context for recovery.

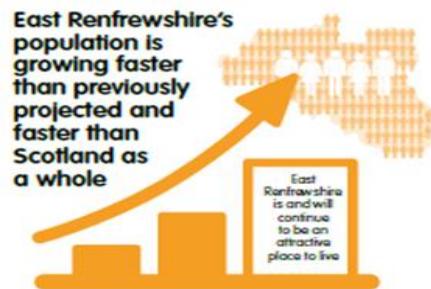
## 5.1 East Renfrewshire's demographics

Detailed needs assessment work has been carried out to support the development of this plan and our full Joint Strategic Needs Assessment is available as a supporting document. A full socio-demographic profile has been developed for East Renfrewshire and covering our two localities (Eastwood and Barrhead) giving information on population, households, deprivation, health profile, life expectancy and use of services. This section provides an overview.

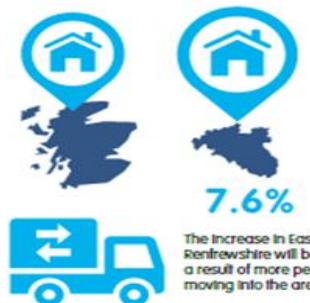
### 5.1.1 Population



## EAST RENFREWSHIRE'S POPULATION – WHAT TO EXPECT



The number of people living in East Renfrewshire is projected to increase by 7.6% by the year 2026 (this is higher than previous projection of 5.7% and higher than the Scottish rate of growth of 3.2%)

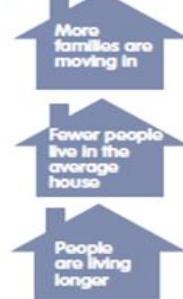


### The two age groups that will grow the most



Children and young people aged 0-15 years  
Older people aged 85+

### More houses are being built for three reasons



### Demand will increase for services



East Renfrewshire currently has the highest average household size in Scotland, but this is projected to shrink as more people live alone



East Renfrewshire has the highest life expectancy at birth for both females and males in Scotland.



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

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

### 5.1.2 Deprivation

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

The table below shows that more than half of East Renfrewshire's population (55%), and 67% of the Eastwood population live in SIMD datazones that are among the 20% least deprived in Scotland. All of East Renfrewshire's neighbourhoods that are among the 20% most deprived are concentrated in the Barrhead locality with a quarter of the population living in these datazones.

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

### 5.1.3 Health outcomes and inequalities

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

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

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

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

## 5.2 Impacts from the Covid-19 pandemic and future challenges

This section considers the impacts of Covid-19 and the changes we have made as a partnership. We continue to learn lessons as we move through and beyond the pandemic period. We also outline what we consider some of the key challenges we face following the pandemic and in light of other external factors facing the partnership.

### 4.2.1 Direct impacts of Covid-19

- **Impacts of increasing poverty on health and wellbeing.** While the full economic consequences of the pandemic are still developing it is clear that there have been negative consequences for businesses and employment prospects nationally and locally. The evidence clearly links economic disadvantage with poorer physical and mental health outcomes and we have seen the unemployment rate rise in East Renfrewshire. The 18-25 age group has been particularly impacted with the proportion of this group claiming unemployment related benefits increasing significantly.
- **Potentially worsening health inequalities.** National evidence shows that the pandemic has had a disproportionate impact for disadvantaged communities and specific vulnerable groups. The loss of social support during the pandemic due to diminished or interrupted care and support has made disabled people, black and minority ethnic people, older people and children and young people more vulnerable. We have also seen at the UK level, that disadvantaged neighbourhoods and areas with poorer, high-density housing have been particularly badly affected by the pandemic.
- **Negative impacts on mental health and wellbeing.** Evidence indicates that the Covid-19 pandemic has impacted on increased social isolation, distress, anxiety, fear of contagion, depression and insomnia in the general population. Studies have concluded there will be significant longer-term impacts on mental health and wellbeing. For some of the population this could exacerbate pre-existing psychiatric disorders and heighten risks of suicidal behaviour. A number of key groups are at higher risk of adverse mental health outcomes. These include front line staff, women, people with underlying health conditions, children and young people (up to age 25). Locally, we know that families and people we support have reported worsening mental wellbeing.
- **Increased frailty and vulnerability.** Although the HSCP has succeeded in maintaining the vast majority of services throughout the pandemic we have been required to adapt provision and prioritise those in greatest need, particularly during the tightest lockdown restrictions. Some service areas have seen increasing levels of need, frailty and

vulnerability among the individuals they are working with where lower level, preventative interventions have been reduced, and increased carer stress.

- **Impacts of ongoing Covid-19 restrictions.** It is unclear how long restrictions such as physical distancing will need to remain in place. These has impacted the way we are able to deliver our services, limiting the numbers of people we can bring into buildings and restricting face-to-face contact and group supports. Alternative approaches are in place and we are working with our partners to re-establish our services and preventative supports as rapidly as possible.
- **Impacts on the wellbeing and capacity on staff.** The Covid-19 pandemic has placed huge demands on the health and care workforce with frontline staff dealing with the immediate consequences of the pandemic and teams having to adjust to radically different ways of working. Staff teams have also had to work with reduced capacity as a result of sickness absence or staff self-isolating during the crisis. Given the level of stress staff are under and potential for staff to feel isolated it is essential that we continue to support staff resilience and connectedness.

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

- **Changing patterns of service use.** The pandemic period has seen new ways that people engage with services with increased use of telephone and video contact. In some instances such as 'wellness calls' people have been able to engage with services in quicker and more convenient ways. We must ensure that we understand people's expectations and preferences when accessing services and make sure that any positive changes to service delivery are retained (while not excluding any groups e.g. those without access to digital technology).
- **Stronger communication across the partnership.** As a partnership the pandemic has brought into sharp focus our shared goals and the shared level of commitment across partner organisations. We have seen increasingly supportive working relationships between statutory, independent and third sector partners. There have been better lines of communication between health professionals, including access to expert consultant advice for GPs, other primary care professionals and care home staff.
- **High levels of community and third sector activity.** Since the emergence of the Covid-19 we have seen high levels of support and participation in our communities. At the height of the pandemic we saw a local surge in residents offering their time as volunteers as well as informal support within neighbourhoods. The experience of the pandemic has reinforced the crucial role of the community and third sectors in delivering essential support to our residents.
- **Capacity for change and innovation.** Over the course of the pandemic we have seen incredible resilience, commitment and creativity from staff. We have seen innovation and collaboration, between partner organisations and with our communities. This capacity for change and innovation will underpin our activity as we move forward.

### **5.2.3 Future challenges for the partnership**

This section sets out some of the key challenges that the partnership faces as we embark on our new Strategic Plan, in the context of the Covid-19 pandemic and other external factors.

- **Increasing and changing service demand pressures.** In the immediate aftermath of the Covid-19 pandemic we are seeing significant increases in demand across service areas and higher levels of complexity among the people we are working with. This includes: higher volume of referrals to adult and child protection; increased CAMHS referrals and increase cases allocated to our children's social work teams; increased referrals to Care at Home services (and capacity pressures on partner providers) and higher levels of frailty and complexity among those accessing adult services. We continue to monitor demand pressures as we move through and beyond the pandemic.
- **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.
- **Delivering a balanced budget.** The funding gap in future years could range anywhere from £0 to £5.7 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. There are still many financial unknowns as we work our way towards recovery and the impact and implications from the plans for a National Care Service are currently unknown. Further information on our financial resources is available in our Medium-Term Financial Plan for 2022/23 to 2026/27 and our Annual Report and Accounts.
- **Minimising delayed discharges from hospital.** 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.
- **Meeting our 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.

- **Supporting the care market and our local 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 which may impact on how we commission services.
- **Impact of Brexit.** The consequences of Brexit have not manifested in any specific issues to date although there are some anecdotal concerns in relation workforce vacancies particularly among partner providers. However, given we remain in a comparatively volatile period, this will continue to be monitored and working groups with partners remain active.

### **5.3 Our planning context**

East Renfrewshire Health and Social Care Partnership operates within an evolving framework of legislation, regulations and national guidance that shape our responsibilities to the people of East Renfrewshire and influence how we deliver our services. The Partnership is committed to incorporating and aligning the key elements of national, regional and local policies in the planning, design and delivery of our services. This section highlights some of the key planning considerations that influence our current strategic direction.

#### **5.3.1 A Fairer, Greener Scotland: Programme for Government 2021-22**

Published in September 2021, A Fairer, Greener Scotland sets out the Programme for Government and recognises the priority continues to be addressing the impact of Covid-19 as the single greatest public health crisis of our lifetimes and the impact on our health, economy and society. The programme also recognises the need to prioritise the recovery of our health and social care services – rebuilding capacity, and establishing a new form of care which people can access in a way, place, and time which works for them. It requires us to redouble efforts to tackle the inequalities that continue to blight our society –eradicating poverty and discrimination, and ensuring opportunity is never limited by economic or social circumstance. The programme also focuses on securing an economic recovery which is green and fair – for everyone and in every part of Scotland – and delivers the Scottish Government's ambition to become a net-zero nation.

#### **5.3.2 NHS Greater Glasgow and Clyde Remobilisation Plan**

The NHS Greater Glasgow and Clyde Remobilisation Plan is the current operational plan for the health board area setting out planned activity in relation to key priority areas. It covers a number of activity areas of particular relevance to the HSCP

including supporting staff wellbeing, recognising the importance of providing on-going support to promote both physical and psychological wellbeing over the coming year and looking to embed systems of support for the longer term.

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

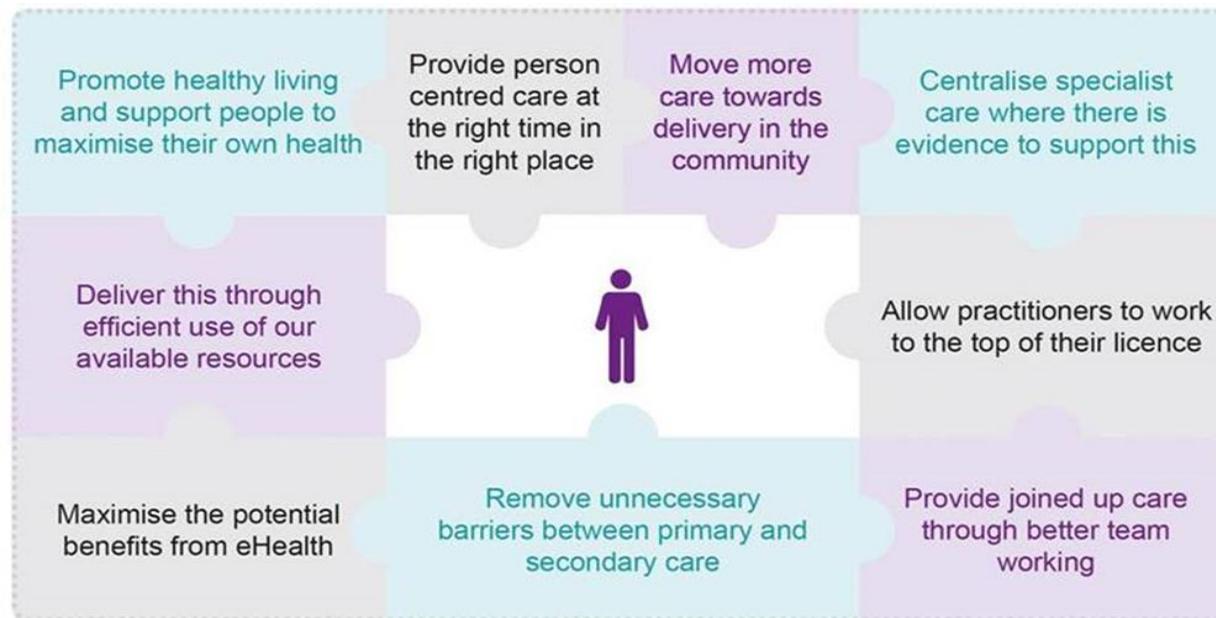
The plan supports the continuing safe delivery of (non-Covid) essential services in parallel with the response to Covid-19. It recognises that optimisation of self-care and an expansion of the role of primary care/community-based services will be a key element of the new “business as usual” following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

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

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

### **5.3.3 Moving Forward Together**

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



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

#### **5.3.4 Independent Review of Adult Social Care & National Care Service Consultation**

The Independent Review of Adult Social Care in Scotland (chaired by Derek Feeley, a former Scottish Government Director General for Health and Social Care and Chief Executive of NHS Scotland) was published on 3rd February 2021. The principal aim of the review was to recommend improvements to adult social care in Scotland, primarily in terms of the outcomes achieved by and with people who use services, their carers and families; and the experience of people who work in adult social care.

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

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

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

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

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

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

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

- Mainstreaming and embedding a human rights approach;

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

The Scottish Government subsequently put forward proposals for the establishment of a National Care Service for Scotland. The proposals go beyond the scope and recommendations of the review and set out how a National Care Service will define the strategic direction and quality standards for community health and social care in Scotland. The consultation proposes that the NCS will have reformed local delivery boards which work with the NHS, local authorities, and the third and independent sectors to plan, commission and deliver support and services.

The consultation ran from 9<sup>th</sup> August to 2<sup>nd</sup> November 2021 and sought views from stakeholders on:

- Improving Care for People
- Establishing a National Care Service
- The Scope of the National Care Service
- Reforming Integration Joint Boards (as new Community Health and Social Care Board)
- Improving Commissioning of services
- Regulation
- Valuing people who work in social care

It is expected that the findings from the consultation exercise will have significant impacts for the delivery of social care and wider supports moving forward. We will support any changes that are adopted and will look to include these in our strategic and operational planning. During the life of this Strategic Plan we will implement any recommendations or specific actions arising from the review as requested by Scottish Government.

### **5.3.5 The Promise – the Independent Care Review for young people**

The national focus on young people emphasises improving access and equality to education and employment for all our young people including our looked after young people. This aligns with the outcome of the Independent Care Review for care experienced young people –The Promise. It works with all kinds of organisations to support shifts in policy, practice and culture so Scotland can keep the promise it made to care experienced infants, children, young people, adults and their families - that every child grows up loved, safe and respected, able to realise their full potential.

### **5.3.6 East Renfrewshire Community Plan & Fairer East Ren**

The East Renfrewshire Community Plan sets out how local services work together to create stronger and fairer communities together with the people of East Renfrewshire.

The Community Plan (2018-28) reflects residents' top priorities and serves as the main strategic document for the East Renfrewshire Community Planning Partnership (CPP). The Community Plan is structured around five strategic priorities:

1. Early Years and Vulnerable Young People
2. Learning, Life and Work
3. Economy and Environment
4. Safe, Supportive Communities
5. Older People and People with Long-Term Conditions

In supporting delivery of the plan, the HSCP has a specific focus on supporting vulnerable young people (Outcome 1), older people and people with long-term conditions (Outcome 5) as well as supporting Outcome 4 through our community Justice services.

The Plan also includes Fairer East Ren – our Local Outcomes Improvement Plan - as required by the Community Empowerment Act. Fairer East Ren focuses on reducing inequality of outcome across groups and communities and sets out the following strategic outcomes:

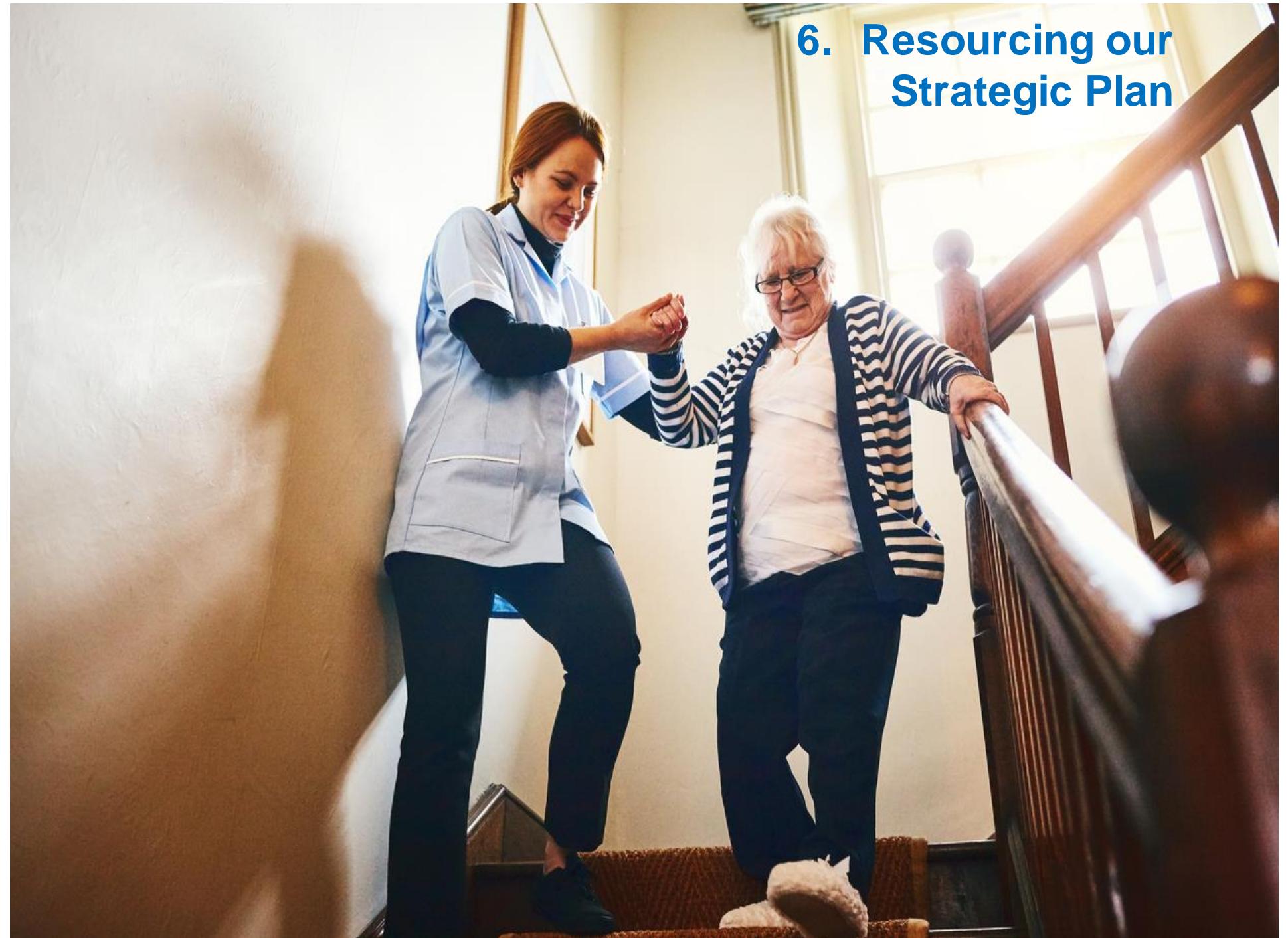
1. Child poverty in East Renfrewshire is reduced
2. Residents have the right skills, learning opportunities and confidence to secure and sustain work
3. East Renfrewshire's transport links are accessible, attractive and seamless
4. Residents' mental health and wellbeing is improved
5. Residents are safe and more socially connected with their communities

### **5.3.7 Planning in collaboration with housing**

Ensuring our communities have access to good quality housing and housing-related services is key to enabling people to live as independently as possible and also makes a significant contribution to reducing health inequalities locally. We have developed a shared strategic focus delivered through the **Housing Contribution Statement (HCS)** which we will update in line with the new East Renfrewshire Local Housing Strategy. The HCS operates as the “bridge” between strategic housing planning and that of health and social care. It constitutes an integral part of our strategic planning and identifies the contribution of the housing sector in achieving the aspirations of this plan. Housing services contribute positively to improving the health and wellbeing of our communities and ensuring that more people are cared for and supported at home or in a homely setting, in a way that is personal to them, respects their rights and maintains connections with important people and places.

The Local Housing Strategy (LHS) is the key planning vehicle that sets out how the Council and its partners will meet the housing requirements of people in East Renfrewshire. The priorities established in the strategy reflect those of the HSCP and set out the specific actions that the ERC Housing Services and local housing providers will undertake to support independent living and the integration of health, social care and housing. The strategy provides details of the services and supports that are available to achieve this goal and provides an estimate of future specialist provision, need and delivery options. The HSCP is working collaboration with housing colleagues to support the development of the next LHS for 2022-27.

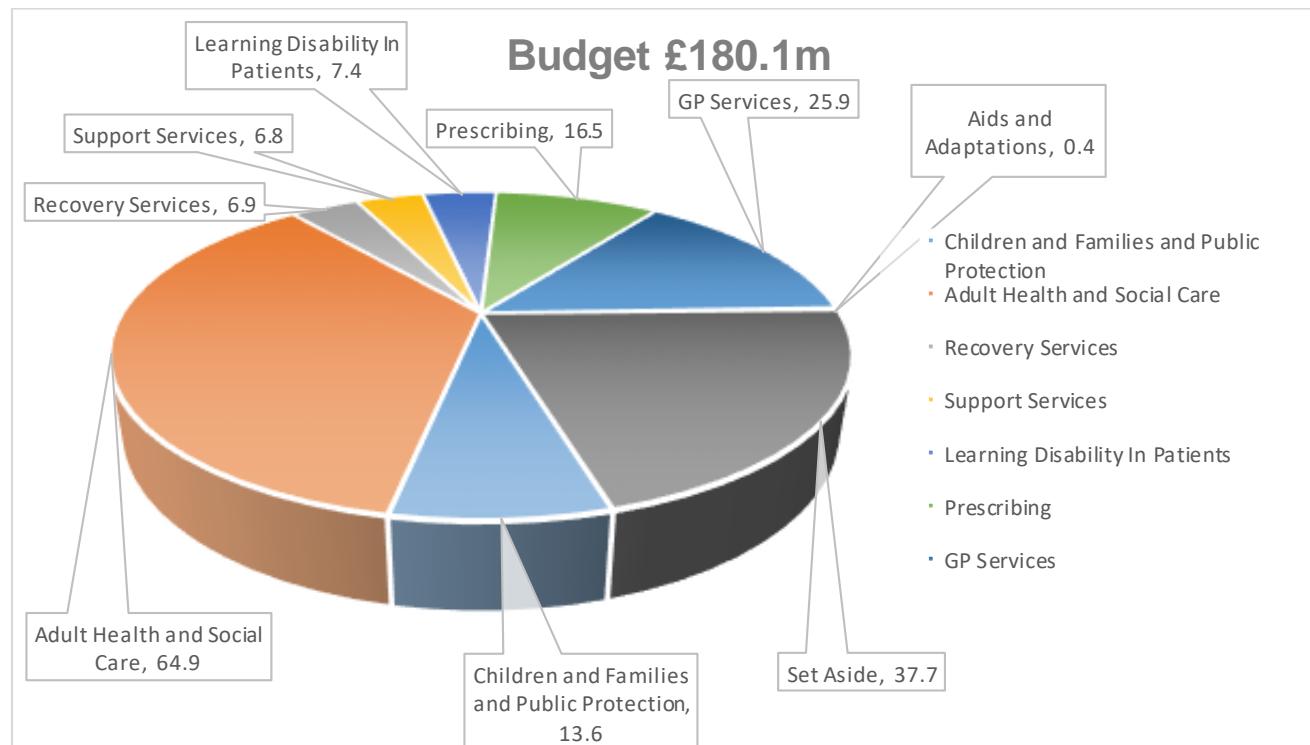
## 6. Resourcing our Strategic Plan

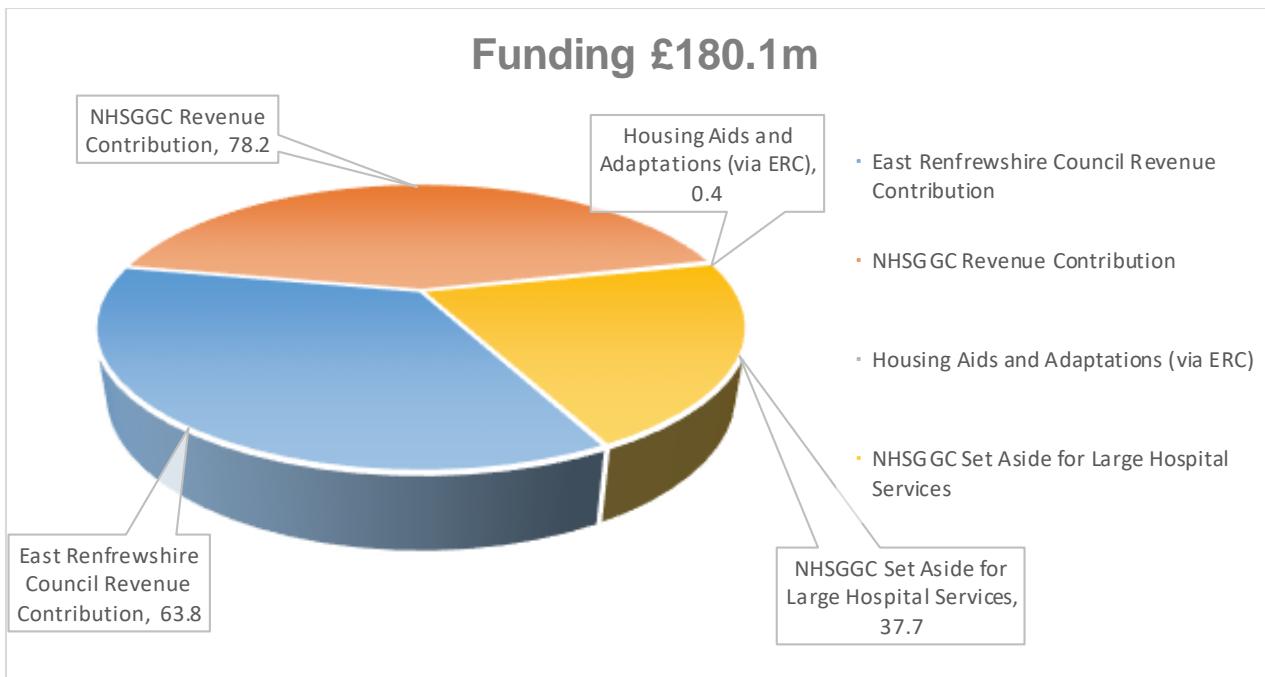


## 6.1 Financial Planning

The medium term financial plan for East Renfrewshire Integration Joint Board sets out the financial outlook covering the next five financial years for the IJB and the associated delivery of services through East Renfrewshire Health and Social Care Partnership, as directed by the IJB.

The IJB receives the vast majority of its funding from our two partners East Renfrewshire Council and NHS Greater Glasgow and Clyde as well as any specific grant funded initiatives from the Scottish Government and / or partner organisations. We recognise that these contributions are determined in the context of our partner funding settlements and any associated criteria and constraints. The IJB is engaged with partners in their respective budget setting processes. The first year of the plan shows the annual revenue budget (subject to IJB approval) for 2022/23 of £180.1 million and this will be spent delivering a range of health and social care services to the residents of East Renfrewshire.





Our budget broadly falls into two types of spending;

- the revenue budget to deliver health and social care services
- housing aids and adaptations and the budget for large hospital services which come under the strategic direction of the IJB.

The revenue budgets for those “day to day” health and social care services delivered by the HSCP is £142.4 million, with a further £0.6 million community justice funded by grant. We usually receive other ad-hoc funding and grants throughout the year to support various initiatives and this is reported within our routine financial reporting.

We also receive funding allocations for specific Scottish Government initiatives such as Primary Care Improvement Fund (c£2.4 million), Mental Health Action 15 (c£0.5 million) and Alcohol & Drugs Partnership (c£0.3 million).

We host the Learning Disability Specialist Services and Augmentative and Alternative Communication Service on behalf of the other 5 HSCPs within the Greater Glasgow and Clyde area, totalling £8 million and this cost is met by the HSCP. Similarly each of the other 5 HSCPs host one or more services on behalf of the other HSCPs. Our use of a range of services is around £9.5 million but the costs are met by the host HSCP under current arrangements.

The respective use of hosted services is shown in each HSCPs annual report and accounts in order to demonstrate the total system wide cost of our populations use of services.

The funding gap in 2022/23 is £2.9 million and presents a significant challenge particularly when taken in context of recovery from Covid-19, however there is also increased investment through Scottish Government funding to support health and social care so this may provide a degree of flexibility where we need to redesign models of care.

The funding gap relates to the balance of the £4.2 million legacy savings from 2020/21 and 2021/22 we did not achieve as a result of the pandemic response. We received financial support from the Scottish Government to meet this pressure in both years as part of the additional costs associated with Covid-19.

The plans we had to review criteria and introduce charges for non-residential care have been overtaken by a combination of the impact of the pandemic with increased demand for services and people having more complex needs. We also know that as part of a national care service the intention is to have a national criteria for care and to eliminate charging for non-residential care, so to progress with previous plans could potentially have caused unnecessary distress and uncertainty. The majority of our care costs are for our older population where our demographic continues to have a high proportion of frail, older people.

The IJB recognises the scale of the challenge; that we are still in response mode at March 2022; 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.

The IJB have recognised that 2022/23 will require an ongoing 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 £2.9 million, we have c£2 million in reserves to phase in those savings we can achieve through change and redesign.

## 6.2 Medium Term Financial Outlook

The funding pressures over the next 5 years relate to demand for services, legislative and policy changes, increasing population, inflation and economic uncertainty. Prescribing is a particularly volatile area as in addition to cost and demand changes this can also be impacted by short supply of drugs, new drugs to the market, existing drugs coming off patent and other price mechanism changes. Most significantly we do not know the ongoing impact and associated financial implications that Covid-19 has had on our population.

The 2022/23 cost pressures are per the proposed budget to the IJB and inform the modelled significant cost pressures for the following 4 years:

	2022/23 £m	2023/24 £m	2024/25 £m	2025/26 £m	2026/27 £m
Pay – assumed at 2% pa	1.5	1.0	1.0	1.0	1.1
Inflation and Policy (care costs) – assume 4% pa	4.5	1.9	2.0	2.1	2.1
Prescribing – assumed 2% pa	0.3	0.3	0.3	0.3	0.4
Demographic and Demand changes - assume 4% pa	1.5	1.9	2.0	2.1	2.1
Legacy Savings	3.6				
Cost Pressures	11.4	5.1	5.3	5.5	5.7
Funding to offset pressures	(8.3)				
Planned Savings – Firm	(0.2)				
Remaining Funding Gap – to be achieved	2.9	tbc	tbc	tbc	tbc

There will be other costs pressures such as general inflation and it is intended that these will be offset by efficiency savings where possible. Additional capacity funding included in the 2022/23 budget has resulted in increased pay and inflation for future years.

For those areas not yet quantified for future years the information and implications will be updated as issues emerge and become clearer. The resulting funding gap will be determined by the difference between pressures and the funding settlement agreed with our partners.

There are a number of areas where caseload or staffing ratio to number of patients will determine changes to the workforce. For example there are staffing models that determine how many District Nurses or Health Visitors are required for the population size, so where we have an increasing population we need to work with partners to assess the impact on the workforce and how this is to be funded.

We have a one year workforce plan in place and our three year plan will be finalised during 2022. This will help inform these discussions and associated cost implications.

### **6.3 Reserves**

Since the IJB was established in 2015 we have prepared for the expected financial challenge of the last few years and pre Covid-19 we had a reserves policy and an agreed strategy that allowed us time to deliver our savings.

We continue with this strategy to phase in savings to minimise the impact on frontline services however the scale of the challenge in 2022/23 means we may fully deplete this reserve. We may receive some Covid-19 support depending on the capacity impact on service redesign.

The projected reserves balance to 31 March 2022 is £16.3 million including an in-year allocation of £14.8 million to support Covid-19 and unscheduled care costs in 2021/22 and 2022/23. Our projected reserves can be summarised into the following categories:

Reserves	Projected balance at 31/3/22 £m
Scottish Government ring-fenced initiatives; fully committed and unable to apply to general use.	10.6
Bridging Finance to support the phased implementation of savings and allow for any in year pressures and flux in activity	3.1
Earmarked funding for projects and initiatives	1.6
Transitional Funding to support the bed model redesign within Learning Disability In-Patients	0.7
General reserves	0.3
Total	16.3

Within the bridging finance reserves of £2.4 million is specifically to support a phased approach to savings and it is likely we will utilise this to support the delivery of our £2.9 million savings in 2022/23.

#### **6.4 Risk**

The medium term plan sets out modelled future implications and that in itself is a risk, underestimated costs pressures mean we may plan to save more than we need to and vice versa – both scenarios will impact on the funding available to deliver services.

Successfully closing the 2022/23 funding gap is a fundamental assumption when assessing future cost pressures. Any shortfall will impact on future year pressures and on financial sustainability.

The success of our Recovery and Renewal programme will be impacted by our ability to adequately resource the programme including wider recruitment and retention challenges.

The impacts of legislative, political or policy changes, with examples included in the national context and in particular any development of a national care service.

Prescribing has always been volatile due to the numerous factors involved and there is a real risk of significant increases post Covid-19. We do have a reserve to help us manage changes in cost and volume.

#### **6.5 Summary**

The IJB budget for 2022/23, subject to agreement, allows us to meet cost pressures, investment in capacity per the Scottish Government budget settlement and implementation of all policy decisions.

Despite this investment we still have a legacy savings challenge of £2.9 million and our Recovery and Renewal programme will support savings delivery to some degree. The programme will also be regularly refreshed based on the latest response, take into account the impact of investment and incorporate further workstreams as required.

As our understanding of the impact of Covid-19 becomes clearer we will review our financial planning and modelling to reflect the impact this will have on demand for services and how we deliver them to meet the needs of our population.

## **7. How we will measure success**

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Our performance reporting is fully aligned to the strategic priorities set out in this plan. In addition to regular performance reporting to our Performance and Audit Committee and Integration Joint Board, we publish Annual Performance Reports giving a retrospective look at the previous year's performance. These reports set out progress made to deliver our strategic priorities over the previous 12 months. We review our performance data against agreed local and national performance indicators, including:

- National Core Suite of Integration Indicators
- Ministerial Strategic Group (MSG), and
- Statutory Performance Indicators.

In addition to data, our performance reports draw on personal experiences, views and examples of service developments and approached to describe the improvement process and how improved outcomes are being achieved.

## **Appendix One.**

### **Review of progress against our strategic priorities (2018-22)**

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In developing our plan we reviewed the progress we have made towards the outcomes and strategic priorities set out in our previous Strategic Plan 2018-21 in collaboration with our Strategic Planning Group (SPG). The review recognised the impact of the Covid-19 pandemic in the final year of the previous Strategic Plan and during 2021-22 and the emerging lessons from the period. More information on our performance is available in our [Annual Performance Report](#).

#### **1. Mental wellbeing for children and young people**

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

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

#### **2. Criminal Justice pathways**

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

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

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

This work needs to continue into the next strategic plan.

### **3. Supporting health and wellbeing in our disadvantaged communities**

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

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

### **4. Supporting people to remain independent and live well at home**

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

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

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

## **5. Supporting recovery from mental ill-health**

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

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

## **6. Reducing unplanned admissions to hospital**

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

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

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

## **7. Supporting unpaid carers to exercise choice and control**

We have seen continued progress in our development of support for East Renfrewshire's unpaid carers working in collaboration with our local Carers Centre. Our most recent report shows 92% of carers reporting satisfaction with their quality of life. This indicator has improved consistently year on year and by 22% since 2016/17. However, the 2017/18

Scottish Health and Care Experience Survey showed that just 37% of carers felt supported in their caring role, although 70% of the people who responded were able to report a positive balance in terms of their caring role and other interests in their life. Whilst our performance is similar to that across Scotland, we know that this is an area that we can improve and we remain focused on ensuring that local people who provide unpaid care are valued and supported.

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

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