Annual Performance Report 2021 / 22

Our vision is for Renfrewshire to be a caring place, where people are treated as individuals and are supported to live well.

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Foreword

Welcome to Renfrewshire Health and Social Care Partnership's (HSCP) Annual Performance Report, which covers the period from April 2021 to March 2022.

For the third year running, this report reflects the HSCP's performance in an operating environment significantly impacted by COVID and other challenging circumstances. While the severity of the pandemic has varied over this time, there has not yet been a period when our services have been free from restrictions of some kind.

Despite this, in collaboration with our partners, the HSCP has continued to deliver essential services for those who need them most. We continue to encourage innovation and flexibility to establish new and different ways of working in response to a changing environment. This is informed by listening to and acting upon feedback from those closest to our services.

This year's report once again measures performance against the nine National Health and Wellbeing Outcomes, National Core Integration Indicators, the Ministerial Strategic Group Indicators and local Key Performance Indicators.

The Integration Joint Board (IJB) receives regular progress reports. These reports, along with previous Annual Performance Reports, can be found on the Renfrewshire HSCP website on our Performance Reports page.

We would like to sincerely thank people with lived and living experience and unpaid carers for their support and patience over the last year. We would also like to acknowledge the dedication and hard work of the staff teams across the HSCP, Renfrewshire Council, NHS Greater Glasgow and Clyde (NHSGGC), providers of services and the amazing network of volunteers within the local communities who have all contributed to the delivery of services.

Thank you all for your unrelenting hard work and for going that extra mile - it really is making a positive difference to people's lives.

John Matthews OBE
Chair, Renfrewshire
Integration Joint Board

Christine Laverty
Chief Officer,
Renfrewshire HSCP

APR Executive Summary

The purpose of this Annual Performance Report is to update on year-end performance for the financial year 2021 / 22. The report also reflects on how we have progressed key service area priorities against the nine National Health and Wellbeing Outcomes over the past, and final year of our Strategic Plan 2019 / 22.

At the financial year end 2021 / 22, the Scorecard (pages 58 to 68) showed an improved position compared to 2020 / 21, with red status indicators reduced by one, amber increased by one and those with green status remained the same.

Considering the staffing challenges due to recruitment and retention, as well as absences due to sickness and COVID, staff have worked hard to ensure, where possible, the quality and professionalism of services was not compromised.

While 2021 / 22 has been another challenging year, services have improved, or at least maintained performance against a number of key performance measures.

Performance Indicator Status	2021/22	2020/21
	Alert: 13	Alert: 14
	Warning: 10	Warning: 9
	Target achieved: 16	Target achieved: 16
	No targets: 18	No targets: 18

Some examples where improvement was evident include:

- Successfully maintaining the UNICEF Gold Award and remaining accredited as a Gold Baby Friendly Service. To maintain gold status, we submit annual evidence to show standards are being maintained and progressed. We were highly commended by UNICEF.
- The number of emergency admissions from care homes decreased, with a reduction of nearly 21% from 506 admissions at March 2021 to 400 admissions at March 2022.
- A good increase in the uptake rate of child health 30-month assessments from 87% at March 2021 to 94.9% at March 2022 against a target of 80%.
- The percentage of complaints we responded to within 20 days increased from 82% at March 2021 to 90% at March 2022 against a target of 70%.
- The rollout of Totalmobile was progressed throughout 2021 / 22 and was completed for all areas of in-house provision by April 2022. The system enhances the way Care at Home can engage and communicate with its workforce, enabling them to better meet service demands with the resources available.
- The ECLIPSE social care case management system went live for Adult Services on 1 June 2021. This will improve service user outcomes by maximising the quality of case records and allowing the sharing of information between relevant services in a secure manner.

APR Executive Summary

New Strategies and Plans

During 2021 / 22, we developed a number of new Strategies and Plans in collaboration with our partners and service users. These included our Strategic Plan 2022-25, Unpaid Adult Carers' Strategy 2022-25 and Palliative and End of Life Care Strategy 2022-25.

Our Workforce Plan 2022-25 has also been developed and will be presented to the IJB for approval by the end of this year.

Our vision is for Renfrewshire to be a caring place where people are treated as individuals and are supported to live well.

Areas for improvement:

Service Waiting Times

Waiting times for several service areas deteriorated during the pandemic, namely Child and Adolescent Mental Health Services (CAMHS), Community Mental Health Services, Paediatric Speech and Language Therapy and Podiatry Services. Referrals have continued to increase for these services and actions are in place to manage the growing demand accordingly. While these actions have resulted in recent improvements, the demand for urgent care remains high and must be prioritised.

Unscheduled Care

As expected, unscheduled care indicators (A&E attendances, emergency admissions, delayed discharges etc.) declined in performance relative to year end 2020 / 2021 as service demand increased to pre-pandemic levels. This mirrored both national and NHSGGC trends as public behaviours changed again as the pandemic eased. The number of delayed discharge bed days lost was 9,177 for 2021 / 22, similar to the level of 9,122 recorded for 2019 / 20. In 2020 / 21, the number had reduced to 8,759.

Within a national context, Renfrewshire was the highest performing HSCP area in Scotland at March 2022 for standard delays, with 80 bed days lost. This equated to a rate of 54 per 100,000 population. The national average rate at March 2022 was 799.9 and the Greater Glasgow and Clyde average was 553.6 per 100,000 population.

Our Continued Response to the COVID Pandemic

Our APR for 2020 / 21 described our response to the first 12 months of the pandemic. As the situation has changed over the last year, we have responded on a range of COVID related matters.

Critical frontline services have continued throughout this period. At the same time, additional services were developed to support the national response to the pandemic. These included:

- A comprehensive COVID vaccination programme in Renfrewshire.
- The continued review of service contingency and deployment plans to ensure our workforce was flexible to respond to changing circumstances.
- Oversight, management and distribution of Personal Protection Equipment (PPE) and testing support.
- A Community Assessment Centre, which provided services to assess people presenting with COVID symptoms, until its closure in March 2022.
- Supporting the health and wellbeing of our staff and wider communities during the pandemic.
- Additional financial support to third sector and independent social care providers and hospices who were key to our response to the pandemic.

COVID Recovery and Renewal

During 2021 / 22, we also began to focus on **recovery** and planning for the **renewal** of services.

However, this period was marked by recurrent waves of the virus, with the Omicron variant in early 2022 resulting in challenges, particularly in relation to staffing absence rates.

Given the need to continue to deliver our essential operational activities effectively and safely it therefore was, and continues to be, necessary to flex the scale of recovery and renewal activity.

That said, the IJB was able to progress with a number of initiatives through our Recovery and Renewal Programme, examples of which are provided throughout this report.

In addition, the development of the IJB's Strategic Plan for 2022-25, undertaken throughout the year, sets a number of principles which will continue to inform organisational and community recovery in future:

COVID Recovery: Our Principles

Maintaining Health and wellbeing

Focusing on service stability

Maintaining flexibility in our pandemic response

Evaluating COVID practice and impact and building on what works

Report Framework

Our 2021 / 22 report is structured around the nine National Health and Wellbeing Outcomes and is divided into six main sections detailed below. We have used a range of key performance indicators to track our progress during the last year.

We have included examples from care groups, individual case studies and service user feedback. We have also linked evidence to service area priorities within our Strategic Plan 2019-2022. Outcomes 8 and 9 include examples of the ongoing work to support staff health and wellbeing throughout the pandemic. We also show how our approach to change and improvement of service delivery has continued to aid our response to ensure we manage our resources as best we can.

Section	Outcome
Community Health and Wellbeing and Reducing Health Inequalities	**Outcome 1 -** People are able to look after and improve their own health and wellbeing and live in good health for longer.
	Outcome 5 - Health and social care services contribute to reducing health inequalities.
Delivering Positive Outcomes for Service Users	**Outcome 2 -** People, including those with disabilities or long terms conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.
	Outcome 3 - People who use health and social care services have positive experiences of those services, and have their dignity respected.
	Outcome 4 - Health and social care services are centred on helping to maintain and improve the quality of life of people who use those services.
Carers	**Outcome 6 -** People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing.
Safer Services	**Outcome 7 -** People using health and social care services are safe from harm.
Effective Organisation	**Outcome 8 -** People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
Supporting Organisational Delivery, Financial Performance and Best Value	**Outcome 9 -** Resources are used effectively and efficiently in the provision of health and social care services.

Outcomes 1 and 5: Community Health and Wellbeing and Reducing Health Inequalities

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Outcome 1: People are able to look after and improve their own health and wellbeing and live in good health for longer.

Outcome 5: Health and social care services contribute to reducing health inequalities.

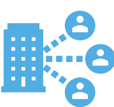
The Community Partnerships and Health Improvement Teams work together to tackle health inequalities and promote health and wellbeing. We do this through collaboration across the area with commissioned providers of health and social care services, third sector and community groups as part of our Strategic Planning Group (SPG). Feedback from all participants has highlighted the benefits of working in partnership to empower people to improve their wellbeing.

During 2021 / 22 we maintained our focus on the six priorities identified by the Strategic Planning Group (SPG), namely:

Outcomes 1 and 5

Examples of some of the work carried out in partnership

A 60-minute virtual Introduction Session to Self-Harm was rolled out across Renfrewshire Council Education staff to support Education Authorities and Schools to consider how they may implement a whole organisation approach to self-harm awareness and training.



The projects include developing a Connectedness Network in a specific geographical area, creating more opportunities for people to be physically active in their local communities, producing mental health information in various languages, funding a post to focus specifically on improving health in ethnic minority group communities and supporting parents with the transitional experiences in early years to nursery and school.

Through funding from Renfrewshire Alcohol and Drug Commission the team recruited a Lead Officer to work with Community Planning Partners to introduce revised policies and practices recognising the impact of alcohol promotion and supply across communities and workplaces. Renfrewshire Council and West College Scotland are working to review and update workplace alcohol and drug policies.

In partnership with Renfrewshire Council, we developed a programme to support mental health and wellbeing in workplaces across Renfrewshire as part of the Renfrewshire Economic Recovery Plan.

Funding was allocated to Roar – Connections for Life and the Star Project to start providing befriending for people experiencing isolation and / or loneliness. The outcomes from this will be evaluated with a view to establishing a longer-term resource.

A resource has been developed in collaboration with Community Planning Partners, following the findings of the Renfrewshire Alcohol and Drug Commission Report for children and young people. Lessons were developed with young people and people who have lived experience of drug and alcohol addiction.
https://www.youtube.com/watch?v=OT1Xjceg48w

The HSCP provided funding to Renfrewshire's new Integration Network "IN-Ren", to enable the co-ordinator to focus on health inequalities. IN-Ren is a forum for people from minority ethnic backgrounds which will allow them to become more involved in all aspects of community planning.

90 Trained in self-harm awareness

Outcomes 1 and 5

Examples of some of the work carried out in partnership – early years

Our aim is to ensure the best start for children, with a focus on early years, to promote healthy development, good health, wellbeing and quality of life by ensuring an evidence based Public Health approach.

Home-Start Renfrewshire received funding from the HSCP to develop a programme, which offers parents with perinatal mental ill health, or those at risk of developing it, the chance to take part in a peer support and parenting support model. We created a package of support for the Home-Start team, ranging from provision of health resources to sourcing and delivering training.

In collaboration with Renfrewshire Council, Health Improvement led on A Smoke Free Play Parks Project to supply all playparks and skate parks within Renfrewshire with no smoking signs which are child friendly and convey the message of ASH Scotland's Charter to become a smoke free generation by 2034.

The Healthier Wealthier Children (HWC) Service has mostly continued to deliver services through online channels. For many families accessing the service, this has proved beneficial, as it removes the burden of travel and childcare costs. However, the service is flexible, adapting to suit individual needs.

There continues to be significant financial gains from the HWC Service in Renfrewshire **- a financial gain of £417,319.15** for HWC families in 2021 / 22, with an overall financial gain of **£9,034,310.92 since the programme began**.

Case Study: Miss A

Miss A was supported by HWC to claim a Personal Independence Payment for herself and Disability Living Allowance for her son, who had been diagnosed with ADHD. She was then able to claim Carers' Allowance for her son, which had the added benefit of removing the cap from her Housing Benefit - enabling her to cover her rent payment. She was also entitled to back pay for her Housing Benefit claim and this cleared her arrears with her private landlord.

Miss A was also supported to claim Child Benefit for her two younger children. This will mean an extra £19,983.60 a year coming into the household. Her backdated money totalled £8,227.70.

By getting all the benefits owed to her, Miss A can now access after school clubs for all her children, get better support for her son at school, and has opened more suitable housing options for her and her family.

Outcomes 1 and 5

Early years - our continued commitment to normalising breastfeeding

Over the last year, Renfrewshire HSCP continued to support families in making informed decisions about infant feeding, as part of our commitment to GIRFEC ("Getting it Right For Every Child"), particularly the post-natal contacts as part of the Universal Pathway. We will continue to explore creative and innovative ways to increase breastfeeding rates in our most deprived areas.

The percentage of exclusive breastfeeding at 6-8 weeks has decreased from 26.8% at March 2021 to 19.7% at March 2022, below the target of 21.4% - amber status

The percentage of exclusive breastfeeding at 6-8 weeks in the most deprived areas has decreased from 23.3% at March 2021 to 11.8% at March 2022, below the target of 19.9% - red status

UNICEF Gold

In March 2022, we successfully maintained the UNICEF Gold Award and remain accredited as a Gold Baby Friendly Service. To maintain gold status, we must submit annual evidence to show standards are being maintained and progressed. We were highly commended by UNICEF and the team praised for its ongoing support, dedication and commitment to families.

Infant Feeding Audits

The UNICEF Baby Friendly Standards continue to be high priority for the Service, supporting our children to have the best start in life. The recent audit results demonstrate the high level of care mothers continued to receive from the Service despite the pandemic.

From July 2021 to March 2022 there have been **708 referrals** from midwifery to health visitors for antenatal contacts as part of the Universal Pathway.

100% of mothers were happy with overall care

100% of mothers stated staff were kind and considerate

Outcomes 2, 3 and 4: Delivering Positive Outcomes for Service Users

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Outcome 2: People, including those with disabilities or long terms conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.

Outcome 3: People who use health and social care services have positive experiences of those services, and havetheir dignity respected.

Outcome 4: Health and social care services are centred on helping to maintain and improve the quality of life of people who use those services.

We have presented outcomes 2-4 collectively as they underpin how we co-design and shape our services. This approach stems from our vision, which brings the outcomes together to reflect our overarching organisational purpose: for Renfrewshire to be a caring place where people are treated as individuals and are supported to live well.

In this section we highlight how we have supported different care groups over the last year, along with our locality services. We have selected some of the key developments and performance from the last year, where we have maintained essential service provision to deliver positive outcomes for our communities and the people who use our services.

Outcomes 2, 3 and 4

Locality Services

Locality service delivery has continued to evolve in line with COVID guidance and the needs of the Renfrewshire community. The teams provide a first response service to a range of people with complex and diverse needs. This includes undertaking comprehensive assessments and in-depth reviews.

Developments during 2021 / 22 include:

Implementing group supervision sessions on a 6-weekly basis, ensuring the development of improved staff knowledge and skills.

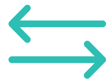
Further developing our partnership approach with Renfrewshire Carers Centre, to support unpaid carers. This led to an increase in referrals to the Carers Centre.

Improving staff awareness of the role of a Mental Health Officer and their duty relating to the 'Adults with Incapacity Act'.

Implementing a new Occupational Therapy (OT) bathing assessment process, which enabled non-OT staff to provide basic equipment for service users, without them having to go on the OT waiting list.

Forming closer working relationships with our ADRS and Community Mental Health teams to support understanding of changes within services and how they will continue to meet service users' needs.

Delivering services by the Sensory Impairment Team to all situations where there has been a critical or substantial need or risk in relation to physical safety, or other harms including social isolation, independence, and emotional wellbeing.



Implementing updated Scottish Government guidance on using SDS budgets flexibly.

Using SDS flexibly

Laura lives alone but is very sociable. She is a full-time wheelchair user. She normally enjoys attending Day Services, but this has not been possible during the pandemic. Her laptop was broken, and she was having difficulty using her mum's temperamental iPad, due to her tremors.

Laura chose to use SDS money to purchase a laptop with an adapted mouse and large screen. This allowed her to participate in zoom classes, calls and stay connected with her friends and family, as well as doing her online grocery shopping.

Outcomes 2, 3 and 4

District Nursing

The District Nursing Service has continued to play a pivotal role by proactively prioritising their workload and working with families and colleagues across the Partnership to maintain this vital service.

Highlights included:

District Nursing Advance Nursing Practitioners (DN ANPs): We have three new DN ANPs sitting alongside our District Nursing Team, who offer advanced clinical assessment to patients with an acute presentation or deteriorating condition and are currently on the DN caseload.

Treatment Rooms: In June 2021, the inception of treatment rooms began in Renfrew Health and Social Work Centre, and we have expanded this to a further five sites over the past year. Patients can attend for wound care, injections and post-operative follow up care, at the right time and right place that is convenient for them. Over the coming months there will be more treatment rooms established meeting the needs of patients across Renfrewshire.

Approx. 2,600 patients have attended the treatment rooms

Service User Feedback

"I am writing to express my gratitude for the excellent care and attention I received from the District Nurse team, based at Dykebar Hospital. For the past month, I have had different members of the team visiting me to change dressings following a cellulitis infection. Without exception, each member of the team was very caring, took time to address any concerns I had and offered good advice and support. I found them to be entirely patient focused, professional, yet warm and friendly. That they are able to deliver such a first-class service in these trying times is testimony to their dedication to their work and to the patients that they have in their care"

Outcomes 2, 3 and 4

Rehabilitation and Enablement (RES)

The RES Team played a major role in in their flexible approach to joint working through the pandemic. Over this time, they have strengthened their team-working ethic and have developed enhancements to some services.

Highlights for 2021 / 22 included:

All staff were set up to work remotely and use Near Me technology for consultations, which helped manage waiting lists. This continues to be used.

Staff helped provide an extended care home response team alongside Care Home Liaison Nurses to support care homes, providing direct patient support.

Ongoing development of the Respiratory Team which now comprises of Nurse Specialist, Occupational Therapist (OT), and Physiotherapy and Psychology input. Supporting patients with diagnosed respiratory disease in their home and preventing unnecessary hospital admission.

RES drop-in sessions were held across 2021 / 22 for information and advice on falls and falls prevention.

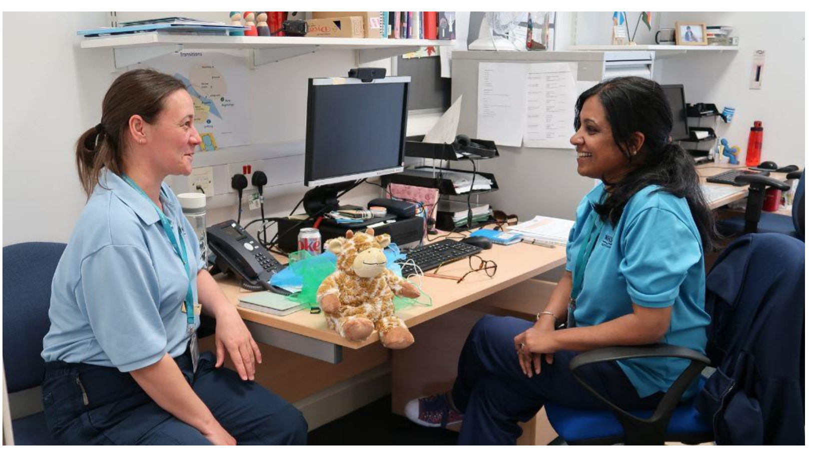
This was following general deconditioning and reduced activity seen during lockdowns and the subsequent impact this had on physical, mental health and risk of falls.

The service aims to hold further sessions in different locations within Renfrewshire in 2022.

Throughout 2021 / 22 the RES team have worked tirelessly to address the demand for Physiotherapy and Occupational Therapy following the easing of COVID restrictions against a context of staffing absence and recruitment issues.

High absences within the Physiotherapy Team due to sickness and vacancies were particularly challenging which saw the waiting list for the service more than double during this period.

Actions being progressed to address the situation included the recruitment of additional staff and support from agency staff which has seen an improved position since March 2022.



Outcomes 2, 3 and 4

Services to Support Older People

Day Support

Falcon Day Centre re-opened for critical building-based support on 15 November 2021. This was complemented by our remote service. As part of recovery activity within day support, we developed an interim hub and spoke approach to day support for older people and adults with a physical disability, which began in April 2021.

This approach combined support provided by the Falcon Day Centre for those with most critical needs, with community outreach services provided to people within the local community and delivered alongside ongoing welfare calls.

We have worked closely with Connecting Scotland and our digital champions to ensure our digital offering has been developed to meet the needs of our service users.

The model has been created in recognition that it would not be possible to re-open every care building immediately, and that buildings will need to operate at reduced occupancy due to infection control and physical distancing requirements.

Virtual Day Centre

The day centre formed a digital team during the pandemic to bring the activities and support of the day centre online. By creating 'how to' guides on everything from how to get the most out of their devices, sending emails and photos, video calling their families in places such as Australia, and even joining in their church services.

Online groups included, quizzes, knitting groups, music and exercise classes as well as reminiscing over film screenings.

Service users never gave up learning and are now video calling each other without staff support and just like day centres they started hosting events such as Christmas parties, St Andrews Day, Platinum Jubilee Celebrations to birthday parties on Zoom.

Outcomes 2, 3 and 4

Care at Home services

Throughout 2021 / 22, COVID once again presented a significant challenge to our Care at Home services. However, our team have continued to provide critical care and support to people of Renfrewshire, in their own homes, throughout the pandemic. Our flexible approach helped us identify and implement improvements across Care at Home services while incorporating learning from our response to COVID. These included:

A revised management structure to support the ongoing service development work commenced in January 2022.

A renewed approach to managing recruitment and absences across Care at Home services.

Continuing to develop staff training programmes to meet Scottish Social Services Council (SSSC) requirements.

Providing staff with increased access to a digital communication portal, reducing paper processes, and providing staff access to a range of online information and guidance.

Rollout of Totalmobile was completed for all areas of in-house provision by April 2022. The system enables greater productivity and more efficient ways of delivering homecare services, supporting people to live independently in their own home for as long as possible.

Percentage of long-term care clients receiving intensive home care - Target: 30%. Performance 29% at March 2022 – amber status

Clients receiving intensive home care are those who receive more than 10 hours of home care per week. It does not include other Home Care Services such as Community Meals and Technology Enabled Care (TEC).

In 2021 / 22, 93% of clients accessed out of hours home care services (65+), above the 85% target - green status

Outcomes 2, 3 and 4

Services to Support Older People

Care Homes

COVID continued to have a major impact on care homes throughout 2021 / 22, with fluctuations in staffing availability and the need to manage periodic outbreaks and closures. Our team continued to play a leading role in delivering support and oversight to care homes across Renfrewshire through our involvement in daily huddles and clinical oversight, with multi-agency input from Public Health, Renfrewshire Council and NHSGGC.

Many family members have provided positive feedback during these difficult times, which is evidence of the commitment and dedication of all our staff and our partners.

Regular meetings were established between HSCP Primary Care colleagues and care home managers which have enabled better communication and understanding of issues on both sides. The working relationships between independent care homes and GPs, Scottish Ambulance Service and the Royal Alexandria Hospital, has helped improve the patient discharge process and assisted in the reduction of emergency admissions from care homes.

Work is also ongoing with our Local Intelligence Support Team to capture the impact of the support provided by our Advanced Nurse Practitioners within Renfrewshire Care Homes to reduce avoidable emergency hospital admissions throughout 2021 / 22.

In response to the prolonged restrictions on visiting, we installed bespoke cabins at each of our 'older adult' care homes as a long-term investment.
The cabins provide comfortable, heated environments for visitors, while allowing adequate airflow to minimise the risk of infection.

In 2021 / 22 there were 400 emergency admissions from care homes. Target: 692 - green status

The number of emergency admissions from care homes decreased, with a reduction of nearly 21% from 506 admissions at March 2021 to 400 admissions at March 2022.

Outcomes 2, 3 and 4

Physical Disabilities

Physical Disability Day Services - Disability Resource Centre

The Disability Resource Centre (DRC) provided an interim service in 2021 / 22. In the first quarter, the team provided a mixture of welfare calls, digital sessions, and face-to-face contact. A preference to get back to a building-based service was highlighted by people who use the service and their families.

Although the DRC was able to re-open in November 2021, a fire in the building meant we had to close the Centre again after only a few days. Partner organisations were extremely supportive and provided accessible venues which have allowed people to organise sessions during the closure.

The DRC opened once again in October 2022.

Online Groups – A selection of feedback from some of the groups that took place during 2021 / 22:

"I'd like to say thank you for the wonderful work you have all done, also what has made a difference to my life."

"It has made such a difference having the zoom groups in my life and I want to thank you for all your caring. Looking after me … still feeling part of the centre."

"Thank you each and every one of you for being there for me, giving me something to look forward to each day, and whatever happens in the near future we will continue to be there for each other."

"I have so enjoyed these groups and they have all brought a bit of stability to my days."

"I've been ever so grateful to everyone at the centre for their help, care, support and just knowing someone cares about me."

Outcomes 2, 3 and 4

Specialist Children's Services

Child and Adolescent Mental Health Service (CAMHS)

The demand for CAMHS has increased by 20% compared with pre-pandemic levels.

- A waiting list initiative for initial assessment has been in place since January 2022. This has significantly increased the number of appointments available to our children, young people and their families.
- Weekend and evening appointments are also now available, providing greater flexibility.
- The introduction of an 'opt in' process has allowed families to book an appointment at a time that suits them.

This improvement activity has decreased the time children and families are having to wait for initial assessment.

Neurodevelopmental assessments were paused during the pandemic, which increased demand. Reducing waiting times for these assessments is a priority. There has been significant investment in training more staff to undertake these assessments to increase capacity.

We continue to invest in the recruitment of clinical staff to increase case co-ordination capacity. Recruitment to traditional CAMHS professions is challenging. However, we are introducing new, innovative roles to support the assessment, care and treatment of our children and young people, including trainee Advanced Nurse Practitioners, Pharmacists and Arts Therapists. These new roles will provide alternatives to talking therapies for our children and young people, support the management of complex cases and increase our prescribing capacity.

As at March 2022, 58.8% of patients waiting were seen within 18 weeks of Referral to Treatment (RTT) below the 80% target – red status

Outcomes 2, 3 and 4

Specialist Children's Services

Paediatric Physiotherapy

During the pandemic, service delivery was amended to ensure the safety of our patients and staff. This resulted in a reduction in available appointments and face-to-face activity, with waiting times increasing. For Paediatric Physiotherapy these peaked in October 2021, when 160 children and young people were awaiting assessment. The longest wait was 38 weeks.

Several service developments were put in place to address this.

Funding was secured to carry out a waiting list initiative clinic in partnership with our colleagues at the Royal Hospital for Children in Glasgow.

A temporary increase in staff, improved utilisation of existing staff and an increased availability of accommodation has allowed us to build capacity within the service.

Telephone triage of referrals was established, allowing clinicians to give advice early and prioritise referrals effectively.

Our previously successful drop-in service has been replaced by a weekly advice line and face-to-face triage clinic. The latter has been incredibly successful with 75% of attendees assessed as needing advice and reassurance only. Informal feedback from parents highlights the value families place on this reassurance from a specialist and their satisfaction in the service provided.

Paediatric Occupational Therapy

Paediatric Occupational Therapy (OT) has used learnings and feedback from service users during the pandemic to provide a patient-centred, group intervention to help children achieve their personal goals.

Two members of the team were instrumental in developing and implementing our Trailblazers Programme, which involved a mixture of online group sessions, smaller break-out groups and outdoor group sessions to demonstrate how skills can be practised and developed within the natural environment. The feedback from these sessions was very positive and will be evaluated to improve and develop the sessions for our next group of Trailblazers.

Child reported to Mum
“It’s not just me who finds these things tricky.”

A Mum reported “I never thought she would be able to manage her buttons and cutlery by herself.”

A Mum reported that a child who was struggling to engage in school was very engaged in Trailblazers every session.

Outcomes 2, 3 and 4

Learning Disabilities

Renfrewshire Learning Disabilities Service (RLDS) has continued to support adults with learning disabilities by developing new and creative ways to support positive outcomes in their lives. Experiences shared during the pandemic have informed conversations about how support can be shaped differently to meet individual aspirations. Working in partnership with people with living experience (PWLE), carers and other stakeholders continues to be a priority. We are working collaboratively with HSCPs across NHSGGC, to meet the objectives of the Scottish Government's 'Coming Home Implementation Report' (CHIR).

Assertive Outreach Model

As part of the implementation of the CHIR, we have invested to bring additional posts to the Community Integrated Team. This has enabled a new approach to support PWLE, their families and providers when experiencing challenge and crisis within their homes. The new outreach support will provide a proactive response to enable preventive interventions and reduce episodes of crisis and promote stability.

Staff Award – 'Innovation of the Year'

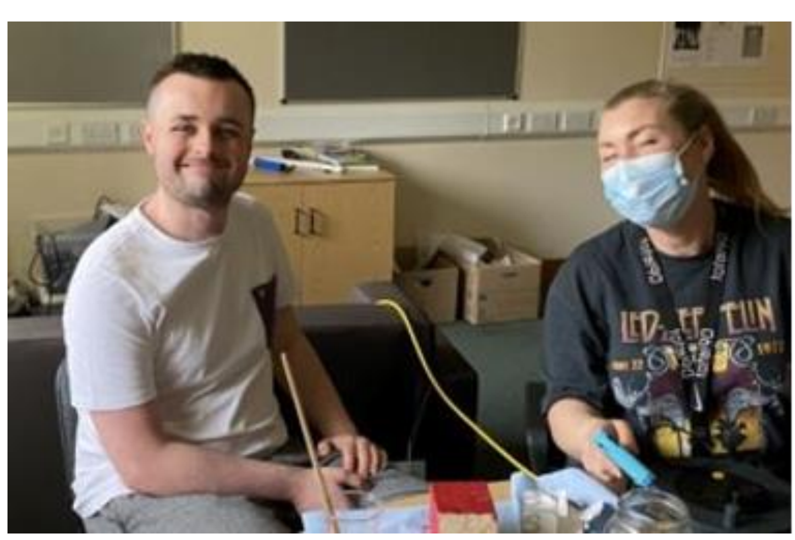
RLDS was delighted to win 'Innovation of the Year' at the 2021 HSCP Awards for its Digital Transformation Project. This was also celebrated at a national level with Health Improvement Scotland (HIS) inviting the team to present at a national conference where the developments were acknowledged as transformational.

Lived Experience Reference Groups

Care planning reference groups have begun for individuals who access Autism and Learning Disability Services. These groups aim to ensure those with living experience are heard as part of the strategic planning process. This newly developed structure includes separate reference groups for carers, facilitated with support from Renfrewshire Carers Centre.

HSCP Strategic Plan – Autism Care Group

Autism was identified as an individual care group within the HSCP Strategic Plan (2022-25). The service has worked closely with lived experienced individuals to help shape input to the Strategic Plan and develop the year one action plan. Many aspects of the action plan are progressing well, with the introduction of new peer-led support groups and the creation of new roles designed to solely support autistic adults within Renfrewshire.



Outcomes 2, 3 and 4

Mental Health

Our Mental Health In-patients and Community Mental Health Services (CMHS) have used a range of flexible options to ensure patient care and treatment has remained their priority through recovery from the pandemic.

Increased use of technology such as Near Me video consultation for routine assessments has enabled more patients to be seen and freed time for speedier access for follow up treatment appointments. Staff have responded quickly to the change in care provision and planning, to ensure movement throughout the secondary care service, re-establishing reviews and meetings using digital technology such as Microsoft Teams. This has reduced time spent travelling, which has freed more time to focus on patient contact and care.

We continue to work with HSCPs across the NHSGGC area on the implementation of the Scottish Government's 10-year Mental Health Strategy 2017-2027. The Mental Health and Wellbeing Strategic Care Plan Group meet quarterly to monitor the progress of impact locally.

In-Reach Service

We have recruited two In-Reach Workers to support a review of discharge processes from our inpatient mental health wards and form part of our new Mental Health Discharge Team. This aims to:

Improve communication between mental health inpatient and the community services to promote a ‘seamless’ mental health service within Renfrewshire.

Improve patient care, with patients seen by the right service, within the right team, at the right time.

Improve the co-ordination and patient experience of discharge, with patient and family’s involvement central to the discharge planning process.

Outcomes 2, 3 and 4

Mental Health

Community Safety Service

Since beginning in March 2021, the Community Safety Service (CSS) has established links with GPs and Link Workers, and worked collaboratively with the Police, Fire and Rescue Service, Social Work, and the CCTV Community Safety Hub. The service collates relevant information and shares this with the relevant Mental Health Services, to ensure vulnerable adults are identified and offered support as quickly as possible. It also assists at the drop-in clinic for Women and Children First, to support people by offering low intensity psychological intervention and anxiety management.

Key highlights include:

The service has established working links with Women's Aid, offering a drop-in clinic for staff where referrals are discussed, and support and advice given to staff.

Staff from the service provide mental health representation on the Multi Agency Risk Assessment Conference (MARAC) group, sharing information and receiving referrals for individuals who may need support for their mental health.

In July 2021, the service began working alongside Housing, Homelessness and Housing Support Services, offering staff the opportunity to refer directly when there are concerns for an individual's mental health. This provides Housing Services with easier access to Mental Health Services and the ability to access support and advice when needed.

The service is also involved as a mental health representative on the HSCP Panel to support housing priority for individuals and has a role in agreeing priority status for housing need.

Community Wellbeing Nurses

Community Wellbeing Nurses work across existing services including the CMHS, GPs and Community Link Workers, to improve links between these services, increase support and improve referrals made to secondary care. This allows all referrals to be triaged within the GP surgery.

There are now five Community Wellbeing nurses working across Renfrewshire GP Surgeries.

Outcomes 2, 3 and 4

Mental Health

Suicide Prevention

It was widely expected that deaths by suicide and instances of self-harm would increase due to the pandemic. Data issued recently has shown that there has been a slight increase in suicides within Renfrewshire. In 2020 / 2021 there were 22 suicides within Renfrewshire and in 2021 / 2022 there were sadly 25, an increase of three.

Our Choose Life Service Co-ordinator developed a suite of 'A Conversation about' sessions, which are delivered via Microsoft Teams. The topics covered are mental health, anxiety, depression, psychosis, suicide and staying safe, self-harm and ASIST (Applied Suicide Intervention Skills Training). Initial uptake was encouraging and has resulted in additional sessions being added to the programme.

The Choose Life Co-ordinator has also been providing the Living Works Start Programme, which raises awareness of suicide prevention and enables participants to connect people to help and safety.

Renfrewshire will establish a new Suicide Prevention Strategy Group early in 2023 which will implement local actions to meet the recommendations of the Scottish Government's suicide prevention strategy 'Creating Hope Together'.

No Substitute for Life - RAMH's Annual Memorial Football Tournament

In partnership with RAMH and St Mirren FC Charitable Foundation, we helped to remember those lost to suicide and promote awareness and understanding of suicide.

The event, held on world mental health day, consisted of a 7-aside tournament, to raise awareness of suicide and show support for all those looking for help and advice around their own mental health. Speakers also took part in the event, telling powerful and emotive stories on their experiences of suicide and mental health.

Outcomes 2, 3 and 4

Alcohol, Drug and Recovery

Renfrewshire's Alcohol and Drug Recovery Service (ADRS) has continued to provide essential services, despite a reduction in face-to-face contact due to COVID. We have continued prescribing specialist medication, including essential Opiate Replacement Therapy and continued Blood Borne Virus Testing, albeit in limited numbers. The Acute Addiction Liaison Service continues to provide service users with essential pathways from acute settings to other services or return to their homes, reducing some of the pressures and demands on acute services. ADRS has contingency in place to provide support to those returning to Renfrewshire following early prison release.

Alcohol and Drug Partnership (ADP) Drug Death Prevention Lead Officer

We have appointed a dedicated role to support the prevention of drug related deaths in Renfrewshire. The ADP Drug Death Prevention Lead Officer will work with partners to implement evidence-based strategies, aimed at reducing drug-related deaths in Renfrewshire. The post has led in the development of the Renfrewshire Drug Death Prevention Group (DDPG), which works to implement national policy alongside local needs, to mitigate the harms caused by drug use.

The lead officer is also coordinating the increase of Naloxone provision throughout Renfrewshire. To achieve this, a multi-agency Naloxone Delivery Group was established. This group's remit includes improving education on overdose prevention and Naloxone, reducing barriers, and ensuring Naloxone is available to those who need it most.

Reduction in Alcohol Related Hospital Stays. 6.8 per 1,000 population aged 16+. Target: 8.9 - green status

We have continued to exceed our target for reducing alcohol related hospital stays. The latest data shows the rate at March 2022 at 6.8 compared with March 2021 when the rate was 6.5 reflecting a slight decrease in performance (target 8.9).

Overdose Response Team

Funded by the Drug Deaths Taskforce, the Greater Glasgow & Clyde Overdose Response Team launched in Renfrewshire in September 2021. The Team provides a rapid response to those who have suffered a non-fatal overdose, offering harm reduction interventions, and signposting and supporting individuals into mainstream alcohol and drug recovery services. The service provides an outreach response and operates out of hours between 10am-10pm, 7 days a week.

Alcohol and Drugs waiting times for referral to treatment. 90.8% seen within 3 weeks. Target: 91.5% - amber status

Waiting times for referral to treatment within 3 weeks has seen a decrease in performance with 90.8% at March 2022 seen within the 3 weeks compared with 98.0% at March 2021 (Target: 91.5) and below the overall rate for Scotland which was 91.8% for the same period.

Outcomes 2, 3 and 4

Palliative and End of Life Care

Palliative Care Strategy

The Palliative Care Strategy was developed during 2021 / 22. A series of initial development workshops were held involving key partners and services across Renfrewshire, including our two local hospices. The workshops encouraged a partnership and collaborative approach to identify our current priorities, and emerging challenges and opportunities following the COVID-19 pandemic.

The Palliative Care Planning Group then took ownership of developing and finalising the strategy. The HSCP received good engagement during the consultation period, which supported development of the final version.

There are four priority areas within the strategy which include:

1. Developing and supporting people that support and provide palliative and end of life care.

2. Improving access and pathways to and from services.

3. Improving, enabling and encouraging better conversations through the enhancement and embedding of Anticipatory Care Planning (ACP).

4. Establishing and strengthening the Palliative Care Planning Group to ensure leadership and governance of the plan.

Anticipatory Care Planning (ACP)

ACP is a person-centred approach, which supports conversations about a person's wishes when it comes to treatment and their future, with the aim of improving their quality of life. Enhancing and embedding ACP is a local priority within the Palliative Care Strategy.

An ACP Work Group has started locally, with engagement across HSCP services. An action plan is being agreed, which will include an element of staff training using both electronic learning, and available bespoke training for each individual service. Training levels are being monitored through the group, and performance data will be available shortly to show how many ACP conversations and plans have been completed. Importantly, further work is underway around assessment of the quality of ACP, with an audit tool being developed across NHSGGC for use locally.

Renfrewshire Bereavement Network

A funded collaboration, developed in response to the pandemic and led by Accord Hospice, the Bereavement Network provides support to people experiencing loss or dealing with grief by offering access to the most appropriate advice, guidance and counselling from a single point of access.

Helping you cope when you need us most

Outcomes 2, 3 and 4

Primary Care

Primary Care continues to play a critical role in supporting our communities through and beyond the pandemic.

Over the last year, the HSCP has continued to implement work in line with the GP Contract and associated Memorandum of Understanding through Renfrewshire's Primary Care Improvement Plan. The key aim of the plan, in line with the GP Contract, is to enable GPs to operate as **'expert medical generalists'** by diverting work that can best be done by others and to improve outcomes for patients.

Key achievements over the last year include:

Responsibility for vaccinations that were previously delivered in GP Practices have now transferred to the Health Board / HSCP.

New treatment rooms have opened locally with migration of patients from 14 of our 28 GP Practices. Work continues to facilitate this for our remaining GP Practices. Community Treatment and Care Services (CTACs) offer standardised interventions for patients, from wound management, removal of sutures, observations, injections, and male / female suprapubic catheters.

Funding for urgent care remains focused on Advance Nurse Practitioners (ANP), who are supporting GPs in caring for residents living in care homes.

Work is progressing on a phased approach to roll out pharmacy hubs across Renfrewshire.

Other new roles have been expanded and aligned to some local GP Practices.

Examples include:

Primary Care Occupational Therapists are now established within three GP Practices in the West Renfrewshire area, with a consistent flow of referrals from Practice staff. This service delivers occupational therapy assessment and intervention.

Community Wellbeing Nurses maintain interagency working, providing input to GP Practices in the Renfrewshire area. The Service provides support for patients with mental health problems and liaises between Practices, CMHTs and other Mental Health Services.

Outcomes 2, 3 and 4

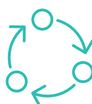
Unscheduled Care

Unscheduled Care (UC) is the unplanned treatment and care of a patient, usually as a result of an emergency or urgent event. Most of the focus on unscheduled care is on accident and emergency attendances and emergency admissions to hospital. We are working with hospital services to avoid unnecessary admissions and focusing on keeping people supported at home where possible.

A local delivery plan is being implemented to monitor the progress of UC aims and the delivery of winter funded priority projects. A local group is in place to pull together these strands. A brief update on some of the key areas of priority within the UC Delivery Plan is provided below:

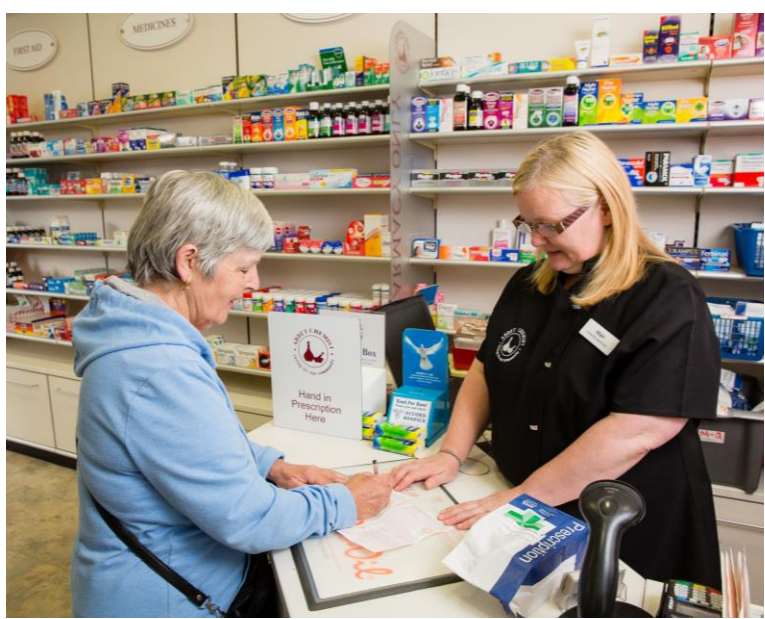
Systematic programme of anticipatory care plans with the aim of reducing emergency admissions has been supported by the establishment of the NHSGGC ACP Design and Implementation Group, including the roll out of HSCP Implementation groups and associated plans. ACP Champions continue to increase in number.

Approved Multi-Disciplinary Team (MDT) Interface model developed (now known as Home First Response Service), with progress made towards the launch and recruitment of associated roles. Pathways developed for implementation of this model for the Royal Alexandra Hospital (RAH) and the Queen Elizabeth University Hospital (QEUH).



Flow Navigation Centre designed and implemented to provide planned urgent care service in partnership with NHS24. The admin hub operates 24 / 7 receiving all Urgent Care Referrals from NHS24.

Nursing / Care Home Falls Pathways via Flow Navigation Centre being developed.



Outcomes 2, 3 and 4

Unscheduled Care

Ministerial Strategic Group Indicators

The table below shows the data for these performance indicators for the 3-year period April 2019 – March 2022. The overall impact of the pandemic on unscheduled care indicators remains unpredictable and it is important to note that performance for 2020 / 21 is reflective of the relative impact on services.

Ministerial Strategic Group Indicators	2019 / 20	2020 / 21	2021 / 22	Direction of travel
Number of emergency admissions	18,173	14,399	17,372	↓
Number of unscheduled hospital bed days (acute specialties)	126,904	112,609	129,987	↓
A&E attendances (18+)	47,297	31,892	40,601	↓
Acute Bed Days Lost to Delayed Discharge	9,122	8,759	9,117	↓
Percentage of last six months of life spent in Community setting	87.3%	89.5%	88.4%p	↓
Balance of care: Percentage of 65+ population living at home (unsupported)	90.7%	91.6%	Data Unavailable	↑

Comparison to previous year:	Improved performance	↑	Decline in performance	↓

Outcomes 2, 3 and 4

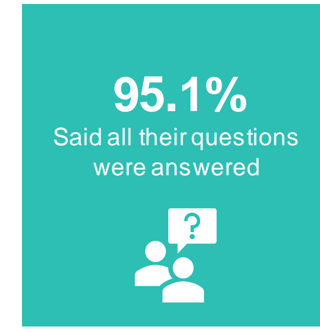
Podiatry

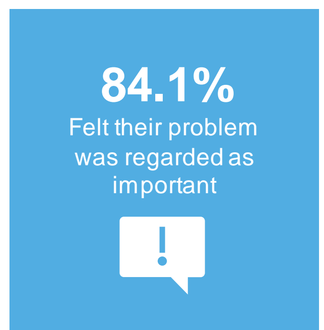
Delivering Person Centred Care (PCC) During COVID

In line with the Digital Health & Care Strategy (2021) the service aimed to improve the care and wellbeing of podiatry patients by redesigning the service to best utilise digital technologies. The referral rate for the service had risen to pre-pandemic rates of over 3,782 referrals per month. With a loss of clinical accommodation of 70% the service had 3,084 new patients waiting to be triaged. To reduce waiting times the project aimed to explore the use of technology enabled pathways of care.

The service worked collaboratively with patients to gain feedback on our new ways of working via telephone, virtual and face to face clinics. Themes gathered from the feedback were used to influence the development of the new blended templates which have improved patient flow. Patients were offered a further opportunity to join any future PCC work carried out by the service, and 21 patients have since volunteered.

Feedback from Care Experience Survey:





Patient Centred Care Survey, January 2022:

8.7 / 10 Patients said they were happy with the outcome of their consultation

8.8 / 10 Patients said they would recommend this service to friends and family

Outcome 6: Carers

Outcome 6: Carers

Outcome 6: People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing.

Refreshing the IJB's Unpaid Adult Carers Strategy

Our new Carers Strategy 2022 / 25 was developed over the last year by our Unpaid Carers Planning Group. This Group includes unpaid carers, the Carers Centre and key operational staff. The new strategy was informed by a programme of consultation, where we tested if the existing priorities remained the most important ones for unpaid carers.

Consultees included carers with lived experience, to ensure meaningful engagement with those who know what it is like to devote a significant proportion of their time to caring for a loved one or friend. Staff, carer organisations and a range of delivery partners were also consulted to make sure those who have responsibilities to support carers had the chance to shape the strategy.

New support for unpaid carers in 2021 / 22 included:

Distributed Scottish Government Winter Recovery Fund grants to **230** unpaid carers to help with fuel bills and emergency items (total of £87,000 distributed).

93 unpaid carers supported to get a break, through the ScotSpirit Holiday Voucher Scheme.

Partnership with Nordoff Robbins to offer music therapy sessions, which both carer and cared for can attend.

Ethnic Minority Carers Information and Development Worker began working to identify and support ethnic minority unpaid carers.

New social activities such as the coffee and cake monthly drop-in.

Benefits advice partnership with Citizens Advice Bureau.

Training courses including Wellbeing, Stress, Power of Attorney, Dementia, Autism, First Aid, Self-Directed Support, Hospital Discharge, and Digital Skills.

Outcome 6

Supporting Unpaid Carers to Access Cultural and Leisure Opportunities

As COVID restrictions eased during 2021, we initiated a 'carers passport' pilot across OneRen facilities, supporting unpaid carers to access leisure facilities free for a 12-week period, beginning in October 2021. 77 carers signed up to the initial pilot and agreed to share their experience.

Due to the reintroduction of some COVID restrictions however, several of the participants were unable to make full use of the initiative, and some felt they were not able to continue participating in the pilot. We agreed at that point to extend the pilot until June 2022 to facilitate the unpaid carers who expressed an interest in continuing. OneRen also removed the requirement to book to attend swimming and / or the gym as COVID guidelines had relaxed, to encourage unpaid carers to use their passport. OneRen, the Carers Centre, and the HSCP are currently working on an evaluation of the pilot, which will inform the development of the passport as well as wider work to support carers to get a break from caring.

963 new unpaid carers received support. This is the highest number since the HSCP started reporting this figure.

2,815 unpaid carers received support.

2,178 subscribers to Renfrewshire Carers Centre's e-bulletin.

148 unpaid carers completed an Adult Carer Support Plan.

96 new unpaid carers received group support.

282 unpaid carers accessed training.

35 unpaid carers received counselling.

71 unpaid carers accessed advocacy.

"What a wonderful, life changing experience [this] has been for me. Due to my daughter's illness, I gained a lot of weight being isolated at home and stress eating. I became unwell myself and my mental health was in a very bad state. I now really understand the positive effect exercise has on mental health and have found the elusive fitness bug that I never understood before. The potential for healing is quite amazing." ***- Feedback on the Passport Scheme trial***

Outcome 7: Safer Services

Outcome 7: Safer Services

Outcome 7: People using health and social care services are safe from harm.

The HSCP's commitment to Safer Services is integral to how we work. In this section we have included an overview of the key areas that support this outcome. We have highlighted some of the ways we ensure people using our services are kept safe from harm and how we support the delivery of safe, effective and person-centred health and social care services:

Quality, Care and Professional Governance Annual Report

The HSCP presented the 'Renfrewshire Quality Care and Professional Governance Annual Report' to Renfrewshire IJB and NHSGGC in September 2021. The report provided a variety of evidence to demonstrate the continued delivery of the governance core components within Renfrewshire HSCP and the clinical and care governance principles specified by the Scottish Government. There is an obligation on each HSCP to complete an annual clinical and care governance report that includes data and activity from throughout the year.

The governance core components within Renfrewshire HSCP are based on service delivery, care and interventions that are: person centred, timely, outcome focused, equitable, safe, efficient and effective.

Oversight of Care Homes and Care at Home Services

In May 2020, the Scottish Government published statutory guidance that required clinical and care professionals at NHS boards and local authorities to provide scrutiny, support, and oversight of care home and care at home services. These enhanced multidisciplinary arrangements will continue to be in place, with some adaptations, until at least the end of March 2023. This includes ongoing assurance visits across Care Homes. In Renfrewshire, we continue to implement the following governance arrangements to strengthen the clinical and care oversight of care homes across Renfrewshire.

Outcome 7

Adult Support and Protection (ASP)

Safety (Incident Management, Reporting and Investigation)

All incidents, regardless of severity, must be reported, to review, action and share learning where appropriate. Incident reports are produced and discussed regularly at relevant HSCP governance groups. There are various systems currently used within Renfrewshire HSCP for incident reporting and management.

From April 2021 – March 2022 there were:

- **1,934** incidents reported on the DATIX incident management system used within health. This compared to **1,821 (+113)** in previous report. Note: this increase may be attributable to more accurate recording / alignment to relevant service on Datix.
- A total of **443** accidents and incidents were reported on the Business World system used within social work services. This compared to **371 (+72)** in the previous report.

Procedure for Large Scale Investigation of Adults at Risk of Harm

Renfrewshire has conducted one Large-Scale Investigation (LSI) during this reporting period. Comprehensive and collaborative reports are completed for every individual included in the LSI, with the reports directly contributing towards risk assessments on both an individual and setting wide basis. LSIs demonstrate exemplary multi-disciplinary and multi-agency cooperation. This coordinated response to shared concerns enhances the efficiency and efficacy of safeguarding measures undertaken.

Independent Inspection of Care Homes

There are **22** Older Adult Care Homes across Renfrewshire of which the HSCP operates 3. The homes are subject to a rolling programme of independent inspection from the Care Inspectorate. Inspection assures us that services are working well and highlights areas for improvement. We work closely with our Scottish Care Independent Sector Representative around the service improvement agenda. Detail on the evaluation criteria used by the Care Inspectorate can be found on the Care Inspectorate website.

Evaluation of HSCP Care Homes at March 2022			
Service Name	How well do we support people's wellbeing	How well is care and support planned	How good is our care and support during the COVID-19 pandemic?
Renfrew Care Home	4 (Good)	4 (Good)	Not assessed
Montrose Care Home	4 (Good)	4 (Good)	Not assessed
Hunterhill Care Home	4 (Good)	4 (Good)	4 (Good)

Risk Management

In April 2021, Renfrewshire IJB approved the implementation of a revised risk framework. This was soft launched to all HSCP services in July 2021. As part of the implementation, we established a risk network, with representation from all services. This aimed to give the process a revised focus and to assure the consistent capture, escalation and reporting of risks and issues across services.

Outcome 7

Adult Support and Protection (ASP)

Audit Activity

The Renfrewshire Adult Protection Committee has taken a very proactive approach to quality assurance and audit activity.

Every quarter, a small-scale audit is completed, based on an identified theme. There are 30 cases audited in the quarterly small-scale audits. The themes these audits have been based on are as follows:

ASP protection plans

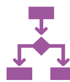
Engagement of service users at inquiry stage

Leadership / management in ASP

The quality of reports submitted to Case Conferences for those invited and those who attended

Review of frequency of invitations and decisions sent to GPs for Case Conferences

Service user engagement in Case Conferences


Outcomes of ASP investigations

Some examples of key areas of development in 2021 / 22:

Renfrewshire Partnership Missing Person Protocol

Renfrewshire have worked with Missing People on the National Implementation Project to develop a best practice protocol for missing people. This work was completed in August 2021 and the Renfrewshire missing person's protocol was launched. The protocol introduces a pathway for return discussions to occur with adults who have returned from a missing episode. The protocol also includes templates for use in risk assessments for children, young people and adults at risk of going missing.

ASP National Minimum Dataset – Learning Partner with Institute for Research and Innovation in Social Services (IRISS)

IRISS has been commissioned by the Scottish Government to work with all Adult Protection Committees and other members of the sector to develop a new National Minimum Dataset for Adult Support and Protection. Renfrewshire Adult Protection Committee (RAPC) was selected as a learning partner to co-design, test and refine a National Minimum Dataset for quarterly indicators and support packages. Several workshops were held from September 2021 which Renfrewshire have attended and contributed towards.

Outcome 8: Effective Organisation
NHS

Outcome 8: Effective Organisation

Outcome 8: People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.

Our Interim Workforce Plan 2021 / 22

Renfrewshire HSCP worked with partners to develop a short, interim, workforce plan for 2021 / 22 which was finalised in April 2021. This Interim Plan was developed in the context of the ongoing COVID pandemic and had a clear focus on supporting our services and workforce through the challenges faced, prioritising health and wellbeing. The Plan also recognised the importance of looking towards service transformation where realistic and possible within the wider context.

A brief summary of progress made against the commitments in the Interim Plan is provided on this and following pages. This does not go into the full detail of the actions identified in that Plan but our assessment has informed the objectives and actions captured in the development of a new HSCP Workforce Plan for 2022-25. We have also considered where actions are required to extend into future years, whether these are currently in progress or yet to be commenced.

Living with COVID

The Interim Plan set out our short-term plans for living with COVID and in particular the continued delivery of new COVID-related services. We noted particular aspects including the COVID Assessment Centre, staff testing and use of Personal Protective Equipment (PPE), support to Care Homes and delivery of the vaccination programme.

The HSCP and partners have continued to support all of these elements, delivering in line with emerging national policy and guidance. All COVID Assessment Centres across NHSGGC closed in March 2022. The use of PPE, staff testing arrangements, support to Care Homes and the vaccination programme all continue and reflect the changing environment as the country transitions to a 'Living with COVID' approach.

Resourcing, Delivering and Supporting Essential Services

The HSCP committed to the continued delivery of essential services, and where possible recovery from the pandemic. This included enabling staff to return to substantive posts and ensuring services are adequately resourced and support to support vulnerable individuals.

The HSCP's actions under this theme have continued to flex in response to the pandemic. Focus has remained on the response to the pandemic and service development and recovery has been undertaken within this frequently changing context. In particular, in early 2022 the HSCP's emergency response was escalated once again to respond to the impact of the Omicron variant. Mitigating plans were put in place to support the deployment of staff to core services where necessary to meet the needs of local citizens.

Staff returned to their substantive positions from the Community Assessment Centre while the HSCP has supported the Winter Flu and COVID booster vaccination

Outcome 8: Effective Organisation

programmes within Care Homes and for the housebound. This work is ongoing.

In addition to the above, rolling recruitment programmes have continued, alongside innovative approaches to attracting talent. However, skills gaps remain and recruitment and retention remains a significant challenge which this Plan will continue to address.

Developing the Organisation and Workforce

In the interim plan we set out objectives to review the HSCP's vision and align forthcoming work with our guiding principles. We also committed to continuing to assess the impact of COVID on our workforce. These actions have been replaced by the work undertaken with staff and partners to develop our Strategic Plan for 2022-25 and work which is currently ongoing to consider how we use our accommodation and technology as part of hybrid working arrangements. The timing of this activity also reflects the impact of the pandemic in the last year.

More broadly, our interim plan set out to develop the scope and timelines for the HSCP's transformation programme. The direction of travel for our transformation programme has now been set out by our new Strategic Plan with further work planned over 2022 to determine a prioritised scope for the programme.

Supporting Staff Wellbeing

In the Interim Workforce Plan, we described how we would support our staff's health and wellbeing through a series of commitments. These included promoting health and wellbeing activities which were available at a national and local level, developing a communications strategy which ensures that staff feel engaged and receive regular updates, providing additional assistance for line managers to support them and their teams in remote working to reduce isolation. We also stated that we will improve our processes for collating and reporting on staff demographics, in particular ethnicity and other protected characteristics to ensure we are being inclusive.

We will continue to maintain and develop these commitments and ensure the health and wellbeing of staff remains a priority. We recognise that the physical and psychological wellbeing of staff is critical to the ongoing recovery of services but also the longer-term sustainability of the HSCP and the wider health and social care sector.

In previous plans we have developed, the correlation between lower mental health and wellbeing and staff absence and turnover has been clear. This in turn places significant pressure on remaining staff to maintain service provision and is often compounded by vacancy levels and retirement associated with an ageing workforce.

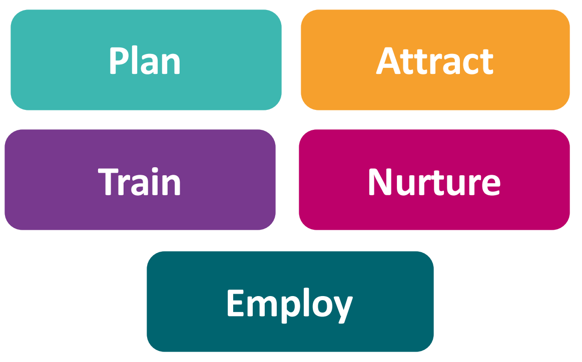
COVID-related absences have also placed a significant strain on the health and social care workforce, with particular peaks of absence observed in Winter 2021 / 22 and Spring 2022. In addition, the extent of Long COVID within our workforce is still emerging and it can be expected that there will be an increase in mental health-related absence as a result of post-traumatic stress.

Outcome 8: Effective Organisation

Details on our Draft Workforce Plan 2022-25

We have developed a draft Workforce Plan for 2022 / 25 to reflect the focus, structure and commitments contained in the National Workforce Strategy for Health and Social Care. This Plan will be submitted to Renfrewshire IJB for review and approval in November 2022. following this, a detailed delivery plan containing deliverables and owners will be developed.

This Plan aligns with the National Strategy's vision, which aims to deliver 'a sustainable, skilled workforce with attractive career choices and fair work where all are respected and valued for the work they do'. This vision is itself supported by an ambition to deliver the recovery, growth and transformation of our workforce. To achieve these aims, the HSCP's draft Workforce Plan sets out key objectives and actions which reflect the five core pillars set out by the Scottish Government. These are:



It is important to note that the development of a three-year Workforce Plan has been undertaken within a highly uncertain context. This extends from the Interim Workforce Plan, where there was a clear focus on responding to the pandemic, recovering where possible, and supporting staff with their health and wellbeing.

This uncertainty includes, but is not limited to, the creation of a National Care Service, which will shape the focus and nature of the IJB and HSCP in coming years. This will need significant resource, but it is also recognised that alongside the range of challenges to be addressed, many opportunities to improve the effectiveness of our organisation will be available. In capitalising on these, we will also be able to support the growth and development of our workforce.

Outcome 8

Staff Engagement and Communication

Staff engagement and communication have played an important role for the HSCP throughout the pandemic. Our approach has been to develop a clear narrative, to help everyone associated with the partnership understand and make sense of the situation as it evolved, and to help bring people with us on our journey towards a vision for the future.

Individual team engagement activity is informed by iMatter, an employee engagement survey, introduced by the Scottish Government in January 2015. The survey provides opportunities for individuals to share their views on work-related issues, and each team are asked to provide robust action plans to make sure any issues or trends identified locally are discussed as a group and given serious consideration.

We communicate with and encourage staff to engage with what's going on across the HSCP in a variety of ways, including:

Chief Officer Updates – are issued regularly to HSCP colleagues, who have fed back positively about this form of communication.

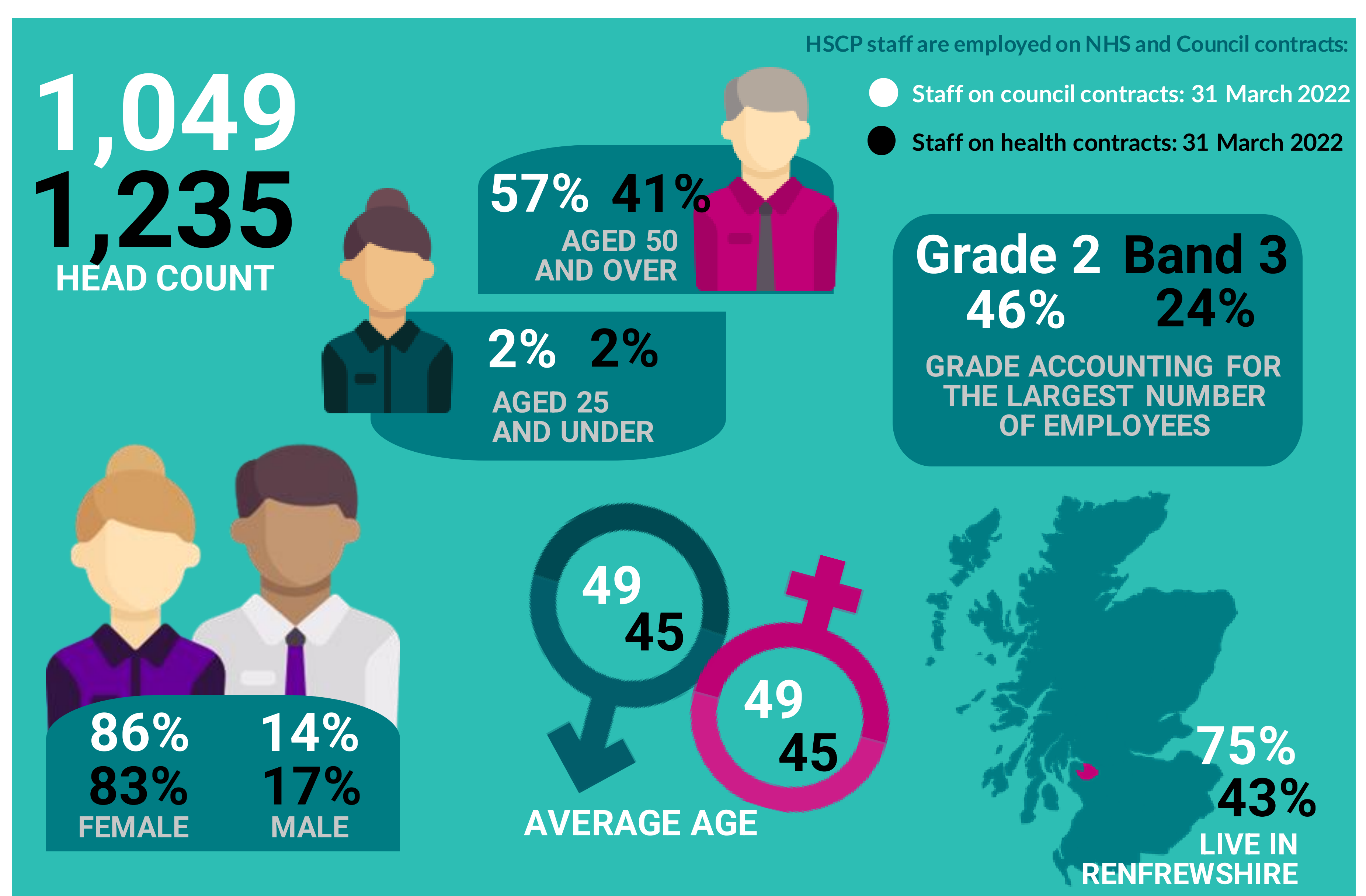
Leadership Network - Leaders play a vital role in engaging with staff at team levels. We reintroduced our Leadership Network in 2021 to drive a consistent message and approach to staff engagement across our services.

Consultation - We also make sure our staff have opportunities to help 'shape the future' of the HSCP and our services. We do this through involving our staff in comprehensive consultation procedures, which allow individuals to take time away from their usual role to participate in consultation sessions and share their views on proposed plans.

Our iMatter response rate in October 2021 was 58% (up from 51% the previous reporting year). This is below the target of 60%, but this can be directly attributed to a period when many staff were focused on responses to emerging personal, clinical and organisational challenges.

Outcome 8: Effective Organisation

Key Workforce Statistics

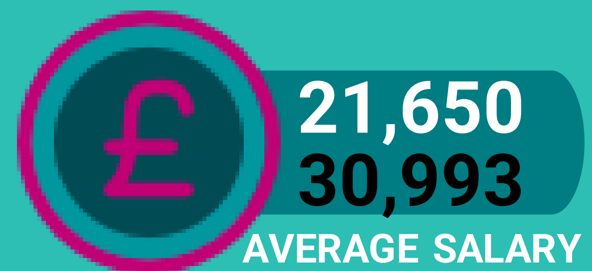


Outcome 8: Effective Organisation

Key Workforce Statistics

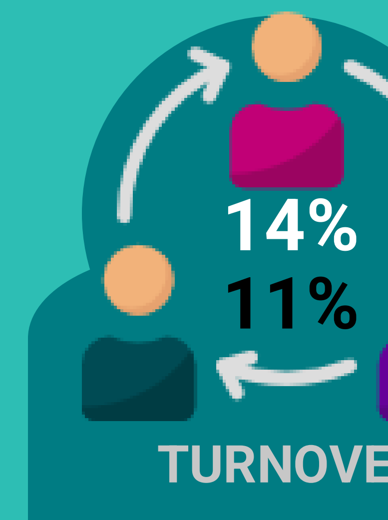
HSCP staff are employed on NHS and Council contracts:

- Staff on council contracts: 31 March 2022
- Staff on health contracts: 31 March 2022

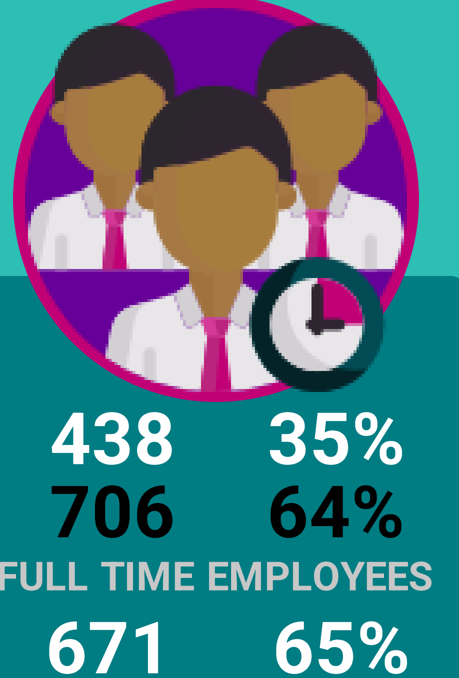


21,650
30,993
AVERAGE SALARY

12 YEARS
10 YEARS
AVERAGE LENGTH OF SERVICE

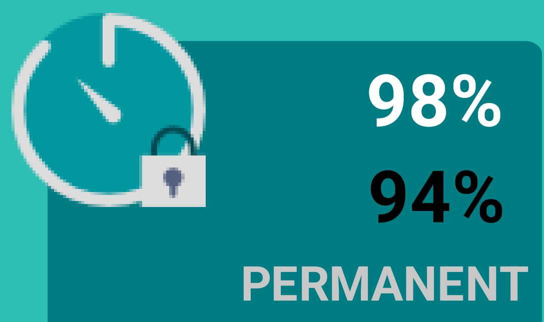


14%
11%
TURNOVER

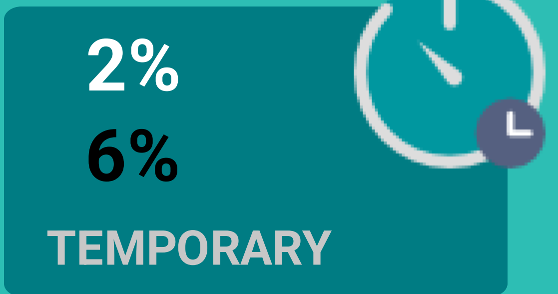


438 35%
706 64%
FULL TIME EMPLOYEES

671 65%
480 36%
PART TIME EMPLOYEES



98%
94%
PERMANENT



2%
6%
TEMPORARY

Outcome 8: Effective Organisation

Sickness Absence

Managing sickness absence and having a healthy workforce continue to be one of our priorities. NHSGGC and Renfrewshire Council - the two employers of HSCP staff - monitor sickness absence rates in different ways. The Local Delivery Plan (LDP) standard is for NHS boards to achieve a sickness absence rate of 4% or less. In line with reporting requirements for Scottish Councils, Renfrewshire Council's staff absence is expressed as a number of work days lost per full-time equivalent (FTE) employee. The annual target for 2021 / 22 was 15.3 days.

The sickness absence level for NHS staff at March 2022 was 6.52%, an increase of 0.87% on the March 2021 figure of 5.65%.

Absence rate (%)	March 2020	March 2021	March 2022
NHS	4.7%	5.65%	6.52%

Absence figures for Adult Social Work show a deterioration from 13.5 days lost per FTE at March 2021 to 17.79 at March 2022.

Absence rate (Work Days Lost)	March 2020	March 2021	March 2022
Adult Social Work	18.0	13.5	17.79

Musculoskeletal issues, stress and mental wellbeing, and respiratory issues were the main reasons recorded for absence across both the NHS and the Council. We remain focused on working with NHSGGC and Renfrewshire Council to implement existing attendance policies, support staff, and improve sickness absence performance.

The figures do not include absences relating to COVID. These absences were recorded separately as Special Leave by both employing organisations and do not count towards an employee's sickness absence record. In addition, absences due to long COVID are also recorded in this way. As our understanding of the impact of long COVID develops, future consideration will be given to how we can support staff most effectively and consistently. NHSGGC, for example, has established a dedicated HR Support Team for staff suffering from long COVID.

Outcome 9: Our Approach to Supporting Organisational Change

Outcome 9: Our Approach to Supporting Organisational Change

Outcome 9: Resources are used effectively and efficiently in the provision of health and social care services.

Our previous Annual Performance Reports (APRs) have described our approach to delivering organisational change through a Change and Improvement Programme. In addition, our APR for 2020 / 21 set out how the HSCP had responded to the COVID pandemic. This focus extended throughout 2021 / 22 following several further waves of the pandemic, and the implementation of an unprecedented programme of vaccinations for both COVID and Winter Flu. Alongside this response, change and support within the HSCP was directed towards (i) continued delivery of existing commitments within Renfrewshire IJB's Strategic Plan for 2019-22; and (ii) facilitating the development of the IJB's new Strategic Plan for 2022-25.

Delivering the Commitments of our 2019 / 22 Strategic Plan

The Strategic Plan for 2019 / 22 outlined four main areas on which the IJB wanted to focus efforts across the lifetime of the Plan:

- Prevention
- Self-management
- Treatment
- Recovery, Care and Reablement

Outcome 9

Developing the IJB's Strategic Plan for 2022-25

Development of the Strategic Plan has been a priority during the 2021 / 22 financial year. The HSCP's Change and Improvement Team have worked closely with NHSGGC's Corporate Planning Team and Renfrewshire Council, and with stakeholders in our Strategic Planning Group to develop a Plan covering 2022-25. The Plan was approved by the IJB in March 2022.

Our new Plan sets out our strategic change and improvement objectives for the coming three years. It takes a different approach to identifying our objectives compared with our previous Strategic Plan; focusing on a range of themes which underpin how we deliver services, rather than looking at individual service areas themselves.

We aim to shape our services around individuals, unpaid carers and communities to support everyone in Renfrewshire to live meaningful lives and achieve their hopes and aspirations. We seek to support the person rather than a condition or particular demographic. In doing so, our focus is on helping people to live independently, exercise choice and control over their care and support, and, where necessary, access the appropriate specialist support to help their recovery and rehabilitation where this is possible.

Our new themes are described on the right of this page.

People experience reduced inequalities and improved health and wellbeing through early action and prevention of more complex need.

People are supported to recover, or manage disabilities and long-term conditions, and to live as safely and independently in their own home or community as possible.

Our services are clinically safe and people have access to the appropriate specialist support to aid them in their recovery and rehabilitation, where possible.

People have access to the right care at the right time and place and are empowered to shape their support at every stage of life.

We maximise the impact of our people and resources by working collaboratively across sectors to deliver integrated services.

Outcome 9

Collaborative Strategy Development

As noted on the previous page, the development of the Strategic Plan was highly collaborative, engaging services, partners, the third sector, carers and service user representatives. The development of the Strategic Plan, and the formal consultation on a draft Plan, sought to reach as many individuals, groups and organisations as possible.

As part of our updated Strategic Planning process, the HSCP designed and implemented Care Planning Groups to support focused discussion at a service level. This approach was agreed with the Strategic Planning Group as an effective mechanism for enabling engagement throughout the development of the Plan's themes and strategic objectives, and for ensuring that care group priorities continue to be reflected within the new approach to the Strategic Plan that has been adopted.

In addition to supporting the development of the objectives described in the Strategic Plan, agreed through facilitated workshops, the Care Planning Groups will also lead the delivery and monitoring of supporting actions within our services over the lifetime of the Plan. Each Care Group will have an annual action plan which will guide the HSCP's approach to organisational change, and will ensure that agreed transformational priorities are developed though ongoing consultation with staff, providers, unpaid carers and service user representatives.

Developing our approach, themes and priorities

5 Sessions with the Strategic Planning Group

2 IJB Development Sessions

18 Sessions with partners and Care Group leads to develop approach

17 Care Group workshops to identify challenges and priorities

Formal Consultation

25,871 Social media views

1,900 Views of the consultation platform

38 Stakeholder engagement sessions

144 Comments analysed

Outcome 9

Financial Performance and Best Value

In this section of our report, we present an overview of financial performance for 2021 / 22 and trend data looking back to the first year the IJB was fully operational in 2016 / 17. We also revisit our commitment to Best Value and reflect on our newly updated Medium Term Financial Plan, as we look ahead to Future Challenges for 2021 / 22 and beyond.

Financial Performance

COVID continued to severely impact public services throughout 2021 / 22 with a changing demographic and increased demand for services compounded by the ongoing pandemic and the associated emergency response.

The financial position for public services continues to be challenging. This requires the IJB to have robust financial management arrangements in place to deliver services within the funding available in-year as well as plan for the years ahead.

Financial performance is an integral element of the HSCP's overall performance management framework. Through regular updates to the IJB from the Chief Finance Officer, members are provided with a detailed analysis of significant variances and reserves activity. This ensures that where required, early decisions are taken to support medium and long-term financial sustainability.

Our Commitment to Best Value

Renfrewshire IJB is accountable for the stewardship of public funds and ensuring that its business is conducted under public sector best practice governance arrangements, including ensuring that public money is safeguarded, properly accounted for and used economically, efficiently and effectively and with due regard to equal opportunities and sustainable development. The IJB has a duty of **best value**, by making arrangements to secure continuous improvements in performance, while maintaining an appropriate balance between quality and cost. In Renfrewshire the IJB achieved this through:

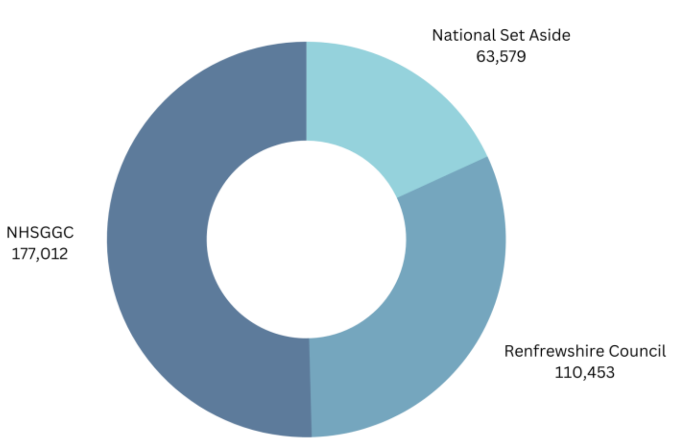
- Regular performance reporting to the IJB members and operational managers.
- Benchmarking to compare performance with other organisations to support change and improvement, with National Outcomes being monitored throughout the year.
- Financial Reporting.
- Reporting on the delivery of the priorities of the Strategic and Financial Plans to the IJB.

Outcome 9

Resources Available to the IJB 2021 / 22

Renfrewshire IJB delivers and commissions a range of health and adult social care services to the population of Renfrewshire. This is funded through budgets delegated from both Renfrewshire Council and NHSGGC. The resources available to the IJB in 2021 / 22 to take forward the commissioning intentions of the IJB, in line with the Strategic Plan, totalled £351,044k. The following chart and table provide a breakdown of where these resources come from.

Included within the Resources Available to the IJB is a 'Large Hospital Services' (Set Aside) budget totalling £63,579k (based on actual spend and activity). This budget is in respect of those functions delegated by the Health Board which are carried out in a hospital within the Health Board area. The IJB is responsible for the strategic planning of these services but not their operational delivery.



Funding Type	2021/22	2020/21	2019/20	2018/19	2017/18
	£000's				
Renfrewshire Council	110,453	104,573	93,797	89,107	82,500
NHSGGC	177,012	166,081	143,218	134,432	133,343
Set Aside	63,579	64,738	56,497	57,461	29,582
Total	351,044	335,392	293,512	281,000	245,425

Outcome 9

Resources Available to the IJB 2021 / 22

The following tables show how the resources available to the IJB have changed over the past five years providing a breakdown of where these resources come from; as well as a summary of how resources were spent over the past five years.
(Note: The following figures are taken from the IJB Annual Accounts Comprehensive Income and Expenditure Statement).

Care group	Actual Outturn				
	2021/22	2020/21	2019/20	2018/19	2017/18
	£000's				
Adults & Older People	76,652	72,628	71,944	69,706	68,711
Mental Health	30,550	26,827	24,984	23,328	24,815
Learning Disabilities	29,685	27,861	27,269	25,760	23,611
Children's Services	6,325	5,943	5,970	5,058	5,023
Prescribing	36,396	34,814	35,276	35,942	36,271
Health Improvement & Inequalities	1,161	890	710	939	1,044
Family Health Services	57,171	53,351	48,535	45,282	45,138
Resources	6,723	6,665	6,273	4,011	1,810
COVID-19	6,951	12,610	-	-	-
Hosted Services	10,713	10,810	11,098	10,603	10,109
Set Aside	63,579	64,738	56,497	57,461	29,583
Other delegated services	1,095	766	912	880	1,363
Movement in reserves	24,043	17,489	4,044	2,030	-2,052
TOTAL	**351,044**	**335,392**	**293,512**	**281,000**	**245,426**

Outcome 9

Summary of Financial Position 2021 / 22

The overall financial performance against budget for the financial period 2021 / 22 was an underspend of £32,899k (prior to the transfer of ring-fenced year-end balances to Reserves), including the net impact of delivering additional services as part of the IJB's response to COVID, and for which additional funding was provided by the Scottish Government at regular intervals.

Once all ring-fenced balances have been transferred to the relevant earmarked reserve in line with Scottish Government guidance the revised outturn for the IJB is an underspend of £2,266k.

The IJB's allocation of COVID monies during 2021 / 22 accounts for £16,453k of the overall underspend position reflecting funding in advance of need to address COVID expenditure commitments in 2022/23.

In addition, a further £14,180k in relation to in-year allocations from the Scottish Government was received in 2021 / 22 relating to ring-fenced funding to meet specific commitments and must be carried forward to meet the conditions attached to the receipt of the funding.

The amounts received in 2021 / 22 are higher than in previous years reflecting additional funding allocated during 2021 / 22 to implement national policy commitments. The level of reserves to be carried forward for these funding streams are reflective of the timing of when this funding was received and the difficulty in securing full spend before the financial year-end.

Care Group	Revised Budget	Spend to Year End (before movements to reserves)	Variance
Adults & Older People	73,553	65,721	7,832
Mental Health	27,835	27,662	173
Learning Disabilities	19,453	19,193	260
Children's Services	8,287	6,660	1,627
Prescribing	37,688	36,396	1,292
Health Improvement & Inequalities	1,153	830	323
Family Health Service	57,172	57,172	-
Resources	9,206	4,508	4,698
Hosted Services	11,642	11,375	267
Resource transfer	-	-	-
Social Care Fund	-	-	-
Set aside	63,579	63,579	-
NET EXPENDITURE (before delegated services)	309,568	293,096	16,472
Other delegated services	1,069	1,095	-26
NET EXPENDITURE before COVID	310,637	294,191	16,446
COVID-19	17,288	835	16,453
NET EXPENDITURE	327,925	295,026	32,899
Transfer to reserves			
COVID-19			-16,453
Other ring-fenced funding			-14,180
			-30,633
Grand total (inclusive of COVID-19 and other ring-fenced funding)			2,266

Outcome 9

Medium Term Financial Plan

Our new Medium Term Financial Plan 2022 – 2025 was approved by the IJB in March 2022. The new plan reflects the impact of COVID and other emerging issues facing the IJB. Bringing together a range of assumptions on future income and expenditure, its intention is to outline, in broad terms, specific service and funding issues over the next three-year period and how the IJB should work towards achieving financial sustainability and resilience, whilst delivering its priorities.

As was the case prior to the pandemic, the IJB's financial planning arrangements remain subject to active review, to enable us to continue to plan for a range of potential outcomes and scenarios. This helps us manage emerging financial risks and challenges and the likely impact these could have on the financial position of the IJB.

Our new plan will deliver several benefits to Renfrewshire HSCP, including:

Playing an important role in the HSCP's strategic planning process, to ensure that where possible resources are targeted at the delivery of the priorities of the Strategic Plan

Helping inform IJB decision making to effectively assess the potential financial impact of current and future decisions to ensure the HSCP remains financially sustainable

Providing a basis for engaging with partner bodies in relation to the annual budget setting process

Supporting the required transformation, to provide sustainable services to the local community to secure financial sustainability

In line with national direction, supporting the delivery of the Strategic Plan and setting out our plans to progress the shift in the balance of care to a community setting, in readiness for the establishment of the planned National Care Service.

Appendix 1

Renfrewshire IJB Scorecard 2021 / 2022

Performance Indicator Status		**Direction of Travel**		**Target Source**	
	Target achieved		Improvement	**N**	National Target
	Warning		Deterioration	**B**	NHSGGC Board Target
	Alert		Same as previous reporting period	**L**	Local Target
	Data only			**M**	MSG Target

13 Red Indicators	**Performance is more than 10% variance from target**						
Performance Indicator	**19/20 Value**	**20/21 Value**	**21/22 Value**	**Target**	**Direction of Travel**	**Status**	**Target Source**
1. Number of adults with a new Anticipatory Care Plan (Outcome 2)	159	201	185	221			L
2. Child and Adolescents Mental Health (CAMHS) - % of patients seen within 18 weeks (Outcome 3)	66.7%	70.1%	58.8%	80%			N

Performance Indicator	19/20 Value	20/21 Value	21/22 Value	Target	Direction of Travel	Status	Target Source
3. Percentage of Primary Care Mental Health Team patients referred to first appointment offered within 4 weeks (Outcome 3)	90.5%	89%	88%	100%			B
4. A&E waits less than 4 hours (Outcome 3)	87.4%	88%	67.1%	95%			N
5. Percentage of NHS staff who have passed the Fire Safety LearnPro module (Outcome 3)	80.2%	84.4%	80.2%	90%			B
6. Reduce drug related hospital stays - rate per 100,000 population (Outcome 4)	303.35	246.79	2021/22 data not available until Oct 2023	170			N
7. Percentage of children seen within 18 weeks for paediatric Speech & Language Therapy assessment to appointment (Outcome 4)	100%	63%	52.7%	95%			
8. Exclusive breastfeeding at 6-8 weeks in the most deprived areas (Outcome 5)	16.7%	23.3%	11.8	19.9%			B
9. % of health staff with completed TURAS profile/PDP (Outcome 8)	49.3%	41.7%	50.5%	80%			B
10. Sickness absence rate for HSCP NHS staff (Outcome 8)	4.75%	5.65%	6.52%	4%			N

Performance Indicator	19/20 Value	20/21 Value	21/22 Value	Target	Direction of Travel	Status	Target Source
11. Sickness absence rate for HSCP Adult Social Work staff (work days lost per FTE) (Outcome 8)	18.08	13.5	17.79	15.3			L
12. % of new referrals to the Podiatry Service seen within 4 weeks in Renfrewshire (Clyde) (Outcome 9)	90.1%	67.0%	41.4%	90%			B
13. % of new referrals to the Podiatry Service seen within 4 weeks in NHSGGC (Outcome 9)	91.4%	62.0%	41%	90%			B

10 Amber Indicators	Performance is less than 10% variance from target						
Performance Indicator	**19/20 Value**	**20/21 Value**	**21/22 Value**	**Target**	**Direction of Travel**	**Status**	**Target Source**
14. Exclusive breastfeeding at 6-8 weeks (Outcome 1)	24.4%	26.8%	19.7%	21.4%			B
15. Percentage of long term care clients receiving intensive home care (national target: 30%) (Outcome 2)	27%	29%	29%	30%			N
16. Alcohol and Drugs waiting times for referral to treatment. % seen within 3 weeks (Outcome 4)	95.9%	98%	90.8%	91.5%			N
17. Reduce the percentage of babies with a low birth weight (<2500g) (Outcome 4)	6.7%	6.2%	6.3% (Dec 21)	6%			B
18. Smoking cessation - non-smokers at the 3-month follow-up in the 40% most deprived areas (Outcome 5)	173	161	167	182			B
19. Improve the overall iMatter staff response rate (Outcome 8)	Paused during COVID.		58%	60%			B

Performance Indicator	19/20 Value	20/21 Value	21/22 Value	Target	Direction of Travel	Status	Target Source
20. Formulary compliance (Outcome 9)	78.1%	77.6%	76.6%	78%			L
21. Prescribing cost per treated patient (Outcome 9)	£91.34	£87.71	£88.28	£86.63			L
22. % of foot ulcers seen within 2 working days in NHSGGC (Outcome 9)	81.2%	75.0%	83.7%	90%			B
23. % of foot ulcers seen within 2 working days in Renfrewshire (Clyde) (Outcome 9)	81.7%	77.0%	84.6%	90%			B

16 Green Indicators	Performance is on or exceeds target						
Performance Indicator	**19/20 Value**	**20/21 Value**	**21/22 Value**	**Target**	**Direction of Travel**	**Status**	**Target Source**
24. Percentage of routine OT referrals allocated within 9 weeks (Outcome 2)	42%	41%	68%	45%	↑	✓	L
25. Percentage of clients accessing out of hours home care services (65+) (Outcome 2)	90%	90%	93%	85%	↑	✓	L
26. Number of clients on the Occupational Therapy waiting list (as at position) (Outcome 2)	315	159	143	350	↑	✓	L
27. Percentage of patients who started treatment within 18 weeks of referral to Psychological Therapies (Outcome 3)	92.3%	86.8%	90.9%	90%	↑	✓	N
28. Uptake rate of child health 30-month assessment (Outcome 4)	95.5%	87%	94.9%	80%	↑	✓	N
29. Percentage of children vaccinated against MMR at 24 months (Outcome 4)	95.0%	98.5%	97.3% (Q3)	95%	↓	✓	N
30. Percentage of children vaccinated against MMR at 5 years (Outcome 4)	99.0%	96.8%	96.8% (Q3)	95%	–	✓	N

Performance Indicator	19/20 Value	20/21 Value	21/22 Value	Target	Direction of Travel	Status	Target Source
31. Reduce the rate of alcohol related hospital stays per 1,000 population (now rolling year data) (Outcome 4)	7.2	6.3	6.8	8.9			N
32. Percentage of paediatric Speech & Language Therapy wait times triaged within 8 weeks (Outcome 4)	100%	100%	100%	100%			B
33. Emergency admissions from care homes (Outcome 4)	746	506	400	692			L
34. Reduce the rate of pregnancies for those under 16 years of age (rate per 1,000 population) (Outcome 4)	1.5 (2017)	1.0 (2018)	1.1 (2019)	1.6			L
35. At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation (Outcome 4)	94.4%	94.4%	93.7%	80%			N
36. Number of adult support plans completed for carers (age 18+) (Outcome 6)	162	86	148	114			L

Performance Indicator	19/20 Value	20/21 Value	21/22 Value	Target	Direction of Travel	Status	Target Source
37. Number of adult support plans declined by carers (age 18+) (Outcome 6)	34	51	36	46			L
38. Number of carers accessing training (Outcome 6)	255	165	282	220			L
39. % of complaints within HSCP responded to within 20 days (Outcome 8)	78%	82%	90%	70%			B

Sensitive Routine Enquiry Indicators (4)							
Performance Indicator	**19/20 Value**	**20/21 Value**	**21/22 Value**	**Target**	**Direction of Travel**	**Status**	**Target Source**
40. Number of routine sensitive enquiries (Outcome 3)	200	1,382	No data available	-			-
41. Number of referrals made as a result of the routine sensitive enquiry being carried out (Outcome 3)	1	* Paused due to COVID	No data available	-			-
42. Number of staff trained in sensitive routine enquiry (Outcome 5)	28	* Paused due to COVID	* Paused due to COVID	-			-
43. Number of staff trained in Risk Identification Checklist and referral to MARAC. (Outcome 5)	64	* Paused due to COVID	* Paused due to COVID	-			-

Ministerial Scottish Government Indicators (5)							
Performance Indicator	**19/20 Value**	**20/21 Value**	**21/22 Value**	**Target**	**Direction of Travel**	**Status**	**Target Source**
44. Number of unscheduled hospital bed days; acute specialties (18+) (Outcome 2)	126,904	112,609	129,987	-			M
45. Number of emergency admissions (18+) (Outcome 2)	18,173	14,399	17,372	-			M
46. Number of delayed discharge bed days (Outcome 2)	9,122	8,759	9,117	-			M
47. Total number of A&E attendances (Outcome 9)	60,238	39,432	54,111	-			M
48. Number of A&E attendances (18+) (Outcome 9)	47,297	31,892	40,601	-			M

Safe from Harm Indicators (6)							
Performance Indicator	**19/20 Value**	**20/21 Value**	**21/22 Value**	**Target**	**Direction of Travel**	**Status**	**Target Source**
49. Number of Alcohol Brief Interventions (Outcome 1)	224	53	7	-	-		-
50. Number of suicides (Outcome 7)	16 (2019)	22 (2020)	25 (2021)	-	-		-
51. Number of Adult Protection contacts received (Outcome 7)	3,106	3,487	4,263	-	-		-
52. Total Mental Health Officer service activity (Outcome 7)	683	627	905	-	-		-
53. Number of Chief Social Worker Guardianships (as at position) (Outcome 7)	110	115	125	-	-		-
54. Percentage of children registered in this period who have previously been on the Child Protection Register (Outcome 7)	11%	29%	30.4%	-	-		-

Social Care Indicators (2)							
Performance Indicator	**19/20 Value**	**20/21 Value**	**21/22 Value**	**Target**	**Direction of Travel**	**Status**	**Target Source**
55. Homecare hours provided - rate per 1,000 population aged 65+ (Outcome 2)	414	390	411	-			-
56. Population of clients receiving telecare (75+) - Rate per 1,000 (Outcome 2)	50	46	58	-			-

Prescribing Indicator (1)							
Performance Indicator	**19/20 Value**	**20/21 Value**	**21/22 Value**	**Target**	**Direction of Travel**	**Status**	**Target Source**
57. Prescribing variance from budget (Outcome 9)	2.61% under budget	5.72% under budget	3.43% under budget	-			-

Appendix 2

Core Suite of Integration Indicators

National Core Suite of Integration Indicators	2017-18 Renfrewshire (Scotland)	2018-19 Renfrewshire (Scotland)	2019-20 Renfrewshire (Scotland)	*2020-21 Renfrewshire (Scotland)	*2021-22 Renfrewshire (Scotland)	Direction of Travel From 2020-21
11. Premature mortality rate (per 100,000 people aged under 75)	473 (425)	465 (432)	463 (426)	507 (457)	494 (466)	↑
12. Emergency admission rate (per 100,000 people aged 18+)	12,536 (12,211)	12,447 (12,280)	13,011 (12,525)	10,552 (10,953)	11,015 (11,641)	↓
13. Emergency bed day rate (per 100,000 people aged 18+)	129,281 (122,571)	132,548 (120,007)	135,715 (118,574)	122,360 (101,166)	127,291 (111,293)	↓
14. Readmission to acute hospital within 28 days of discharge rate (per 1,000 population)	90 (103)	88 (103)	93 (105)	100 (120)	81 (106)	↑
15. Proportion of last 6 months of life spent at home or in a community setting	88.5% (88.0%)	87.2% (88.0%)	87.3% (88.3%)	89.5% (90.2%)	88.4% (89.8%)	↓
16. Falls rate per 1,000 population aged 65+	18.8 (22.2)	22.1 (22.5)	21.3 (22.8)	19.0 (21.7)	20.6 (22.9)	↓

KEY: (current year)	Better than Scotland average	Poorer than Scotland average

Comparison to previous year:	Improved performance ↑	Decline in performance ↓

National Core Suite of Integration Indicators	2017-18 Renfrewshire (Scotland)	2018-19 Renfrewshire (Scotland)	2019-20 Renfrewshire (Scotland)	*2020-21 Renfrewshire (Scotland)	*2021-22 Renfrewshire (Scotland)	Direction of Travel From 2020-21
17. Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	88.1% (85.4%)	87.3% (82.2%)	85.2% (81.8%)	85.5% (82.5%)	81.5% (75.8%)	↓
18. Percentage of adults with intensive care needs receiving care at home	62.1% (60.7%)	63.4% (62.1%)	65.5% (63.0%)	64.7% (63.0%)	64.5% (64.9%)	↓
19. Number of days people spend in hospital when they are ready to be discharged, per 1,000 population**	190 (762)	246 (793)	383 (774)	368 (484)	298 (761)	↑
20. Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	23.4% (24.1%)	23.7% (24.2%)	24.0% (24.3%)	Not available	Not available	

INDICATOR DATA STATUS – DATA PUBLISHED (updated) in September 2022
***2020-21 data is currently reported as 2020 calendar year for indicators 11-16, 18 and 20.**
Previous years (2016-17 to 2019-20) are reported as financial years for all indicators 11-20.

**** NI 19:**
1. Please note definitional changes were made to the recording of delayed discharge information from 1 July 2016 onwards. Delays for healthcare reasons and those in non-hospital locations (e.g. care homes) are no longer recorded as delayed discharges. In this indicator, no adjustment has been made to account for the definitional changes during the year 2016/17. The changes affected reporting of figures in some areas more than others therefore comparisons before and after July 2016 may not be possible at Partnership level. It is estimated that, at Scotland level, the definitional changes account for a reduction of around 4% of bed days across previous months up to June 2016, and a decrease of approximately 1% in the 2016/17 bed day rate for people aged 75+.
**** NI 20:**
2. NHS boards were not able to provide detailed cost information for 2020/21 due to changes in service delivery during the pandemic. As a result, PHS have not provided information for indicator 20 beyond 2019/20. PHS previously published information to calendar year 2020 using costs from 2019/20 as a proxy but, given the impact of the COVID pandemic on activity and expenditure, PHS no longer consider this appropriate.
Source: PHS Delayed Discharge data collection