Renfrewshire
Health & Social Care
Partnership

Annual Performance Report 2018/19

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

Brighter futures

Contents

Foreword

We want to improve the health and wellbeing of the people of Renfrewshire. We will do this by delivering the right service, at the right time and in the right place, and by working in partnership to support the person as well as the condition.

Welcome to Renfrewshire Health and Social Care Partnership's Annual Performance Report 2018-19.

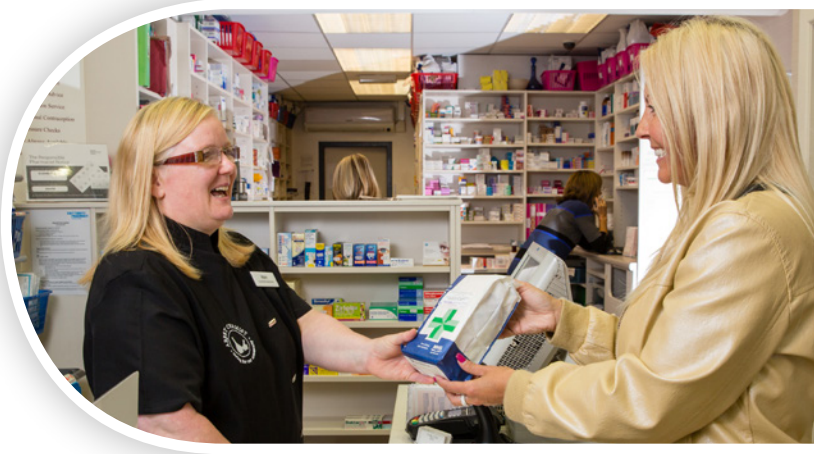
Now in our third year as a Partnership, our report measures performance against a set of National Outcomes and Performance Indicators and will help us plan and improve our services moving forward. We report regularly on our progress to our Integration Joint Board and these reports, along with previous Annual Performance Reports, can be found on the Renfrewshire HSCP website at www.renfrewshire.hscp.scot/article/6316/Performance-Reports

Key achievements

Some of our key achievements during year three of the Partnership include:

- A continued communications drive to provide information to people in Renfrewshire about the best health and care service for their individual needs. By continuing this approach, we hope to see a reduction in inappropriate attendances at GPs and A&E departments by ensuring everyone has access to the service they need in the most suitable setting. Where possible we want to keep people out of hospital and well supported in their own homes and communities
- We have further exceeded our target for reducing alcohol related hospital stays for the period April 2018 to March 2019 at a rate of 7.7 per 1,000 population aged 16+ (target 8.9). Maintaining this rate will be challenging, however it is a significant improvement (29.3% reduction) on the rate of 10.9 at September 2014
- We have also exceeded our target for reducing drug related hospital stays (rate per 100,000 population). The rate has reduced from 179.6 in 2016/17 to 156.1 in 2017/18 against a target of 170
- Following the successful pilot in 2017/18 when District Nurses delivered flu vaccinations to housebound patients in partnership with 14 GP surgeries, the programme was rolled out to all GP practices in 2018/19. We vaccinated 1,928 patients in 2018/19: 1,762 patients and 166 carers compared to 1,179 patients and 88 carers during the pilot
- Two Community Nurses were nominated, recruited and have successfully completed the Queen's Nurse Development Programme in 2018/19. This title is awarded to clinical leaders who can demonstrate their impact as expert practitioners. Three nurses within Renfrewshire HSCP have now gained this title

- Community Connectors are now available in all GP practices in Renfrewshire. As well as relieving pressure on GPs, they provide information and support to patients for issues that are not medical in nature and help patients take responsibility for their own health and wellbeing. The Partnership won two awards for this initiative in 2018/19, the Herald Society Award and a Bronze COSLA Award
- Telecare, or Technology Enabled Care Service (TECS,) provides an emergency response service by supplying community alarms to vulnerable people in the community. The service supports service users from 18-95+ and provides families in Renfrewshire with emergency response cover for their family member 24 hours a day. The rate for people receiving telecare aged 75+ (rate per 1,000 population) has increased from 29.13 in 2016/17 to 40.17 in 2018/19
- Self-Directed Support (SDS) services have been extended across Renfrewshire using a multi-disciplinary approach to plan support that will result in positive outcomes for the supported person



Tell us what you think

Responses to our feedback questionnaire on the 2017/18 report were positive and we have taken on board your feedback while producing this year's report. Please see the outside back cover for full details on how to get in touch and share your views on the 2018/19 report.

Circumstances remain challenging with continued financial constraints and increased demand for both Community Services and at the Accident & Emergency Department at the Royal Alexandra Hospital, so we would like to thank all staff and volunteers for their continued dedication and professionalism throughout 2018/19.

David Leese
Chief Officer

Dr Donny Lyons
Chair, Renfrewshire Integration Joint Board

Background

Background

Renfrewshire Health and Social Care Partnership (HSCP), is responsible for Adult Social Work and all Health Services within the community. These include Health and Community Care, Learning Disability, Mental Health and Addictions, and all health related Children's Services.

Our Strategic Plan

We have completed our new Strategic Plan for the period 2019-2022. In order to deliver our vision, our Strategic Plan describes the themes and high level priorities which will direct the Partnership over the next three years.

Our three strategic priorities are:

- Improving health and wellbeing
- The right service, at the right time, in the right place
- Working in partnership to support the person as well as the condition.

We do this by:

- Bringing services together and improving pathways
- Ensuring services in the community are accessible to all
- Giving people more choice and control
- Helping people to live as independently as possible
- Tackling inequalities and building strong communities
- Focusing on prevention and early intervention
- Providing effective support for carers
- Listening to patients and using service users' feedback to improve services.

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

The new Strategic Plan takes account of national strategies and legislation, regional planning, and Renfrewshire Council's Plan and Community Plan. It also highlights NHS Greater Glasgow and Clyde's Moving Forward Together (MFT) programme, which aims to help us to develop and deliver a tiered model of services where people receive treatment as near home as possible, travelling to specialist centres only when expertise in specific areas is required.

The development of our Strategic Plan has been an accessible and inclusive process, which has been enabled and supported by the Partnership's Strategic Planning Group (SPG).

Strategic Planning Group

The role of the Strategic Planning Group is to give its views during the development, implementation and review of strategic plans. As the main group within the strategic planning process, it represents the interests of local stakeholders, carers, members of the public and the third sector.

Workshops were established to develop individual sections of the Strategic Plan, involving a wide range of staff and stakeholders. These sections were then brought together and tested with the SPG and other stakeholders.

The draft was launched for formal consultation on 18 January 2019 at an event in Johnstone Town Hall. During the formal consultation period, the Plan was presented to the HSCP Leadership Network and to Renfrewshire Council's Corporate Management Team. We have used social media to reach into the community for additional feedback. The new Strategic Plan is now available online at http://www.renfrewshire.hscp.scot/StrategicPlan

Renfrewshire Localities

Our services are delivered in two geographical localities (Paisley and West Renfrewshire) and each has a Locality Manager co-ordinating a range of multi-disciplinary teams and services. Since publishing our last Strategic Plan, the 29 GP practices within Renfrewshire have been formed into six clusters - two in Paisley and four in Renfrewshire North, West and South. We have highlighted performance at Renfrewshire and Locality level using a selection of indicators from the Scottish Public Health Observatory (ScotPHO) Health and Wellbeing Profiles, please see Appendices 2a-c on pages 82-84.

The HSCP is also a key partner in the new Community Planning arrangements developed by Renfrewshire Council which sees seven Local Area Partnerships taking responsibility for community level governance and setting priorities and aspirations for their area.

National Outcomes

The Public Bodies (Joint Working) (National Health and Wellbeing Outcomes) (Scotland) Regulations 2014 requires Partnerships to assess their performance in relation to 9 National Health and Wellbeing Outcomes. These outcomes provide a strategic framework for the planning and delivery of our health and social care services. They focus on the experiences and quality of services for patients, service users, carers and their families.

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

Our performance is assessed in the context of the arrangements set out in our Strategic Plan 2019-22 and Financial Statement.

We aim to continue to build on our commitment to community engagement and participation, reduce inequalities, and tackle loneliness and social isolation.

We have included Case Studies on pages 13 to 20 to illustrate more outcome based performance, alongside our Scorecard at Appendix 1, which shows our progress against a range of local and national performance indicators. These help demonstrate how we are tackling inequalities and adapting our services to improve outcomes for Renfrewshire residents.

Report Framework

This report describes our performance in a number of different ways, recognising that information is used and understood differently by different audiences.

Case Studies (p13–20): for those who want to see how the Partnership makes a difference in the lives of individuals and families.

Care Groups (p29–52): for those who are interested in particular services including addictions, learning disabilities, carers' support, and mental health.

National/Local Outcomes, Appendix 1: for those who want to see quantitative data and assurance that national and local outcomes are being progressed.

Financial information is also part of our performance management framework, with 2018/19 seeing continued financial challenges. On pages 67-75 we have detailed our financial position, how we have delivered best value whilst having to make difficult budget decisions, and the outlook for 2019/20.

Renfrewshire HSCP also has lead Partnership responsibility for Podiatry and Primary Care Support across NHS Greater Glasgow and Clyde. This report features some of the excellent work underway as well as a few of the challenges of leading these services for the largest NHS Board in Scotland.

As we move into our fourth year of integration, we continue to highlight the significant benefits of joint working and our endeavours to provide high quality, compassionate care and support for the people of Renfrewshire.

Benchmarking

In 2018/19 we measured Renfrewshire's performance against the other Health and Social Care Partnerships within the Greater Glasgow and Clyde area (East Dunbartonshire, East Renfrewshire, Glasgow City, Inverclyde and West Dunbartonshire) and also within our 'Family Group', as determined by Healthcare Improvement Scotland. Our Family Group consists of Stirling & Clackmannanshire, Dumfries & Galloway, Falkirk, Fife, South Ayrshire, South Lanarkshire, Stirling and West Lothian. Councils are arranged in 'family groups' so the comparisons are similar in terms of the type of population (e.g. relative deprivation and affluence) and the type of area (e.g. urban, semi-rural, rural). The point of comparing like with like is more likely to lead to useful learning and improvement. For full information and results please go to Appendix 3.

We have used the most recent National Core Suite of Integration Indicators data (Appendices 3a and 3b) and the most up to date data from the ScotPHO Health and Wellbeing Profiles (Appendices 3c and 3d). These present a range of indicators to give an overview of health and its wider determinants at a local level and are updated quarterly, annually and bi-annually depending on the frequency of the data. It should be noted that data for the full financial year 2018/19 is not yet available for indicators 12, 13, 14, 16 and 20, so we have used 2018 calendar year data instead.

Results highlighted in pink are the same as the Scottish average; green is better than the Scottish average; orange is worse than the Scottish average; while blue highlights the best Group result. A full summary of results is available at Appendix 3.

Joint Inspection of Adult Health and Social Care Services in Renfrewshire

Following the joint inspection of Adult Health and Social Care Services in Renfrewshire which took place between October and December 2017, the Care Inspectorate and Healthcare Improvement Scotland published their findings in a report in April 2018 entitled 'Joint Inspection (Adults) the Effectiveness of Strategic Planning in Renfrewshire'.

The report highlighted that Renfrewshire Health and Social Partnership was making significant progress in improving residents' health and social care services. However, some areas for improvement were identified and an Inspection Improvement Plan was developed.

The Plan is progressing well with work ongoing to gather feedback from health and social care service users. Our Strategic Planning Group established a short life working group to co-ordinate work on loneliness and social isolation which was a priority area identified in our recent Adult Health and Wellbeing Survey Report. www.renfrewshire.hscp.scot/media/9026/NHS-GGC-HW-Survey-1718/pdf/..pdf?m=1548089480210

We have included a Benchmarking section in this year's Report (please see Appendices 3a-3d) to compare our performance against other Partnerships across the country as well as within NHS Greater Glasgow and Clyde, and we continue to produce a Quality, Care and Professional Governance Report, which goes to our Integration Joint Board annually.

Our draft Market Facilitation Plan was presented to the Integration Joint Board in June 2018 and we are working with the local community and other stakeholders to ensure this meets the changing needs of Renfrewshire's population. This is a live document and will be updated and continue to evolve in response to changes in both national and local policies.

2018/19 saw the HSCP begin a series of service reviews in consultation with staff, key stakeholders, service users and their carers, with two short life working groups set up for older people and for people with a learning disability. We also used an accessible, inclusive and consultative approach to develop our new Strategic Plan 2019-2022, further enabled by our Strategic Planning Group.

The final recommendation was for IJB members to undertake a Training Needs Analysis and develop a programme of development sessions for IJB members. This has been completed, with four sessions taking place between June 2018 and March 2019 covering topics such as Financial Planning, the Strategic Plan, the Code of Conduct for IJB members, and the Ministerial Strategic Group Review of Integration.

Case Studies

The following case studies show how the HSCP and its partners made a difference in the lives of individuals and families. Names have been changed to protect the identity of individuals and families.

District Nursing

The District Nursing (DN) Service provides high quality, culturally sensitive and effective nursing care to permanent and temporarily housebound adult patients within the community, working in partnership with service users, care providers and external agencies.

Examples of the care provided by District Nurses includes palliative and end of life care and support, wound care, medication administration, chronic disease management, continence assessments, catheter management, enteral feeding, bowel management and venepuncture. In order to provide the above care holistically, District Nurses work closely with GPs, Palliative Care Teams and Carers.

Background

Mr A was an 82 year old male who was paralysed from the chest down following a spinal cord injury. Carers attended four times a day to assist with personal care and his wife provided bowel care three times a week following education and support from the District Nurses. The Nurses also visited three times a week or as needed for wound care to a chronic pressure ulcer obtained during a prolonged hospital admission and provided catheter care, administered his medication as prescribed, and provided support and assistance to maintain his care in the community.

Mr A had previously attended the local Hospice Day Centre but stopped attending because of the pressure ulcer. Over the past year Mr A had suffered from recurrent chest infections and his quality of life had deteriorated.

Continuity of Care

Mr A was admitted to the local Hospice for symptom control and assessment following yet another chest infection and general deterioration. Hospice staff, District Nurses and Mrs A worked together to ensure good continuity of care.

On returning home, Mr A continued to require wound care for the pressure ulcer as well as catheter management, medication administration and support. In addition Mr A resumed his weekly visits to the Hospice Day Centre.

By gaining access to Clinical Portal (a web based system that gives a single view of patient information), Hospice staff could access Mr A's details regarding current District Nursing care and his medical needs. This made the transfer of his care much easier as it can often be an emotional and stressful time for relatives.

Relationship

The District Nurses built a strong relationship with Mr A and his wife due to his complex needs. This was possible due to the comprehensive assessment undertaken by the District Nurses and communication between them and Hospice staff. By involving Mr A and his wife in all decisions and care plans, partnership working was achieved and the patient felt included and in control.

This case study shows how effective partnership working and person-centred care has helped Mr A remain at home and maintain a good quality of life in the community.

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

ROAR: Loneliness and Social Isolation

Jane was referred to ROAR (Reaching Older Adults in Renfrewshire) by Renfrewshire Health and Social Care Partnership's Adult Mental Health Team 10 months ago.

At 83 she had been widowed for a long time, her family all lived in the south of England and she had no friends. Her only company was her dog. Her mood was low and she was very isolated.

Roar's 'Stay Mobile, Stay Connected' worker visited Jane at home to make an assessment. This looks for any physical or functional reasons why someone may not be getting out and about and socialising, as well as other social and psychological factors.

At first Jane was very resistant to looking at options in the community, saying that "she just wasn't a club sort of person", but she didn't want nor was she eligible for befriending. After looking through a range of options from both Roar's menu of services and from the ALISS website, Jane agreed to try a Roar Health and Wellbeing Lunch Club as she liked the idea of the meal but was very resistant to the idea of exercise.

The next barrier to her becoming more socially connected was that part of her mental health issues manifested in suspicion about people in the neighbourhood around where she lived, so although there was a Roar group in her area, she didn't want to go there. This created a logistical challenge which was resolved with help from her Community Psychiatric Nurse who supported her introduction to the Roar group in another part of Paisley by accompanying her on public transport until her confidence grew.

At first Jane was very reserved and sceptical but she agreed to return to the group. Initially she was also unwilling to take part in the Otago* exercises. However within a matter of weeks she became more relaxed and began engaging with the rest of the group and all the health and wellbeing activities – even the exercises!

In December, Jane suffered a heart attack and was admitted to hospital. She was extremely touched by the cards and well wishes from members of her club and she realised she had made true and valuable connections. She made a full recovery and now uses a combination of MyBus and public buses and meets up with her new friends outside of club times.

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

* Developed and tested by the New Zealand Falls Prevention Research Group, Otago is a falls prevention programme that improves strength and balance and reduces falls and fall related injuries among older adults.

Frequent Attenders at A&E

One of our key priorities as an HSCP is to reduce the number of inappropriate attendances at the Emergency Department as well as reducing the number of emergency admissions.

Part of this work has focused specifically on people who attend Emergency Departments frequently. We are working in partnership with GPs and Community Link Workers in Renfrewshire to help people change their behaviour. There is now a Link Worker in every GP surgery in Renfrewshire who can help provide information and support to connect people into the right services in their community. We have highlighted four people below who have benefited from this help.

Elizabeth, 75 years old – Bronchiectasis (lung condition) and Opiate Addiction (painkiller addiction)

Elizabeth's GP contacted her to discuss her health issues. Together they initiated a plan to gradually reduce her painkillers. The GP also updated her Electronic Key Information Summary (eKIS) summary to better inform health professionals of her progress, especially when contacting Out of Hours services or attending the Emergency Department in the future.

Tony, 56 years old – Alcohol Abuse, Gastritis (stomach complaint), Angina (heart condition), Claudication (leg complaint affecting mobility)

The GP contacted Tony, who has a long history of alcohol abuse but was keen to get better. The GP referred Tony to the local Integrated Alcohol Team and the Link Worker based within the surgery. He also referred Tony to Gastroenterology at the local hospital for treatment for his stomach complaint. Tony has now attended hospital and has been through alcohol detoxification. This has led to reduced symptoms and Tony's life is getting back on track. He has now stopped attending the Emergency Department.

Andrew, 34 years old – Alcohol Abuse and Learning Disability

Andrew's GP contacted him to discuss his health needs. Unfortunately it seemed Andrew had been lost to follow up within the Learning Disabilities service. The GP discussed Andrew's options with him and has re-referred him to Learning Disabilities for support.

Brian, 38 years old – Diabetes, Mental Health Issues, Alcohol Abuse

The GP contacted Brian who has multiple issues, mainly around alcohol abuse leading to poor control of his diabetes. The GP referred Brian to the Integrated Alcohol Team and encouraged him to keep his diabetes appointments. As a result, Brian is now drinking less and his diabetes is much better controlled.

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

Renfrewshire's Learning Disability Service

Renfrewshire's Learning Disabilities' Gateway Service offers learning opportunities for people with autism and complex learning disabilities. This case study gives an example of the positive impact the service has made on Ryan, who was becoming increasingly isolated as his condition worsened.

Ryan's Story

Over a period of many years I gradually lost most of the skills I needed to live on a day to day basis.

My mobility deteriorated, and I withdrew from the activities I used to love.

My hearty, baritone laugh became a barely-audible whisper.

I was the drummer in a rock band at my day service. We used to raise money at our charity gig!

But eventually I just sat at the drums staring in front of me.

Even when prompted I didn't respond. I didn't appear interested in any of the things going on around me.

The same happened on the hill walking group. I physically slowed down, taking ages to walk a short distance.

I'd often stop mid-stride, or on stairs with one foot on one step and one on another. Sometimes I'd walk sideways, slowly, stopping a lot.

At lunch I lost the ability to pick up a spoon, put it into my soup, move it to my mouth and eat it.

I simply got stuck at one point in the process and had to be prompted and physically shown how to do it. Even that stopped working.

Gateway's Story

Ryan's developing symptoms were closely observed and recorded by concerned Gateway staff.

Gateway is a specialist autism-specific day service. Our experienced team are highly-trained in strategies and interventions that support the profile of autism.

These include SPELL, sensory integration, Picture Ex-change Communication System (PECS), Touch Trust, DIR Floortime, Intensive Interaction, Promoting Positive Behaviour, massage and music therapy. There are many more.

We employed the full range of our interventions to support Ryan, but nothing seemed to be working.

Then there was a Eureka moment.

At a conference on Autism and Movement, Gateway's team leader heard a delegate speak of Autism and Catatonia.

She was struck by how similar the symptoms matched the behavioural evidence the team had been gathering.

She shared her understanding with a psychologist within the RLDS service team who at the time was mentoring a trainee clinical psychologist, who had neurology experience. She then compiled a report discussing Ryan, his Autism, Epilepsy and Catatonia.

I'd still be sitting at lunch an hour after all my friends had already finished.

Sometimes staff had to actually feed me.

I stopped cooking and doing jigsaws. I wouldn't pay attention to the iPad or my DVD player.

I lost interest in social group activities.

Physical tics appeared, and I would grimace and seem to pull faces.

I often became anxious and scared.

Sometimes I would have loud outbursts: shouting, waving my hands and sweating profusely. I would often go to a quiet room to calm down.

At home my family found it extremely difficult to cope with these changes in my behaviour, especially in the social settings I used to enjoy. My sleep became disturbed and I was often tired on arrival at Gateway.

My communication skills faded away - once I could use a complex picture symbols system to communicate my needs, eventually I found it difficult to recognise a single picture.

The deterioration was relentless, and nobody knew where it would end.

Well, that was up until a few months ago.

Something remarkable happened and I can now do most of the things I used to.

My family have noticed a marked improvement in my life skills and are continuing to offer me all the love and support I need on this journey.

If you want to know what changed for me please read Gateway's Story!

Her findings were then presented to the psychology team and a psychiatrist. This led to Ryan being given a formal diagnosis of Autism and Catatonia.

The team prescribed medication for Ryan.

Unfortunately the medication could not be given to Ryan in a hospital setting, so a RLDS practice nurse became involved to monitor any potential adverse side effects.

Thankfully, however, the medication had a positive impact. Ryan began to become more aware and alert.

A physiotherapist then became involved to encourage physical movement and advised Gateway staff on an exercise regime for Ryan.

Gateway decided to assign a single worker to Ryan to ensure consistency in his care. He was partnered with a staff member from the Autism Connections' team who then began the process of reintroducing the PECS system. A speech and language therapist was also on hand to offer valuable advice.

Ryan is now beginning to use his communication aid in various settings; at the centre, in restaurants and supermarkets etc.

He has once again taken his rightful place behind the drums in the 'Gateway Clash' rock band.

His mobility has improved.

His life skills and independence have increased and he is more aware of the people and activities around him.

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

Paisley Puffins: Renfrewshire Council Sheltered Housing

Mrs M is 89 years old and has lived in one of Renfrewshire Council's 10 sheltered housing complexes for over eight years.

Mrs M, who is blind in her right eye, has in recent years suffered from severe pain due to arthritis, and uses mobility aids to help her walk. After being widowed six years ago, the Sheltered Housing Officer noticed that Mrs M seemed to be experiencing feelings of loneliness and isolation.

This was particularly hard for Mrs M, who previously had a very fit and active lifestyle. When she was younger she joined the Scottish Youth Hostelling Association, going on many walking holidays all over Scotland. It was through this hobby that she met her husband.

In recent years Mrs M felt her walking days were over due to her poor eyesight and mobility.

Another tenant within the sheltered complex recommended the Paisley Puffins Walking Group, available for those living in the Council's sheltered* and amenity housing**. The group is managed by Renfrewshire Council's Housing Support Service's Health and Wellbeing Team, who plan the walks, organise transport, and ensure walking leaders are always on hand.

With encouragement from staff, Mrs M decided to give the group a go and absolutely loved it, saying: "It is the best thing since sliced bread! I really had no idea that this kind of activity was available within my sheltered housing complex."

Mrs M explained that she loves getting out in the fresh air and exploring new places, and she particularly enjoys getting to know people from other housing complexes when they meet up on the regular walks.

Mrs M feels safe as she knows the routes have been carefully planned to ensure they are easily accessible for everyone, no matter what age or ability. This has helped her feel more independent.

As a direct result of attending the Paisley Puffins' Walking Group, Mrs M believes her quality of life has improved, and the group is now the highlight of her week. She also reports that she is feeling the benefit of the exercise in both her mobility and balance. She feels stronger, healthier and fitter - both physically and emotionally.

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

* sheltered housing: self-contained housing designed for older people. It has all the features of amenity housing but properties are grouped together, have a built in community alarm service, a tenants' lounge and a shared laundry.

** amenity housing: self-contained housing designed to meet the needs of older people. It will have some or all of the following: no stairs inside, raised electric sockets and lowered switches, handrails in the bathroom, lever handled taps, slip resistant flooring in the kitchen and bathroom.

A Week in the Life of RHSCP

Reducing Health Inequalities

Renfrewshire HSCP continues to focus on tackling health inequalities by prioritising early intervention and prevention activity. Reducing the health inequalities gap has the potential to increase life expectancy, improve health and wellbeing outcomes and reduce the personal, social and economic cost of reacting to the impact of poverty and inequality.

Below are some examples of the range of interventions implemented in 2018/19 to support individuals and communities to take more positive steps towards better mental and physical health outcomes and to reduce health inequalities.

Capacity Building

We have delivered a number of capacity building activities which support our staff, partners and communities to understand some of the determinants of health which may impact on health inequalities. These include:

Understanding Mental Health Training

We trained 188 staff from the HSCP, Housing and Third Sector partners. Participants reported an increase in their skills and knowledge of mental health issues and recognised how mental health can have an impact on their clients and patients.

Sensitive Routine Enquiry of Domestic Abuse, Childhood Sexual Abuse and Risk Identification Training

Children's Services and Mental Health and Addictions Services staff were supported to enquire sensitively and respond appropriately to Domestic Abuse disclosure and assess the risk posed to those experiencing Domestic Abuse.

Universal Credit Training

Partnership staff were given the opportunity to increase knowledge of the new Department of Work and Pensions' benefit Universal Credit, and how the implementation of this benefit may impact the health outcomes of patients.

Early Intervention and Prevention

It is recognised that prevention and early intervention approaches will not prevent all negative health outcomes. However there are a wide range of opportunities where early intervention could prevent or reduce negative outcomes. The HSCP has developed a number of interventions in 2018/19. These include:

Social Prescribing

Social prescribing is an approach used to support self-management. It is used primarily for connecting people to non-medical sources of support or resources within their community, aiming to prevent the deterioration of patients' health. The Community Link Workers' social prescribing intervention was previously tested in three GP practices with many examples of patients gaining great benefit by increasing social interaction in their communities. This service is now available in all 29 GP practices across Renfrewshire.

Income Maximisation – Healthier, Wealthier Children

The Scottish Government identified poverty as 'the single biggest driver of poor mental health' (Scottish Government, 2017). Renfrewshire HSCP has focused on increasing referrals into income maximisation services to help tackle poverty, in turn preventing the onset of poor mental health for patients. The Healthier Wealthier Children intervention aims to support families by ensuring they claim the benefits they are entitled to and also to manage any debt. By managing the financial strain on families, both parents' and children's health outcomes are more positive, in particular mental health outcomes. In 2018/19, referrals to the project from HSCP Children's Services increased by 51%.

Gender Based Violence (GBV)

One third of young people across Renfrewshire have experienced controlling behaviour, the threat of physical harm or actual physical harm in their relationships. In response, Renfrewshire HSCP has supported the delivery of the Mentors in Violence Prevention (MVP) training in six secondary schools. MVP is a peer education programme that gives young people the chance to explore and challenge the attitudes, beliefs and cultural norms that underpin gender based violence, bullying and other forms of violence. The delivery of this programme contributes to tackling health inequalities as women and girls experience gender based violence disproportionately and as a consequence have poorer health outcomes. By raising the issue of gender based violence with young people we aim to increase their knowledge of the causes and consequences of GBV, preventing poorer health outcomes in the long term.

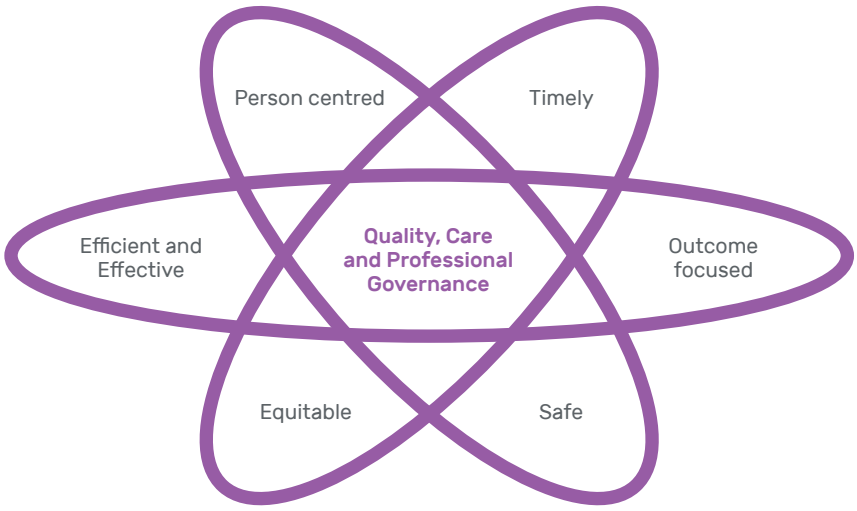
Intergenerational Interventions

It is acknowledged that intergenerational activities have a positive impact on improving the health and wellbeing of older adults and strengthening communities. The Partnership supported the development of an intergenerational quiz, which was a fun, informal way to bring older and younger people together. Intergenerational working is an effective way to reduce social isolation as well as tackling the negative attitudes children, young people and older people have towards each other. The project involved a range of learners from both primary and secondary schools, as well as older people from the local community, and a spin-off was the development of an intergenerational choir.

Quality, Care and Professional Governance

Quality, Care and Professional Governance

The core components of Renfrewshire HSCP's Quality, Care & Professional Governance Framework are based on service delivery, care, and interventions that are person-centred, timely, outcome focused, equitable, safe, efficient and effective.



Over the last year the HSCP has continued to review its governance arrangements, to ensure that structures going forward are both efficient, effective and avoid areas of duplication and overlap.

In the HSCP's last Annual Quality, Care & Professional Governance report, Link: (IJB Gov Report), a number of specific commitments were made that have now been implemented. Some examples include:

Commitment: Governance	**Progress Update**
Continue to facilitate bespoke sessions to support Quality, Care & Professional Governance arrangements and to learn from incidents and complaints.	Two complaints sessions were held in early 2019. The complaints paperwork is currently being updated in light of feedback from these sessions.
Commitment: Legislative Requirements	**Progress Update**
Ensure compliance with the new General Data Protection Regulation (GDPR).	A comprehensive programme of work has been undertaken within the HSCP to ensure compliance with the new GDPR legislation. Around 70+ presentation meetings have been held across the Partnership.

Examples of incident management/investigation/reporting improvements:

- A number of bespoke events have been held to support system-wide learning from Significant Clinical Incidents (SCI) and improve patient outcomes. The Significant Clinical Incident Review Executive Group (SCIREG) held a Patient Safety Learning Event across NHS Greater Glasgow and Clyde (NHSGGC) HSCPs in June 2019, with the purpose of sharing key messages from Significant Clinical Incident reviews
- Learning from SCIs is presented at the local GP Forum (as appropriate)
- A process is in place to share learning across HSCP Governance Groups and NHSGGC Primary Care and Community Clinical Governance Forum
- A thematic analysis exercise was carried out to identify recurring themes and to ensure actions put in place following SCIs have been implemented
- SCI review teams are now required to provide feedback sessions to members of staff who were interviewed as part of the SCI review, to discuss the findings of the investigation, the learning and the actions put in place to improve systems and processes
- There are several audits as part of SCI Action Plans which are progressing at present.

Feedback

Renfrewshire HSCP has a positive approach to feedback and uses it to inform continuous improvement in service provision and ways of working. The Partnership continues to ensure mechanisms are in place to obtain feedback from patients/service users/carers.

Some examples include:

- Renfrewshire Learning Disability Services (RLDS) have a Communications Officer in post to support individuals who have difficulties with aspects of communicating
- The Speech and Language Therapy Service within RLDS have supported client communication, with group and individual strategies across the service
- Client and carer involvement is widely recognised across our services and we liaise closely with Renfrewshire Carers' Centre. Adult Carers' Support Plans and Young Carers' Statements are offered to those who have a caring responsibility, and the use of independent advocacy is supported
- A recent review of the Assertive Outreach Team within the Adult Community Mental Health Teams (CMHTs) evidenced a positive approach to person-centred care for people who would otherwise be challenging to engage in services
- A Peer Support Worker role has been established in Adult Mental Health wards as part of the Action 15 proposals. The new post aims to run activities to support recovery and positive role modelling through lived experience.

Unscheduled Care

Unscheduled care 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.

The Scottish Government has made unscheduled care an important area of focus for the Health Service in Scotland, with reducing waiting times in Emergency Departments and reducing the number of emergency admissions key targets. In Renfrewshire, most emergency admissions (86%) are to the Royal Alexandra Hospital (RAH), with 8% going to the Queen Elizabeth University Hospital (QEUH).

The Integration Joint Board's budget includes a 'set aside' budget for the commissioning of acute hospital services. For 2018/19, the set aside budget for unscheduled acute services in Renfrewshire was £30.468m.

Our priorities in 2018/19 have been to address local and national targets.

Locally, we progressed our joint Work Plan with acute colleagues in the RAH and Primary Care Services. Key priority areas included:

1. Further development of our GP/health professional section on the HSCP website to give clinicians easy access to information about services to avoid hospital admission. This page is one of the most frequently visited on our website.
2. Better use of information about frequent service users to help community and primary care services work in a more preventative manner with these patients.
3. Targeted support to specific care homes with higher than average admission rates to hospital to help them support people to remain in the community.
4. Community pharmacies are participating in an initiative to supply rescue medication for patients who require them for Chronic Obstructive Pulmonary Disease (COPD), without the need for GP or hospital input. The pilot has gone well and has been welcomed by patients and professionals. Evaluation will be carried out in August 2019 once confirmed admission data is available. It is hoped that this initiative will have a positive impact on COPD admissions to acute settings.

We are also working to progress the six national priorities identified by the Ministerial Strategic Group (MSG):

1. Emergency admissions to hospital.
2. Occupied bed days for unscheduled services.
3. Delayed discharges.
4. A&E attendances.
5. End of life care.
6. Balance of care across hospital community services.

MINISTERIAL STRATEGIC GROUP INDICATORS	2015/16	2016/17	2017/18	2018/19
Number of emergency admissions	22,652	22,448	19,681	18,958
Number of unscheduled hospital bed days (acute specialties)	128,936	128,961	130,409	144,712
A&E attendances	56,119	57,244	56,681	61,175
Acute Bed Days Lost to Delayed Discharge (Over 65s including Adults with Incapacity)	6,099	3,205	4,680	6,085
Percentage of last six months of life spent in Community setting	87.4%	86.9%	88.5%	Qtr.3 90%
Balance of care: Percentage of population at home (unsupported)	89.9%	95.3%	95.4%	Currently Unavailable

There has been a slight reduction in the number of emergency admissions from 19,681 in 2017/18 to 18,958 in 2018/19. However, unscheduled bed days, A&E attendances, and acute bed days lost to delayed discharge have increased. Renfrewshire does continue to perform well when compared to other Partnerships in Scotland for delayed discharge lost bed days. In 2018, Renfrewshire was third top out of 31 HSCPs, with a rate of 14.6 per 1,000 population.

During 2018/19, we have continued our communication drive to provide information to people in Renfrewshire about the best health and care service for their individual needs. Our Know Who to Turn to campaign has used public events, our website and social media to publicise health and care services to ensure people know about the wide range of services available. We hope this work will reduce demand on A&E services and GPs.

Care Groups

Population Health and Wellbeing

We want to support the health and wellbeing and improve quality of life for the people of Renfrewshire. We do this by working in partnership and targeting our interventions and resources to promote prevention, early intervention, self-management and independence. We also focus on reducing inequalities and strengthening community assets and resources to build stronger, more resilient communities.

Examples of this work include:

Eat Better, Feel Better Courses: offering community groups cookery courses and information about food and health developments. Courses were offered to people with Type 2 diabetes, as well as their carers, to help promote healthy eating and self-management of their condition. Courses were also offered to individuals with mild Learning Disabilities by a community dietician to help encourage healthier eating choices and the benefits of increasing physical activity. Train the Trainer courses were also offered and were attended by Young Carers, Renfrewshire Council staff and Families First staff.

We have continued to develop the HSCP's website to provide information on Health and Social Care Services in Renfrewshire. During 2018/19 there were 9,500 visitors to our website with 62,670 page views.

Tobacco Prevention: we have used social media to promote tobacco prevention across the Partnership and to gain commitment to the ASH Scotland Charter with key stakeholders. The Charter aims to help deliver a tobacco free Scotland by 2034. 19 primary schools in Renfrewshire have registered to date with a view to reducing exposure of children to second hand smoke to 12% by 2020.

Healthier Wealthier Children (HWC): the HWC Income Maximisation programme being delivered in Renfrewshire was recognised as an example of good practice by Health Scotland and we were invited to contribute to a video describing our partnership approaches to delivering financial inclusion referral pathways between money and welfare services and maternity and health visiting services. The video can be viewed here: https://www.youtube.com/watch?v=bM7V9S3vKzs#action=share

Sensitive Routine Enquiry Training: in 2018/2019 a programme of sensitive routine enquiry of domestic abuse and childhood sexual abuse training was delivered to staff in Mental Health and Addiction Services who undertake initial assessments.

97 staff from Mental Health Services and 30 staff from Addiction Services were trained. As a result, staff have reported increased confidence and the routine enquiry audits that have taken place in the Community Mental Health Service since the training programme was delivered, have shown that a consistent approach to routine enquiry has been embedded into the assessment process. In August 2018 routine enquiry took place in 93% of cases audited (56/60), increasing to 97% in February 2019 (58/60).

ALISS: we have been working with the Health and Social Care Alliance to populate ALISS (A Local Information System for Scotland) with local community groups in Renfrewshire. The aim is to make it easier for people to find local groups and activities which can support their health and wellbeing. There are currently more than 300 entries for Renfrewshire and this will continue to increase.

27

From 2015 to 2018, Renfrewshire has supported 27 Syrian families to resettle in the local community – 56 adults and 68 children – with 19 babies born during this period.

Managing Your Condition: there has been a real shift to empower and support people to manage their long-term health conditions, including mental health conditions. The Partnership does this in a variety of ways including supporting community-led activity with our community and third-sector partners, promoting tools such as My Diabetes My Way (MDMW) and encouraging people to access local resources to maintain their wellbeing. Over the last year there has been a steady rise in people signing up to MDMW in Renfrewshire, from 1,713 (April-June 2018) to 1,869 (January-March 2019).

673

Health Improvement supported the coordination of Universal Credit training for staff. A total of 673 members of staff were trained.

Child and Maternal Health

Childhood Immunisation

We continue to maintain an excellent uptake rate for our pre-5 immunisation programme. However we know that across the Health Board area, the uptake in more deprived areas is lower. We have undertaken an Equality Impact Assessment of our services to ensure we are doing everything possible to reduce barriers to children being vaccinated.

MMR protects against three separate illnesses – measles, mumps and rubella (German measles) – in a single injection. The full course of MMR vaccination requires 2 doses; the first by 24 months and the second by age 5.

Two important targets for MMR are for 95% of children at 24 months and at 5 years of age to be vaccinated. The following table shows that Renfrewshire exceeded the target for those aged 24 months for all three calendar years. Unfortunately at 5 years, the rates in Scotland, Renfrewshire and across NHSGGC were below the 95% target.

MMR Vaccination % Uptake

Age	2016	2017	2018
24 months Renfrewshire	95.4%	95.8%	96.0%
24 months NHSGGC	**94.8%**	94.9%	94.4%
24 months Scotland	94.9%	94.6%	94.2%
5 years Renfrewshire	93.8%	92.2%	90.4%
5 years NHSGGC	92.2%	91.1%	89.5%
5 years Scotland	92.9%	92.2%	91.2%

Breastfeeding

At 24.4%, the rate for the number of babies exclusively breast fed at their 6-8 week review remains above target for 2018 (target 21.4%). This is an increase on the 2016 figure of 23% and a further 1% increase on the 2017 rate of 23.4%.

For the first time ever we are pleased to report that all our Early Education and Childcare establishments (local authority, partnership and private) are Breastfeeding Friendly Nursery Accredited.

	2016/17	2017/18	2018/19
Exclusive breastfeeding at 6-8 weeks	23.0%	23.4%	24.4%

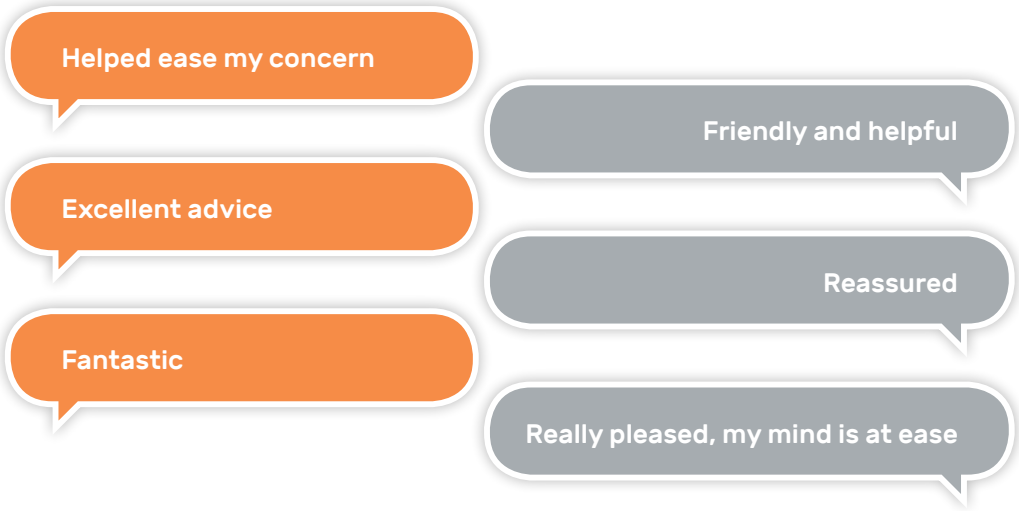
Oral Health

74% of Renfrewshire's Early Education and Childcare establishments remain engaged in the national Childsmile Tooth brushing programme with additional fluoride varnishing delivered in 12 targeted sites with an additional 8 on board by 2019/20. In 2018/19 we have also focused on increasing dental registration rates for 0-2 year olds. A small test of change has been developed with a local pharmacy in an SIMD 1&2 area to identify families who are not registered with a dentist, providing them with information on registration and key oral health messages. To date 28 families have engaged; 15 received key oral health messages and 12 were signposted to their nearest dentist. A social media clip has also been developed to support this initiative and has been shared by the HSCP and key partners. The clip can be viewed on this link: https://youtu.be/fvth6zIDGMg

Specialist Children's Services

There have been a number of service developments across Specialist Children's Services in 2018/19:

Paediatric Speech and Language Therapy (SLT) Drop-in Clinics are now running in five community health settings across Renfrewshire. This allows parents to attend without a referral for a consultation with a registered Speech and Language Therapist at a venue and date that suits them. Data suggests that around one-third of parents only required advice and reassurance. Current feedback comments include:



SLT waiting times for assessment are consistently within the 8 week target.
The longest waiting time from referral to treatment was 30 weeks at March 2019; however this has reduced to 22 weeks at June 2019, just above the 18-week Referral to Treatment Target. This is a further improvement from 27 weeks at May 2019.

The Physiotherapy service will be the second area to introduce community Drop-in Clinics for 0-5 year olds. A scoping exercise was undertaken in 2018/19 and a pilot clinic will begin in one location from September 2019. If this proves successful the project will be upscaled to provide multiple clinics throughout Renfrewshire. The service will also support Health Visitors carrying out 14-month assessments to assist with targeted interventions, which will help ensure specialist advice is provided at the appropriate time. A handy leaflet has been produced titled 'Common Concerns about Normal Development' targeted at all referrers but particularly GPs, with the aim to encourage early intervention advice that may reduce the need for referral to specialist services. This will be audited as it rolls out.

Occupational Therapy successfully launched and is now evaluating its digital 'Kids' platform, which provides an immediate single point of access to advice, strategies and self-help support prior to a need for direct referral to the service. Indications suggest there are around 20,000 hits per month. Occupational Therapy waiting times have consistently met the 18 week Referral to Treatment (RTT) target. The longest wait at March 2017 was 15 weeks; this reduced to 10 weeks at March 2018 and was 16 weeks at March 19.

Paediatric Speech and Language Therapy, Occupational Therapy, and the Child and Adolescent Mental Health Service (CAMHS) Referral to Treatment

Referral to Treatment	Date	Longest Number of Weeks Wait	Date	Longest Number of Weeks Wait	Date	Longest Number of Weeks Wait
SLT	March 2017	25 weeks	March 2018	17 weeks	March 2019	30 weeks
Occupational Therapy	March 2017	15 weeks	March 2018	10 weeks	March 2019	16 weeks
CAMHS	March 2017	18 weeks	March 2018	21 weeks	March 2019	33 weeks

Renfrewshire's Child and Adolescent Mental Health Service (CAMHS) has seen an increase in waiting times with 82.5% of children being seen within the 18-week target at March 2019, against a target of 100%. Our performance around waiting times can be attributed to an increase in referrals and a 12-month period of workforce turnover, however two new nursing posts are being recruited to which will enhance the capacity of the team and address the increased waiting times.

Renfrewshire Disability Team

Enhanced pathways and use of EMIS data has improved the efficiency of the Renfrewshire Disability Team (paediatricians and nursing staff). This has resulted in waiting times for an initial non-urgent paediatrician appointment reducing by 50% from 8 months to a current average of 4 months.

Primary Care and Long Term Conditions

Primary Care Improvement Plan

In 2018 we produced Renfrewshire's Primary Care Improvement Plan (PCIP) which takes account of population needs, local priorities, existing services and builds on local engagement.

Implementation has involved adding expanded teams of HSCP and NHS Board employed health professionals to support patients who do not need to be seen by a General Practitioner (GP).

The illustration below shows the positive progress made in Renfrewshire in 2018/19.

1,928 Housebound patients/carers were vaccinated by the HSCP Flu Team

Pre-school Community Immunisation Clinics are in place

School-based Immunisations are being provided by the NHSGGC School Health Immunisation Team

Additional Pharmacist & Pharmacy Technicians support is freeing up more GP time

10 GP Practices are benefiting from a new Phlebotomy service

2.5 new Advanced Nurse Practitioners have been aligned to 5 GP Practices

1.5 new Advanced Physiotherapy Practitioners have been aligned to 4 GP Practices

Community Link Workers have been aligned to every GP Practice

Diabetes

The Renfrewshire Integrated Diabetes Interface Group continues to prioritise diabetes and health inequalities, in particular taking diabetes awareness and education out into the community.

Ferguslie Diabetes Drop-in Service

One of the main achievements in 2018/19 saw the group successfully secure funding to set up a specialist drop-in service in Ferguslie for people with Type 2 diabetes via the pharmacist at Lloyd's pharmacy. The Health Improvement Team secured funding to provide a pharmacist with specialist dietetic training prior to the project which ran from November 2018 to February 2019. Diabetes UK provided self-management booklets for those patients who attended and the service was promoted using social media.

The Health Improvement Team also organised three Eat Better, Feel Better Diabetes Courses in October 2018 and January 2019. These courses teach basic cooking skills, how to cook nutritious meals and the nutritional values and portions of the meals specifically tailored to people with diabetes.

Flu Vaccination

Uptake rates of seasonal flu vaccine in Renfrewshire are similar to the rates for NHSGGC and above the Scottish average for 2017/18 and 2018/19. The over 65s rate has remained fairly stable with a rate of 75.1% in 2018 compared to 75.4% in 2019, however there has been a slight reduction in uptake for the 'Under 65s at risk group' - 45.5% in 2018 compared to 44.2% in 2019 - and both pregnancy groups: Pregnant (not in clinical at risk group) 58.3% in 2018 compared to 54.0% in 2019; and Pregnant (in clinical at risk group) 63.7% in 2018 compared to 59.5%.

Seasonal Flu Vaccine Uptake Averages - as at week 15, 2019 (end of uptake surveillance period)				
HSCP	Over 65s	Under 65s in at risk groups	Pregnant (not in clinical at risk group)	Pregnant (in clinical at risk group)
Renfrewshire	75.4%	44.2%	54.0%	59.5%
NHSGGC	73.8%	42.8%	50.7%	58.4%
Scotland	73.7%	43.4%	44.5%	57.4%

Housebound Flu Immunisation

Renfrewshire HSCP worked closely with GP clusters to test a change of delivery of the flu vaccine to the housebound population. In 2016-17, in the traditional model of delivery, District Nurses vaccinated 369 housebound patients during the months of October 16 to February 17. A pilot was carried out in 2017/18 and a total of 1,176 patients were vaccinated during the pilot, including 88 carers vaccinated at the same time as the patient.

The programme was extended to all Renfrewshire GP Practices in 2018/19 and we are pleased to report a further increase with 1,762 patients and 166 carers vaccinated in 2018/19.

1,762

+ 166 carers were vaccinated during our 2018/19 Housebound Flu Vaccination Programme

Improving the Cancer Journey

During 2018/19, Renfrewshire Council and Renfrewshire Health and Social Care Partnership successfully secured £500,000 from Macmillan Cancer Support to develop the Macmillan Renfrewshire Improving the Cancer Journey (ICJ) project. The project aims to support people affected by cancer in Renfrewshire by building on existing links in local communities to deliver high quality, accessible care with clear pathways, centred around the individual's Holistic Needs Assessment. Access points will be created for information, advice and other support services, including access to financial and welfare benefits advice.

Cancer Screening Awareness

Health Improvement activity in 2018/19 centred around raising awareness of both the national bowel and cervical cancer screening programmes. Breast screening data is currently unavailable but is expected later in 2019.

The rate of uptake for bowel screening in Renfrewshire at 55.9% is slightly higher than NHSGGC, but both remain below the target of 60%. Renfrewshire's rate of uptake for cervical screening is 5% above the NHSGGC rate; however both are below the 80% target.

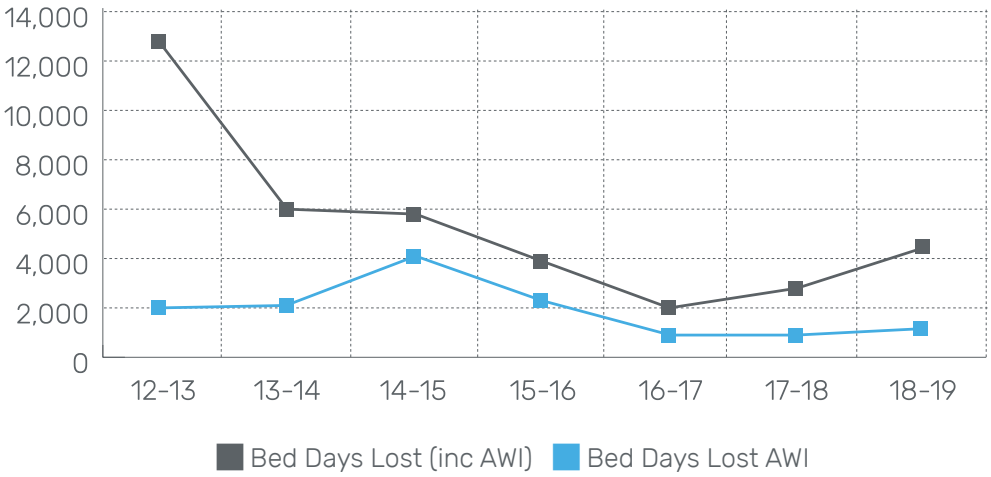
	Bowel Screening 2016-2018	Cervical Screening March 2018
Renfrewshire	55.9%	76.9%
NHSGGC	52.3%	71.9%

Older People

Delayed Discharge – lost bed days for those aged >65

Reducing delayed discharges remains a high priority for the HSCP. Good progress was made in 2016/17; however it was a challenge to maintain this level in 2017/18 and 2018/19 has seen a further increase in bed days lost to delayed discharges (including Adults with Incapacity. It should be noted, however, that the increase is not unique to Renfrewshire and we are working hard to improve performance in this area.

Lost bed days >65 years: 2012/13 – 2018/19



	2012/ 2013	2013/ 2014	2014/ 2015	2015/ 2016	2016/ 2017	2017/ 2018	2018/ 2019
Bed days lost (inc AWI)	12,698	5,835	5,325	3,633	1,910	2,712	4,203
Bed days lost AWI	2,050	2,288	4,301	2,624	664	652	1,188

Work continues to reduce delayed discharges in Renfrewshire. In a small number of cases there have been difficulties with Care at Home provision due to levels of demand in particular areas, but steps are being taken to address this. The remainder are awaiting care home places and either in the process of assessment or looking at second or third choices due to unavailability of their first choice option.

Phase 1 of the Older Peoples' Services Review is now complete. The Partnership engaged with over 100 people to identify eight themes that are important to Older People. Phase 2 will begin in summer 2019 when we will begin to identify priority areas and actions for change.

Dementia

850,000 people in the UK live with dementia. This figure includes 93,000 in Scotland, with approximately 2,994 of those living in Renfrewshire. It is expected that this will increase to around 4,400 people by 2035; an increase of 47%.

Renfrewshire Dementia Strategy

The Renfrewshire Dementia Strategy Group has developed a work plan to ensure the required actions and outcomes of Scotland's Dementia Strategy 2017-2020 are achieved. This aims to ensure in-patient and community services across statutory, independent and third sector agencies, develop person-centred services to assist people with dementia to live as independently as possible and ensure they are treated with dignity and respect. The Group is currently preparing and consulting on the development of our local Renfrewshire Dementia Strategy. With support from the Health Improvement Team, public engagement events have been held along with an online survey and several focus groups.
The Strategy is expected to be published in early 2020.

Sharing Good Practice

Health Improvement and the Community Links Team also visited a Day Centre in West Dunbartonshire to explore examples of dementia friendly good practice to feed back to Renfrewshire and help inform our Older People's Review.

Staff Training

Two staff nurses from Ward 37 at the Royal Alexandra Hospital have undertaken the Dementia Specialist Improvement Leads Programme, allowing them to train and educate all staff on the ward in Specialist Dementia Care. There is also an ongoing project to offer all Renfrewshire care homes the NHS Education for Scotland (NES) & Scottish Social Services Council (SSSC) 'Promoting Excellence in Dementia Care' training.

An @AHP Dementia Twitter page has been launched with contributions from Renfrewshire Allied Health Professional staff. This provides daily advice and support on how to live as independently as possible with a diagnosis of dementia.

In line with the NHSGGC Moving Forward Together (MFT) Programme, we intend to look at new approaches to community based dementia care as alternatives to hospital care. It should also be noted that Inverclyde HSCP has been chosen as a national Demonstrator site to trial a new model of community care coordination for people with a diagnosis of dementia. This will run until 2021.

Falls Prevention

Falls and fragility fractures remain a concern, particularly in the context of an ageing population. At Q3 2018/19, 16.7 people per 1,000 of the Renfrewshire population aged 65 and over were admitted to hospital following a fall-related injury, compared to 13.9 in 2017/18. Full financial year data for this indicator is currently unavailable for both Renfrewshire and Scotland. The rate for the full financial year 2017/18 was 18.7 compared to the Scotland rate of 21.6.

Introduced in December 2016, The Renfrewshire Falls Prevention & Management Strategy aims to reduce falls in the community. Taking a proactive approach, individuals at risk of falls and fragility fractures are identified and appropriate interventions are provided. We work in partnership across the HSCP, Acute Services and with a range of agencies in the third and independent sectors to achieve this.

In 2018/19 we have continued the delivery of Positive Steps training to a range of frontline staff, including Care at Home staff, to increase their awareness and maximise their capacity to identify individuals at risk. This also allows staff to provide practical advice to promote independence and facilitate safe and healthy lifestyle choices to prevent falls and fragility fractures.

Clear pathways are also now in place to signpost individuals to relevant information resources, services or groups to promote falls prevention through behavioural changes, advice or equipment provision.

Three work streams supported the roll out of the Falls Prevention & Management Strategy. Areas prioritised included:

- Partnership working with the Scottish Ambulance Service to increase referrals to the Falls Team rather than unnecessary transfers to hospital for individuals who experience a fall at home, but sustain no injury
- Care Home Falls Prevention and Management Group, with a specific aim to share good practice and minimise the risks of falls for residents
- Community Falls Prevention and Management Group, which aims to build community resilience in relation to falls and frailty, in particular prevention and early intervention and comprises of members from the third and independent sectors
- The importance of recognising and responding to frailty is core and embedded in all professionals' work in Renfrewshire HSCP. A test of change is underway between GPs and Social Work to share information on older adults who are considered frail, to develop a plan on how best to care and respond. The third sector is considering using the Rockwood tool for those who are not likely to be known to services, to encourage people to remain active.

Care Homes

Renfrewshire has 22 care homes (three local authority residential homes, 16 private/third sector nursing homes and three private/third sector residential homes). Around 1,200 Renfrewshire residents live in care homes. The current vacancy rate is over 10% and this varies greatly across Renfrewshire. The average age of residents in Renfrewshire care homes has increased from 82 to 88 over the last five years. This means that the typical care home resident is older, frailer, likely to have dementia and have a range of long term conditions.

Care Home Partnership Group

A Renfrewshire Care Home Partnership Group was established with representation from community, primary care, acute and care homes. The aim of the group is to improve pathways for care home residents who require unscheduled care at the Royal Alexandra Hospital (RAH) and reduce levels of preventable admission to hospital.

Red Bag Initiative

A Red Bag initiative has been rolled out in all care homes in Renfrewshire. The Red Bag contains important information about a resident's health so if they require a hospital admission they can receive quick and effective treatment by ambulance and hospital staff, aiming to reduce their length of stay in hospital.

Standardised Anticipatory Care Planning

In Renfrewshire we have widely promoted the use of eKIS for Anticipatory Care Planning. We have communicated with all HSCP staff the need to use the 4-page summary at the end of the Healthcare Improvement Scotland (HIS)/NES national Anticipatory Care Plan (ACP) if eKIS cannot be accessed. Currently all local authority care home residents have an ACP in place.

Chronic Obstructive Pulmonary Disease (COPD) Pilot

Community pharmacies participated in an initiative to supply rescue medication for targeted patients who require them for Chronic Obstructive Pulmonary Disease (COPD), without the need for GP or hospital input. The COPD pilot started in January 2019 and all GP practices, and the chest clinic within the Royal Alexandra Hospital, have distributed cards to patients who fit the agreed criteria. So far the pilot has been very well received and welcomed by both patients and professionals. We will evaluate the pilot as soon as data is available.

Enabling Independent Living for Longer

Our Care at Home Transformation Programme continues to work with our staff, service users, Trade Unions and partners to develop services which will allow us to meet ongoing demand for our services within current budgets, while supporting people to live as independently as possible in their own homes.

The importance of recognising and responding to frailty is core and embedded in all professionals' work in Renfrewshire HSCP.

Learning Disabilities

The Disability Resource Centre (DRC) is a purpose built day centre providing services for physically disabled and sensory impaired people living in Renfrewshire. It is located centrally in Paisley and as well as being a place to socialise and take part in classes, it also actively promotes independent living through various educational and employment activities.

Throughout 2018/19 there has continued to be a strong commitment to continuous professional development and a rolling programme of training for all staff across the service. Some of this work is highlighted below:

- Approximately 90% of staff in day services have had autism awareness training
- Approximately 80% of staff in respite service have had autism awareness training
- 45 staff across the services have accessed training provided by the Oral Health Team and Nurses from the Community Team
- 90% of all staff across the service have completed Adult Support and Protection Training relevant to their role. 100% of Community Team staff have completed necessary training, with social work staff 100% compliant with requirements of their role as Council Officers
- Dementia link workers within the community team have been established and additional specific training across Renfrewshire Learning Disabilities Service (RLDS) and the community team has increased specialist knowledge and capacity ranging from diagnostic to post diagnostic practical support. Six staff within the day and respite services are accredited trainers with more than 50% of service staff trained and a rolling programme of training in place.

A new Participation Officer post has been created to support service user engagement and inclusion in service development and improvement.

In terms of our services, highlights from 2018/19 include:

- Completion of the refurbishment of Spinners Gate and Anchor Service
- Successful expansion of the Gateway Intensive Support Service
- Care Inspectorate - all day and respite services have continued to receive positive inspection reports with grades of 4-6. The Anchor Service achieved higher grading than previously, with all other services maintaining their previous good and very good standards

- RLDS Day Services continue to focus on achievement of personal goals and outcomes in line with the strategic outcomes of The Keys to Life e.g. Limelight Music and Duke of Edinburgh Awards
- Autism Connections have developed Autism Awareness training for Renfrewshire HSCP and external organisations including Housing, Fire and Police Services
- In response to a request from carers, we have re-established a Learning Disability Planning Group.

Over 300 people engaged with Paradigm for the independent review of Learning Disability Day and Respite Services. We have consulted on the findings through a series of events, which have reached a wide audience. We will now work with stakeholders to develop our priority actions during 2019/20.

We have had a number of successful initiatives in 2018/19 which include:

Oral Health

RLDS Community Team Nurses have been trained to deliver awareness sessions to service users. A rolling programme of training will continue to be provided by the Oral Health Team. 45 staff have been trained across the services as part of the initial phase.

Psychological Therapies

The RLDS Community Team has achieved 100% performance (90% target) relating to timescales for interventions and National HEAT targets. Work will continue to maintain this high standard.

Dementia Post Diagnostic Support

All RLDS patients with a diagnosis of dementia are offered an allocated worker in the first 12 months post diagnosis. Further to recommendations within the National Dementia Strategy, nurse-led post diagnostic support for adults has been maintained at 100% within the service.

Autism

In recognition of the growing number of adults with autism, the performance target of providing relevant Autism Awareness Training to 90% of health and social care staff in our Learning Disabilities Service has been achieved once again in 2018/19.

Health Improvement

Staff from the Community Team are supporting a men's health group for all service users at Community Networks, while the Health Improvement Team at Johnstone Clinic are supporting the 'Waist Winners' project with Community Networks' service users and staff.

The Gateway Intensive Support Service won the Improving Care category at the NHS GG&C Celebrating Success Staff Awards. Gateway's 'Think Tank' initiative demonstrates excellent joint working between the staff team and the people who attend Gateway on shaping ideas and developing new ways of improving and modernising our service. The service was also nominated for the NHS GG&C Platinum Chairman's Awards in Glasgow.

Tackling Health Inequalities

RLDS specialist health professionals continue to focus on the reduction of health inequalities through health education, nurse-led assessment, and adapting information into suitable formats for people with Learning Disabilities. These include: sexual health, epilepsy risk management, bowel screening, breast screening, mental health, falls assessment, MUST nutritional screening, development of communication profiles, and the oral health strategy.

Social Work Review and Commissioning Team

The Team has continued to support the development of a Provider's Forum with RLDS to further enhance joint working and build closer working relationships.

The Team has increased knowledge, skills and confidence in the use of telecare to support adults with Learning Disabilities to reduce dependencies on staff supports where appropriate.

Transitions from Children's Services: RLDS has identified a dedicated resource of multi-disciplinary staff to identify and support young people with learning disabilities at age 16-18 as they enter adulthood. This consists of robust assessment and screening, provision of advice and transferring health and social work links from children's teams to adult teams

Mental Health

Renfrewshire Health and Social Care Partnership supports the Scottish Government's Mental Health Strategy 2017-2027, and in response has commissioned and developed The Five-year Strategy for Adult Mental Health Services 2018-23 in partnership with NHS Greater Glasgow and Clyde and the other five HSCPs in the Board area.

We recognise that good mental health and resilience are at the heart of our vision and we will ensure mental health and wellbeing is a priority across the whole of Renfrewshire.

Doing Well

Over the last four years, the Primary Care Mental Health Team has introduced a self-referral route to the service. Previously, clients could only be referred by a GP or other qualified professional. Self-referrals have increased from 207 in 2013/14 to 1,352 in 2018/19, successfully and appropriately redirecting work away from GP surgeries.

Waiting Times

We continue to monitor the Primary Care Mental Health Service waiting time indicator: the percentage of patients referred to first appointment offered within 4 weeks, which has increased from 79% at March 2018 to 86.5% at March 2019. There are factors that have influenced performance in this area, reducing capacity to meet the demand on the service and the completion of assessments within 28 days, including:

- 4% increase in referrals, including a 12% increase in self-referrals which require additional telephone triage time
- increased long term sickness absence within the service.

Renfrewshire Clozapine Clinic Review

The Clozapine Clinic is well established within the Community Mental Health Teams and provides a service to our patients who suffer from severe and enduring mental health issues. We have enhanced this service by providing physical health checks to patients who are prescribed clozapine, depot injections and those patients who require high dose monitoring.

An independent review was carried out to gauge the opinion of clinicians, patients and carers.

Comments from service users included:

The staff are fantastic – very trustworthy – which is very important to me as my illness makes it difficult for me to trust people.

I feel listened to.

I feel valued and get all my questions answered.

Comments from staff included:

The physical health checks at the clinic are invaluable. This group of patients are at risk of health complaints and generally don't attend their GP.

Good attendance rates from patients. Some health problems have been detected and successfully treated.

Sensitive Routine Enquiry

An audit of Sensitive Routine Enquiry (SRE) of the Community Mental Health Teams is carried out twice a year. The audit aims to identify the extent to which Routine Enquiry of Domestic Abuse and Childhood Sexual Abuse occurs and the numbers of referrals made as a result of a disclosure of current or historical abuse.

Of the Mental Health records audited in February 2018, Sensitive Routine Enquiry (SRE) took place in 83% of the cases. In February 2019, SRE took place in 97% of cases, showing that a consistent approach has embedded sensitive routine enquiry into the initial assessment process.

Mental Health Inpatient Service - Welfare Commission

Inspectors from the Mental Welfare Commission visited Arran Ward in May 2018 as part of a planned review of all Rehabilitation units across Scotland.

The ward was complimented on the variety of activities for patients and the fact that staff both empower and encourage patients to take part. They also found the links and communication between the Multi-Disciplinary Team were strong and very well evidenced with good Occupational Therapy input. The ward received good carer feedback and the Commission was impressed with carer involvement at in-depth reviews, ensuring they were involved in care decisions and personal care plans for all patients.

Alcohol and Drugs

Reduction in alcohol related hospital stays

We have exceeded our target for reducing alcohol related hospital stays for the period April 2018 to March 2019 at a rate of 7.7 per 1,000 population aged 16+ (target 8.9). The rate at March 2018 was 9.0.

Alcohol and Drug Waiting Times for Referral to Treatment

The target for the percentage of people seen within three weeks for alcohol and drug services is 91.5%. Our performance reduced from 87.3% at December 2017 to 74.4% at December 2018. Currently an increase in referrals and staffing issues have decreased performance as a whole. The pathway has now been refined and extra resources have been transferred from the Drug Service to address the imbalance.

The Drug Action Partnership Group

The Drug Action Partnership Group (DAPG) has been set up to reverse the upward trend of drug related deaths. Led by Police Scotland, the Group has been meeting regularly and aims to identify innovative ways to reduce the risk for those most vulnerable to harm and to provide information around evolving trends.

Changing Stigma to Respect Exhibition

Stigma associated with addiction to alcohol and drugs can have a negative impact on an individual's recovery as well as their families and the wider community. An education and awareness-raising campaign was organised by the Alcohol and Drug Partnership to challenge stigma. The Changing Stigma to Respect Exhibition was held in Renfrewshire over a two-day period with more than 100 people attending. A short film was made by men and women from the local recovery community, highlighting the different forms of stigma people endure in recovery from addiction. There was also an exhibition of photographs showing what recovery means to those affected by addiction and mental health. This was also replicated within the Sunshine Recovery Cafe. Both events were peer-led with graduates from our peer training programme guiding visitors through the exhibition and engaging in conversations around stigma.

10 Renfrewshire students graduated from the Recovery College in 2018/19. The College aims to build the community development skills of individuals in recovery from addiction with the opportunity to complete a number of modules over an eight-day period.

Frequent Attenders at the Emergency Department

To reduce the number of repeat attenders at the Emergency Department in the Royal Alexandra Hospital (RAH), the HSCP has been monitoring addictions/mental health related attendances. As a result, a process has been established where specialist services will review the client/patient contact and make necessary arrangements to address any unmet need. Two Navigator posts for the RAH are also being recruited to. It is expected they will be in post by late autumn/winter and will help re-engage frequent attenders at the Emergency Department with community Mental Health and Addictions supports.

Alcohol Brief Interventions (ABI)

Performance at March 2019 was 306 compared to 549 at March 2018. To improve performance and in line with other areas in NHSGGC, funding is now in place to recruit an ABI post for Renfrewshire. The post would be delivered by the third sector with the specific aim of increasing the number of ABIs delivered.

Alcohol and Drugs Commission

During 2018/19, Renfrewshire Community Planning Partnership agreed to establish an independent commission to establish a true picture of drug and alcohol use in Renfrewshire, and to make recommendations on what partners can do together to support local people and communities adversely affected by drug and alcohol use. The first meeting of Renfrewshire's Alcohol and Drugs Commission took place on 19 March 2019 and is supported by the HSCP Chief Officer and members of the Senior Management Team.

Sunshine Recovery Café

The Café was established to promote recovery in Renfrewshire and to improve the life chances of individuals affected by alcohol and drugs. The Café provides peer-led support to assist individuals becoming abstinent and sustaining abstinence from alcohol and drugs. It also provides support to access training and employment opportunities. Between 50-60 individuals attend on a weekly basis and benefit from a broad network of activities such as volunteering in the Café and accessing a variety of holistic therapies.

In 2018/19 we have begun to implement the Addictions Service Whole System Review findings, which will introduce a fully integrated alcohol and drug recovery service model in Renfrewshire.

Carers

The Carers' Act came into force on 1 April 2018. The Act applies to both adult and young carers and aims to provide more support to unpaid carers and improve their health and wellbeing.

Carers and Renfrewshire Carers' Centre have played a key role in the following achievements throughout 2018/19:

Adult Carers' Support Plans (ACSP)
In order to increase the number of carers with a Support Plan (formerly a Carers' Assessment), a new process has been developed whereby carers do not have to contact statutory services to request an ACSP. Carers without a critical or substantial need can complete their ACSP with the Carers' Centre. 93 ACSPs have been completed this year.
Young Carers' Statements (YCS)
A dedicated Young Carers' Resource Worker was recruited to work across Children's Services and within Renfrewshire Carers' Centre to support the delivery and completion of Young Carers' Statements. 78 have been completed this year.
Eligibility Criteria for Adult Carers
Renfrewshire's Adult Carer Eligibility Criteria was approved by the Integration Joint Board (IJB) on 26 January 2018 and has now been published. Levels of eligibility criteria are 'Critical and Substantial'; 'Moderate'; and 'Low or None'. The HSCP has a duty to provide support to all carers whose circumstances are Critical and Substantial, and the power to support those carers whose circumstances are assessed as 'Moderate', or 'Low or None', which fall below the Eligibility Threshold (the duty to provide support).
Staff Training
Training and awareness sessions on all aspects of the Act were delivered to HSCP staff between February and April 2018.
Carers' Information Service
Renfrewshire Carers' Centre offers an excellent information and advice service. Find out more at http://renfrewshirecarers.org.uk or you can call the Centre on 0141 887 3643 or email them at enquiries@renfrewshirecarers.org.uk
Carers' Strategies
Following a period of consultation with Carers and Renfrewshire HSCP's Strategic Planning Group, the draft Adult Carers' Strategy will be consulted on during summer 2019 and is expected to be published late autumn. The Young Carer's Strategy was published in 2018 following extensive consultation with local young carers who receive support at Renfrewshire Carers' Centre. You can find the Strategy here: http://www.renfrewshire.hscp.scot/carers

Young Carers

Lots of brilliant work is also being done with young carers in Renfrewshire. During 2018/2019 a fortnightly walking group for young carers has been set up along with a 12-week group work programme, and a monthly drop-in session. In partnership with Impact Arts, some young carers took part in an arts programme exploring creativity and identity, while a young carers' App called 'What's Going On' (designed by young carers), has been rolled out across Renfrewshire. Professionals and young carers can use the App to access information as well as make a referral to the Young Carers' Service.

Eat Better, Feel Better

Three young carers attended a six-week Eat Better, Feel Better course at Our Place, Our Families in October 2018. The course teaches basic cooking skills, how to cook nutritious meals and the nutritional values and portions of the meals. It also offers young carers an opportunity to socialise with other carers and meet new people.

In 2018/9, 1,435 carers received support from the HSCP and its partners, including 616 new carers.

229 carers accessed training in 2018/19

Effective Organisation

iMatter

iMatter is a team based, employee engagement questionnaire which was introduced by the Scottish Government in January 2015. Renfrewshire HSCP implemented iMatter as part of our Organisational Development and Service Improvement Strategy and our staff undertook the most recent survey in January 2019.

The Benefits

- Gives staff the chance to feed back on specifics and to influence change and improvement in the workplace
- Helps managers understand a team's perspective on what it means to be in the team and service area
- Provides an opportunity for local partnership groups to incorporate actions to their Directorate Staff Governance Action Plan
- Improves outcomes for patients, families and other users of health and social care services as a result of teams taking action in respect of their experience at work
- Identifies themes that may require addressing across the organisation.

Results

This year's response rate was 64%, a 5% increase on 2018's response rate of 59%, with staff giving positive responses at a level equal to or higher than last year's results.

Each team will now refresh their Action Plans based on this year's results, adding new actions that will contribute to improving the areas where we have achieved the lowest scores. Further evaluation and monitoring will continue throughout 2019/20.

Sickness Absence

Sickness absence and a healthy workforce remains a priority for the Partnership. Subject to continued rigorous monitoring and evaluation, regular performance reports are taken to our Integration Joint Board throught the year. Work continues to ensure absence performance is improved and best practice is applied across the Partnership.

The two employers of HSCP staff, NHS Greater Glasgow and Clyde (NHSGGC) and Renfrewshire Council, 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 target in 2018/19 was 2.69 days per quarter per full-time equivalent employee.

The sickness absence level for NHS staff at the end of March 2019 in Renfrewshire was 5.39%, almost a 1% decrease on the February 2019 figure of 6.36% and marginally lower than the March 2018 figure of 5.49%. The highest rate in 2018/19 was 7.29% in January 2019, while the lowest rate of 4.92% was seen in October 2018.

Absence Rate (%)	Jun 2018	Sep 2018	Dec 2018	Mar 2019
Health	5.53%	5.13%	5.67%	5.39%

Adult Social Work sickness absence rate was 4.13 days per employee at March 2019 against a Quarter 4 target of 2.69 days, a slight improvement on the March 2018 rate of 4.34.

Absence Rate (Work Days Lost)	Jun 2018	Sep 2018	Dec 2018	Mar 2019
Adult Social Work	4.02	4.64	4.64	4.13

Supporting Attendance Activity

Work remains focused on improving sickness absence performance. Planned actions include:

- HR Teams continuing to work closely with service management teams to identify areas that require additional support
- A Council review of current attendance policies. Meetings have taken place with Trade Unions to ensure this is a fully collaborative process
- Human Resource (HR) Operational Teams continue to proactively advise and support managers, particularly in teams where absence rates are high
- The delivery of supporting attendance training for managers; with the provision of tailored training for managers and employees at a service level
- Ongoing health improvement activities and support through Healthy Working Lives (HWL), aimed at raising employee awareness of health issues.

Workforce Planning

Our vision is for Renfrewshire to be a caring place where people are treated as individuals and supported to live well. Since 2015, this vision has been the starting point for our work in shaping and taking forward our organisational culture.

It is underpinned by the professionalism, values and behaviour of our staff, by how our services and teams work, and by our leadership approach across the organisation. This approach was endorsed by our recent Inspection of Adult Health and Social Care Services, when positive feedback was received from the Inspectors on the HSCP's leadership and direction.

We have invested in:

- Regular Senior Management Team (SMT) development sessions and extended business development days
- Establishment of a Leadership Network comprising over 160 managers and leaders from the organisation
- Supporting leadership training, including the Ready 2 Lead programme
- Developing our Strategic Planning Group (SPG) to support its active role vin strategic planning.

Improving communication and making better use of technology have been two key strands of activity we have used to develop the culture of our organisation. Our social media presence is significant and growing, and we have used this to communicate both internally with our staff, and externally to share public health messages with local communities. Public facing newsletters have been produced twice per year, and monthly Team Bulletins are also cascaded to all staff.

Our Organisational Development, Service Improvement and Workforce Implementation Plan covers the planning period 2017-20 and supports the workforce to be committed, capable and engaged in person-centred, safe and effective service delivery.

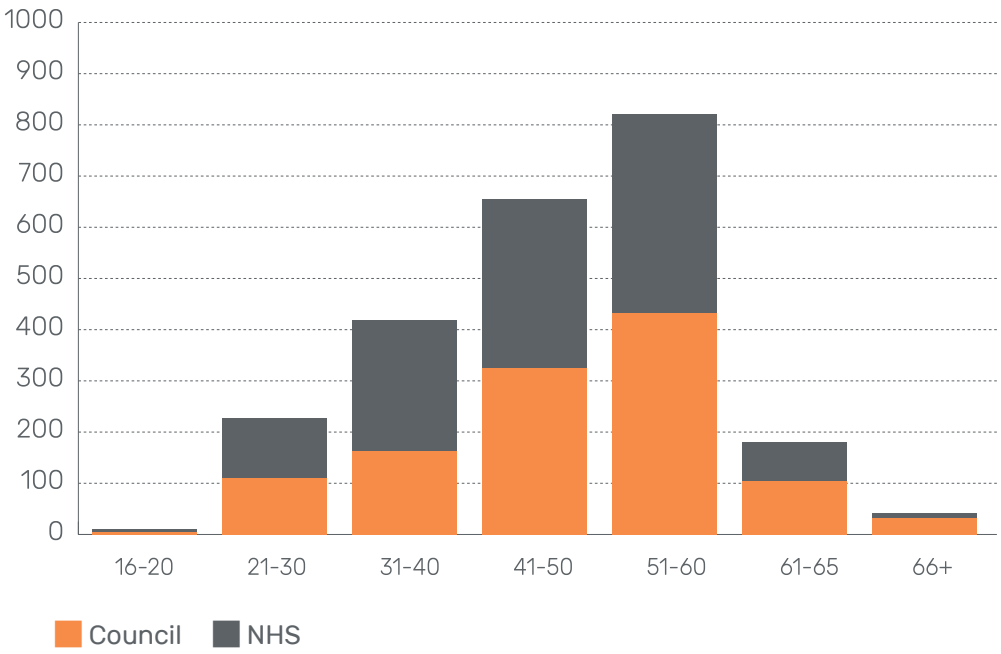
Workforce Data

Age Bands	Renfrewshire Council Workforce Data		NHS Workforce Data		HSCP Total		% of available workforce
	Headcount	WTE	Headcount	WTE	Headcount	WTE	%
16-20	3	2.68	2	2	5	4.68	0.21
21-30	102	82.14	115	99.95	217	182.09	9.34
31-40	163	132.5	261	210.87	424	343.37	18.23
41-50	320	259.9	339	277.23	659	537.13	28.33
51-60	425	343.92	394	329.38	819	673.3	35.21
61-65	106	80.37	67	56.37	173	136.74	7.44
66+	22	13.69	7	4.82	29	18.51	1.25
Total	1,141	915.2	1,185	980.62	2,326	1,895.82	

Age profiles

The chart below shows the HSCP head count workforce in age profiles:

Renfrewshire HSCP Age Profile by Employer (Headcount)



The profile shows a number of workforce characteristics which are important in relation to our workforce planning processes:

- 35.2% of the combined HSCP workforce is over 50 years old
- 37.2% of the Council workforce is over 50 years old, with the NHS figure at 33.2%
- The largest age band falls between 51 and 60, with significant numbers also falling in the 41-50 year old grouping
- 7% of the workforce is over 60 years old
- Almost 10% of the workforce is in the 21-30 age band, with just 5 staff members under 20.

A shortage of key professionals including General Practitioners, District Nurses, Mental Health Officers, Psychologists and Care at Home Staff are a current recruitment and retention challenge for Renfrewshire HSCP.

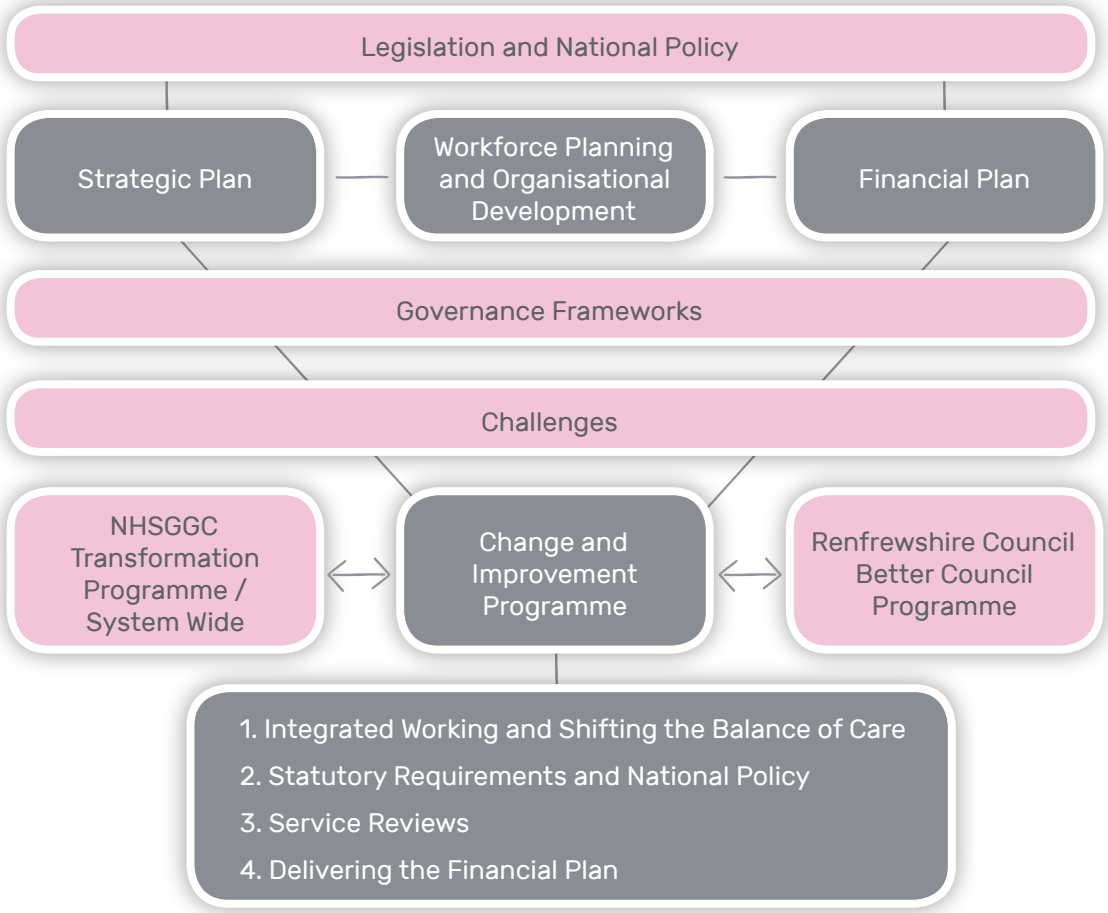
2,326 **people work in Renfrewshire HSCP**

Change and Improvement

Our Programme provides a structured way to manage and optimise change and improvement approaches, and develop and share best practice to deliver on this vision.

Our Approach

A Change and Improvement Programme has been established in support of the IJB's Vision and to enable the delivery of our Strategic, Workforce and Financial Plans in line with the direction set out in the National Clinical Strategy and Health and Social Care Delivery Plan - see diagram below. Our Programme provides a structured way to manage and optimise change and improvement approaches, and develop and share best practice to deliver on this vision.



Our Workstreams

Optimising Joint and Integrated Working and Shifting the Balance of Care

To proactively develop our health and social care services, exploiting the opportunities joint and integrated working offers and with service redesign being informed by a strategic commissioning approach. This in turn will support the financial sustainability of the Partnership.

Statutory Requirements, National Policy and Compliance

To ensure the timely delivery of legislative requirements and national policy, whilst managing the wider service, financial and workforce planning implications these can often present.

Service Reviews

The HSCP is committed to undertaking regular Service Reviews to ensure our Services are: modern, flexible, outcome focused, financially efficient and 'fit for the future', whilst taking account of changing trends, demographics, demands, local and national policy drivers, changing needs, inequalities, good practice, and service user and carer views.

Delivering Safe and Sustainable Services

To identify innovative and smarter ways of working to support the HSCP to deliver on its strategic priorities within budget.

Key Highlights

330+ smartphones and digital skill assessments carried out with Care at Home staff

29 GP practices with 100+ GPs supported by a HSCP liaison role

Successfully procured a replacement social care Case Management System and a Scheduling & Monitoring System for Care at Home

400+ people engaged across our 4 service reviews

Care at Home Transformation Programme

Supported the delivery of the HSCP's Initial Primary Care Improvement Plan

Unscheduled Care – supporting work to reduce demand on hospital services

The maturing of our 6 GP clusters

Supported Financial Planning and Savings to the value of £1.1m

Reporting on Lead Partnership Responsibilities

Renfrewshire HSCP is the lead Partnership for Podiatry and Primary Care Support for NHS Greater Glasgow and Clyde. This means we are responsible for the strategic planning and operational budget of all issues relating to Podiatry across six Health and Social Care Partnerships. We also support primary care contractors within the Board area.

Podiatrists are health care specialists who treat problems affecting the feet and lower limb. They also play a key role in keeping people mobile and active, relieving chronic pain and treating acute infections.

NHS Greater Glasgow and Clyde (NHSGGC) employs approximately 200 podiatrists in over 60 clinical locations spread across the six Health and Social Care Partnerships. The Podiatry Service currently provides over 166,000 treatments each year for around 38,000 patients across the NHSGGC Board area, representing 3.4% of the population.

In 2013, the service set a target that 90% of all new referrals wait less than 4 weeks by April 2016 in order to comply with the 4 week target suggested by the Scottish Government. Since then, the service has consistently achieved 90% for 33 out of the last 36 months.

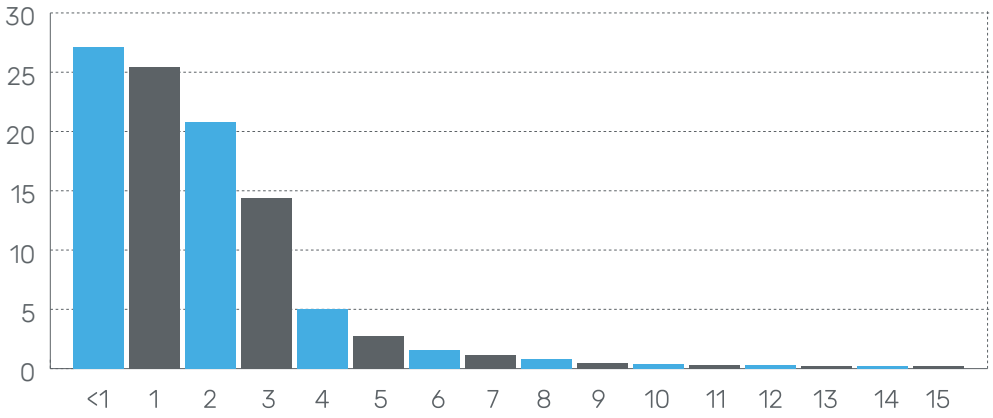
- In 2018/19, 95.4% of new patient referrals were seen within 4 weeks in Renfrewshire – despite an 11% increase in referrals - with 93.5% seen within in 4 weeks in Greater Glasgow and Clyde.

Performance Indicator	2016/17	2017/18	2018/19	Target
Percentage of new Podiatry referrals seen within 4 weeks in Renfrewshire	95.7%	96.6%	95.4%	90%
Percentage of new Podiatry referrals seen within 4 weeks in NHSGGC	96.3%	97.4%	93.5%	90%

The NHSGG&C podiatry service aims to see 90% of foot ulcer referrals within two working days and 45% within one working day of referral.

There has been a 233% increase in the number of referrals from 2015-2019

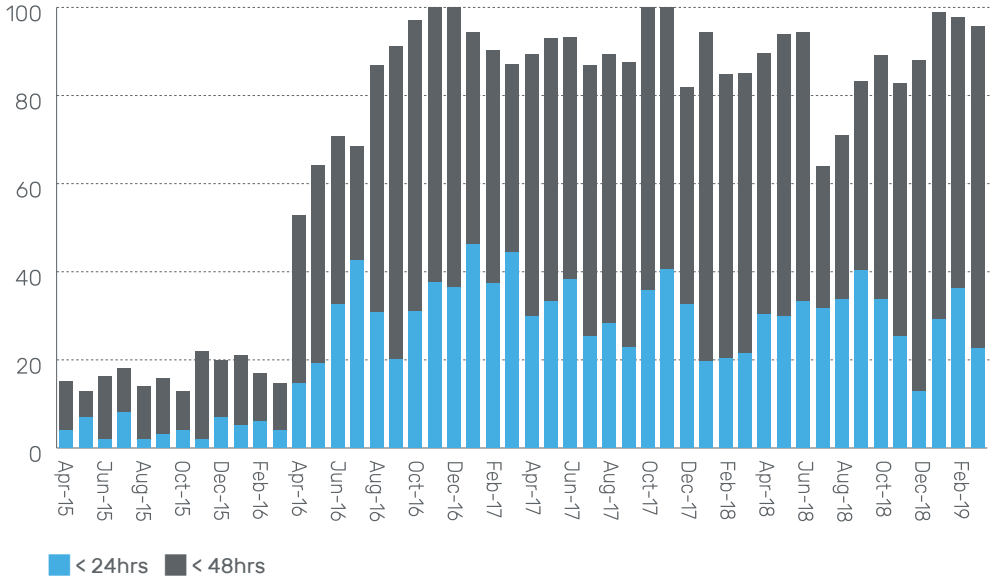
NHSGGC Podiatry Service new patient referrals % seen by weekly intervals 2018-19 (n=41,314)



- In 2018/19, an average of 88.4% of diabetic foot ulcers were treated within two working days and 30% within one working day. This is a decrease of 6% on 2017/18 performance for those seen under two working days and 1.3% of those seen within one working day, due to a 32.5% increase in referrals

Performance Indicator	16/17 Value	17/18 Value	18/19 Value	Target
Percentage of new Diabetic Foot Ulcer referrals seen within 4 weeks in CLYDE Quadrant (Renfrewshire data unavailable)	77.8%	93.7%	91.1%	90%
Percentage of new Diabetic Foot Ulcer referrals seen within 4 weeks in NHSGGC	83.6%	90.5%	87.4%	90%

NHSGG&C Podiatry Service % of foot ulcers seen <24hrs & <48hrs, Apr 15-Mar 19



Primary Care Support

Primary Care Support (PCS) is hosted by Renfrewshire HSCP. The team works across the whole of the NHS Greater Glasgow and Clyde area to support primary care contractors. This includes managing contracts and payments; working with Health and Social Care Partnerships on future planning and any changes to practices; GP appraisal; Practice Nursing Support; and Screening and Immunisation Services. The team works with 238 GP Practices and 184 Optometry premises.

GP Contract

In 2018/19, the Primary Care Support (PCS) Team has been overseeing the implementation of the new GP contract, which means every practice within NHS Greater Glasgow & Clyde (NHSGGC) will be supported by expanded teams of HSCP and NHS Board employed health professionals to support patients who do not need to be seen by a General Practitioner (GP). The Team also provides support and training to GP Clusters and Cluster Quality leads, supporting practices to understand the new ways of working and how to signpost patients appropriately.

Primary Care Improvement Plans

The PCS team has also been supporting all Health and Social Care Partnerships with the ongoing development of their Primary Care Improvement Plans (PCIPs) which take account of local priorities, population needs and existing services. The Team provide advice and oversight on funding arrangements, and ensure effective governance arrangements are in place.

Screening and Immunisation

The Screening and Immunisation Team have continued to achieve core targets in support of immunisation and screening delivery. They have also been supporting the implementation of changes as a result of the Vaccination Transformation Programme, which aims to modernise the delivery of vaccinations to better suit patients' needs. This may mean vaccinations are delivered in local clinics rather than in GP surgeries. The Team has also had significant input into the national Human Papillomavirus Vaccination (HPV) programme and the new Child Health IT system.

Positive progress has been made in 2018/19, with patients benefiting from a range of expert advice and services, accessed more quickly by direct referral from a trained receptionist rather than through the GP.

Palliative Care

In line with the Strategic Framework for Action on Palliative and End of Life Care, our aim is that by 2021 everyone in Renfrewshire who needs palliative care will have access to and benefit from it, regardless of age, gender, diagnosis, social group or location.

Work has been ongoing in this area throughout 2018/19. Examples include:

- **Anticipatory Care Planning (ACP)** supporting people's end of life preferences by ensuring vital information from sensitive ACP conversations and documented in 'My ACP' is transferred to the patient's eKIS record so it can be shared, particularly with Out Of Hours services
- **Scale up of SPARC (Supportive and Palliative Action Register in the Community).** This is a joint Renfrewshire and Healthcare Improvement Scotland (HIS) project around identification and care planning for people who would benefit from a palliative care approach. We have been working with four GPs in Renfrewshire to test this approach, exploring referral pathways and the support available locally for people with stable, changing and end of life palliative care needs based around the Supportive and Palliative Care Action Register (SPAR) approach traffic light model. The SPARC approach has been testing a weekly community Multi-Disciplinary Team to discuss and agree lead service and care coordination actions. These are fed back to GP practices for people with changing needs, and a social prescribing model in partnership with Community Connectors and Gleniffer Outreach for those with stable needs.
- **Introduction of SPAR (Supportive and Palliative Action Register) to Care Homes.** Initially we have been working with nine care homes across Renfrewshire to implement SPAR, which will help with the identification of patients with palliative care needs and will also assist with the conversations that require to take place around ACPs within care homes.
- **District Nurses, Care at Home, Specialist Hospice Services and GPs** are working together to provide end of life care for people in their own homes.
- **Community Connectors** is a social prescribing model within GP practices. All 29 GPs in Renfrewshire now have an assigned Link Worker. Patients with stable palliative care needs will be referred to the Connectors for holistic assessment and onward sign-posting to relevant services in a supportive, self-management approach.

Advice Works Cancer and Palliative Care Service helps people with palliative care needs maximise their income and benefits.

Housing

The right kind of housing in sustainable, attractive places with appropriate housing related services are critical to ensuring people are able to live independently for as long as possible in their own community. In order to help achieve this outcome, housing-led regeneration and new build affordable housing developments are progressing well across Renfrewshire, in partnership with local housing association partners.

- Re-development and re-housing in Johnstone Castle is ongoing and will deliver 95 new Council properties, with two purpose-built wheelchair accessible bungalows and level access lower cottage flats
- Renfrewshire Council is developing 80 new homes in Bishopton, including properties that are adaptable for particular needs
- New plans for Ferguslie Park were approved by the Communities, Housing and Planning Policy Board in October 2018
- In Paisley's West End, Sanctuary Housing Association is nearing completion of the development at the former Co-op site in Wellmeadow Street.

Digital Inclusion

Following on from the success of the Golden Surfer Digital inclusion project, essential digital skills classes have had an ongoing positive impact across the Council's sheltered and amenity housing complexes with attendance steadily increasing throughout the year. Feedback has shown that tenants feel more confident online after this training and felt that the training itself was very good.

Using a bank of technology, older individuals are supported to gain a variety of digital skills, including online banking, internet safety and using email and video calling to stay in touch with family, friends and the wider community. Tenants have also been able to use new devices such as Alexa, Google Home and the latest virtual reality technology. The 'Celebrating Digital in Renfrewshire' event in September 2018 supported those learning digital skills to come together socially and provide a signpost for other people across Renfrewshire to access digital training services. The latest project, 'Lives in Binary' is currently underway and seeks to use digital technology with older adults to capture stories of their lives and history across Renfrewshire.

Make It Your Own

Make It Your Own (MIYO), which commenced in April 2017, is a creative approach to tenancy aimed at helping vulnerable tenants and homeless applicants in Renfrewshire. Delivered by Impact Arts and Housing Support Services, the programme aims to help tenants develop a sense of ownership of their tenancy, ultimately turning it into a welcoming home in which they wish to live and sustain their tenancy. The project engages with individuals on a one to one basis to provide full support, teaching the necessary skills to create a home to be proud of and comfortable to live in. An evaluation was carried out at the end of March 2018 which found that 96% of the referrals who engaged in the Make It Your Own programme have sustained their tenancy.

Inspection of Services

Renfrewshire Health and Social Care Partnership commission several externally provided care and support services. Maintaining a high standard in the quality of service is vital to ensure positive outcomes for our service users.

Monitoring and evaluation play a key part in ensuring these services meet contractual standards and obligations, as well as delivering planned commissioning outcomes on the ground.

External Services

The HSCP has an internal Contract Performance Management Team which monitors externally provided services. A rolling programme of contract monitoring visits cover:

- 10 Supported Living providers
- 22 Care Home Services
- 4 Care Homes for people with Learning/Physical Disabilities
- 7 Care at Home companies
- 11 block funded services covering mental health, carers' services, domestic violence, advocacy and older people.

Through a proactive approach, our Contract Performance Management Team ensure externally contracted organisations are person-centred, safe, effective and sustainable. Services are visited regularly and any performance issues are addressed through jointly negotiated service improvement action plans and follow-up visits.

The team also adopts a reactive practice and keeps a 'watchful eye' on services as the main point of contact for managing significant events, Adult Protection referrals, managing complaints and investigations, and through regular liaison with:

- The Providers on an individual basis or through organising provider forums; and
- The Care Inspectorate through joint working and regular information sharing.

Internal Services

The Partnership directly provides a number of services which 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. The inspectors examine the overall quality of care and support, the staffing, the management and leadership, and the environment in which the care is provided. Inspections are designed to evidence the impact that care has on people's individual experiences.

The Evaluation table provides the grades our services received using a six-point quality scale:

6	Excellent	Outstanding or sector leading
5	Very good	Major strengths
4	Good	Important strengths, with some areas for improvement
3	Adequate	Strengths just outweigh weaknesses
2	Weak	Important weaknesses – priority action required
1	Unsatisfactory	Major weaknesses – urgent remedial action required

Table 1: Evaluation of services as at April 2019

Service name	Theme 1: quality of care & support	Theme 2: quality of environment	Theme 3: quality of staffing	Theme 4: quality of management & leadership
Montrose Care Home	4	6	5	4
Falcon Day Centre	6	5	5	5
Johnstone Day Centre	6	6	5	5
Montrose Day Centre	6	5	5	5
Ralston Day Centre	6	5	5	5
Renfrew Day Centre	5	4	4	5
Mirin Day Opportunities	4	4	4	4
Milldale Day Opportunities	4	4	4	4
Anchor Day Centre	4	5	4	4
Weavers Linn	5	5	6	5
RLDS Gateway Intensive support service	5	5	5	5
Community Networks	5	N/A	5	5
Disability Resource Centre	6	5	6	6
Care at Home services	4	N/A	5	3

In July 2018, the Care Inspectorate introduced a new framework for inspections of care homes for older people. The new approach remains familiar to people who have experienced inspections in recent years, however it better reflects the Scottish Government's new Health and Social Care Standards and provides more transparency around what is expected. The new Quality Framework for Care Homes for Older People is structured around the following five key questions:

1. How well do we support people's wellbeing?
2. How good is our leadership?
3. How good is our staff team?
4. How good is our setting?
5. How well is our care and support planned?

As with previous inspections, the evaluation (grades) of services is based on the six-point scale. The following inspections have been undertaken using this new framework.

Service name	How well do we support people's wellbeing	How good is our leadership	How good is our staff team	Theme 4: quality of management & leadership	How well is care and support planned
Renfrew Care Home	4	not assessed	not assessed	not assessed	4
Hunterhill Care Home	4	not assessed	not assessed	not assessed	4

Financial Performance and Best Value

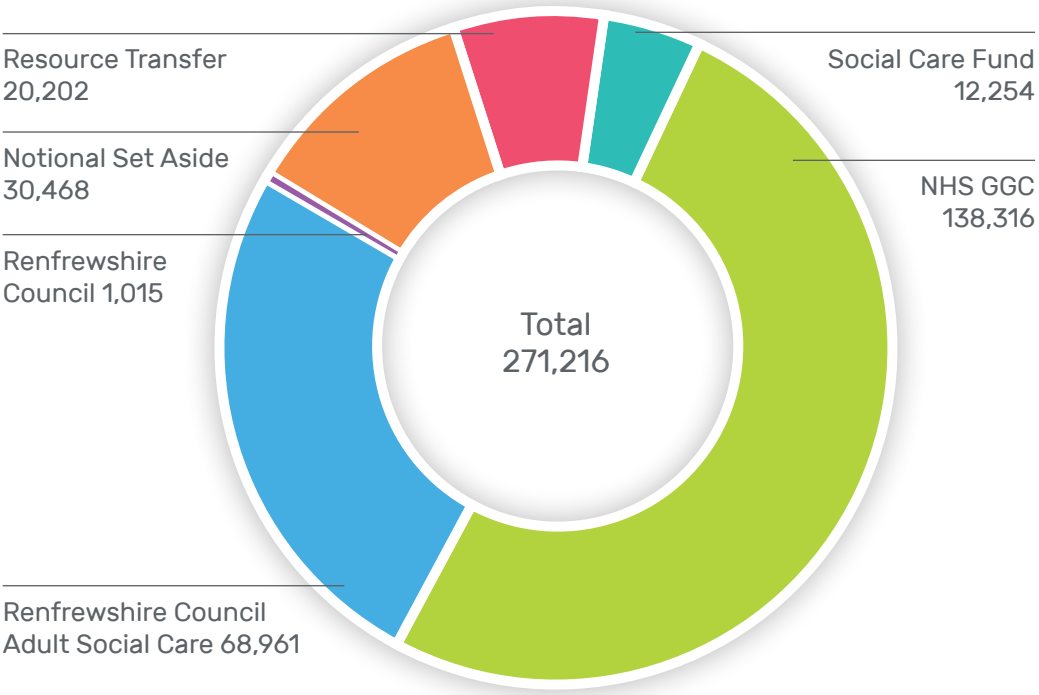
The financial position for public services continues to be challenging, with the IJB operating within ever increasing budget restraints and pressures, reflected in the Integration Joint Board's Financial Plan and regular monitoring reports by the Chief Finance Officer to the Integration Joint Board (IJB).

This also requires the IJB to have robust financial arrangements in place to deliver services within the funding available in year, as well as planning for 2019/20.

Resources Available to the IJB 2018/19

The resources available to the IJB in 2018/19 to take forward the commissioning intentions of Renfrewshire Health and Social Care Partnership, in line with our Strategic Plan, totalled £271.216m. The chart below provides a breakdown of where this funding came from.

Resources Available (£000s)



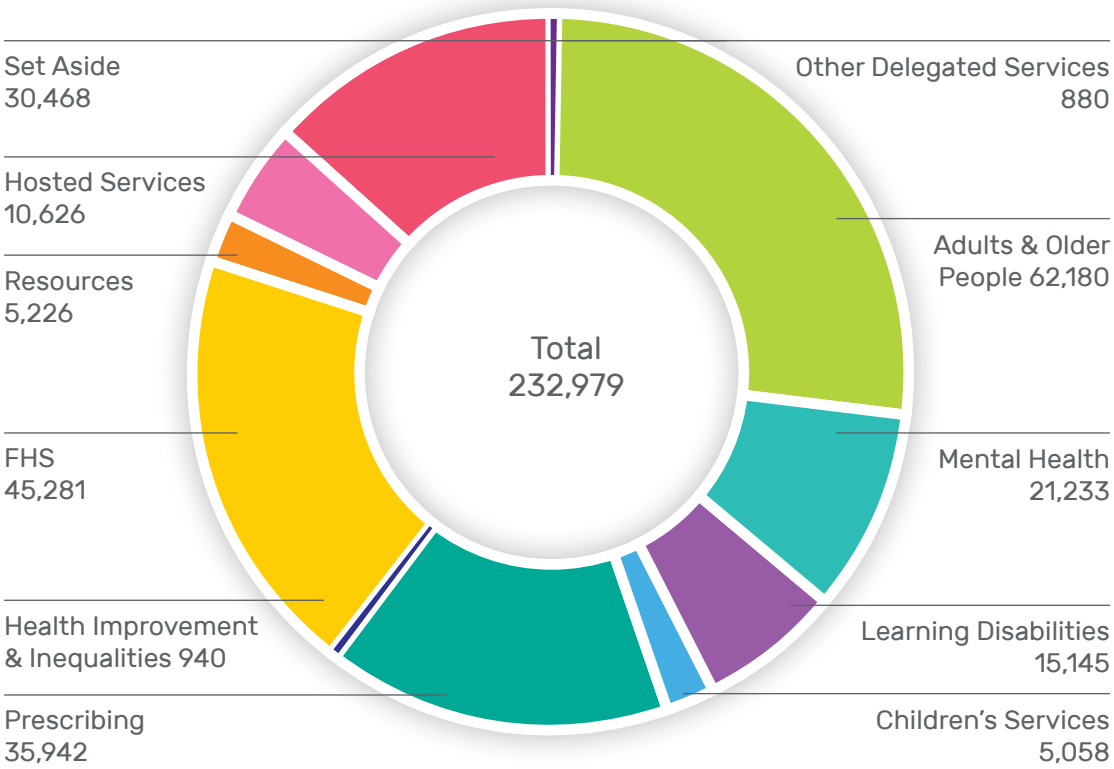
Included within the funding sources above is a 'Large Hospital Services' (Set Aside) budget totalling £30.468m. This is a notional allocation in respect of those functions delegated by the Health Board which are carried out in a hospital within the Health Board area. The IJB is responsible for the strategic planning of these services but not their operational delivery.

Summary of Financial Position

Throughout 2018/19, the Chief Finance Officer's budget monitoring reports to the IJB forecast a breakeven position. This was subject to the drawdown of reserves to fund any delays in the delivery of approved savings, and the transfer of specific ring-fenced monies (including Scottish Government funding for Primary Care Improvement, Mental Health Action 15 and Alcohol & Drug Partnership (ADP) monies), and transfers to earmarked reserves which, relate to commitments made in 2018/19 that will not be fully delivered until future years.

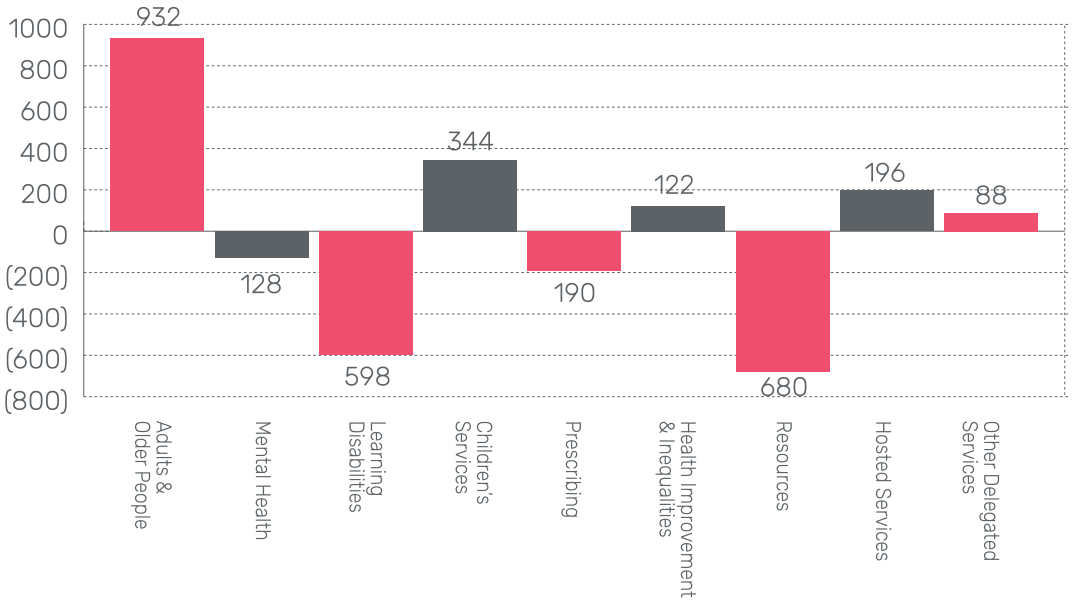
The final HSCP outturn position was an underspend of £1.293m, which includes the flexible use of recurring and non-recurring resources made available by Renfrewshire Council to support the financial sustainability of Adult Social Care services, as well as a draw down from earmarked and general reserves.

The diagram below shows the final outturn position for all delegated Renfrewshire HSCP services in 2018/19.



The following graph summarises the year-end variances, per client group, for all delegated HSCP services in 2018/19.

Year-end Variance £000s



The main broad themes of the final outturn include:

Adults and Older People Underspend £932k

- Care at Home: continued pressures within the Care at Home service, which was subject to a range of strengthened financial governance arrangements put in place by the Chief Officer and Chief Finance Officer early in 2018/19. However, success in minimising delayed discharges has had a significant adverse impact on this budget
- Employee Costs - Adult Social Care: underspend reflecting vacancies throughout all service areas which helped to offset pressures within the Care at Home service
- Addictions (including ADP): underspend reflecting planned hold on recruitment pending the implementation of the review of Addiction Services.

Learning Disabilities - Overspend £598k: overspend due to ongoing pressures within the Adult Placement budget and the historical budget profile versus current client mix.

Children's Services – Underspend £344k: underspend reflects vacancies within School Nursing and Health Visiting.

Resources – Overspend £680k: the mechanism to create reserves from the delegated Health budget to the IJB balance sheet is via the 'resources' account code within the Health ledger. Accounting for reserves through this resource code ensures the client group year-end position is accurate. A number of accounting entries in relation to the draw down and creation of reserves are posted through this code, which resulted in the overall net overspend of £680k.

Enhanced Observations: as part of the 2018/19 Financial Plan, a £900k budget was created for Enhanced Observations and a commitment was made by the management team to work towards reducing these costs in line with this budget, which they successfully delivered. At 31 March 2019, expenditure on enhanced observations was £902k.

Prescribing: with the end of the risk sharing arrangement across NHSGGC Partnerships on 31 March 2018, prescribing costs represent the greatest financial risk to the HSCP, mainly due to the volatility of global markets and the impact of drug tariffs in relation to contracts with community pharmacy.

The year-end position for prescribing was an overspend of £0.640m. Earmarked reserves of £0.450m were drawn down to partially offset this pressure, reducing it to an overspend of £0.190m. As activity data is two months behind the figures in the financial ledger, the year-end adjustments were based on the position as at 31 January 2019.

Financial Outlook, Risks and Plans for the Future

Looking into 2020/21 and beyond, it is anticipated that the public sector in Scotland will continue to face a very challenging short and medium-term financial outlook.

There is significant uncertainty over the scale of this likely reduction in available funding. It is therefore important the Integration Joint Board (IJB) plans for a range of potential outcomes, ensuring sufficient flexibility to sustainably manage the position which emerges over the next few years – with the likely scenario that a significant level of further recurring savings will be required.

Taking into account a range of scenarios, current projections for the two-year period 2020/21 to 2021/22 include a wide range of assumptions in respect of key cost pressures and demand, highlighting a potential budget gap for the Partnership of between £11m to £14m for this period. Subject to clarification over the coming months and years, the Chief Finance Officer (CFO) recommends that the IJB adopts a financial planning assumption to deliver savings between £5m - £7m per annum in the years 2020/21-21/22. This assumed budget gap does not take into account potential additional funding for any pressures from either the Scottish Government or our partner organisations.

Local demographics and socio-economic issues such as poverty, deprivation and inequalities can vary significantly across Renfrewshire, which in turn can impact upon the demand and supply of services in the community. In addition to local pressures, it is important to note the impact of pressures associated with national strategies such as the Scottish Living Wage and local GGC system-wide pressures.

Other key financial risks and pressures for Renfrewshire include:

- The Health Board is required to determine an amount set aside for integrated services provided by large hospitals. Since the Joint Bodies Act came into force, this has not operated fully as the legislation required. The recent Ministerial Strategic Group (MSG) Review of Integration Report (February 2019) proposed that all delegated hospital budgets and set aside requirements must be fully implemented during 2019
- The increased costs of drugs in short supply created an additional financial pressure in the region of £2.1m during 2018/19, and this is projected to remain at a similar level for 2019/20

- A number of new statutory requirements such as the Carers' Act, the Living Wage, free personal care for under 65s, and the National Dementia Strategy are anticipated to create additional financial pressures for the Renfrewshire IJB over 2019/20, some of which cannot yet be fully quantified. Without raising eligibility criteria to manage demand for services, any required funding will need to be redirected from other sources
- Investment in Digital technology is required, creating a further financial pressure. The Health and Social Care Delivery Plan identifies digital technology as key to transforming social care services so care can be more person-centred. Locally all telecare equipment (used to support our most vulnerable service users in their home) must be upgraded from analogue to digital by 2025, creating a pressure of circa £1m
- Unintended consequences of our partner organisations' changes in activity from 2019/20 onwards.

The HSCP will continue to monitor and update these key assumptions and risks to ensure the IJB is kept aware of any significant changes, especially where there is an indication of an increased projection of the current gap.

In addition, there remain wider risks which could further impact on the level of resources made available to the Scottish Government, including the changing political and economic environment within Scotland, the UK, and wider. This could potentially have significant implications for Renfrewshire IJB's parent organisations, and therefore the delegated Heath and Adult Social Care budgets.

These wider strategic risks and uncertainties for the IJB include:

- The impact of Brexit on the IJB is not currently known
- The Scottish Government response to Brexit and the possibility of a second Independence Referendum creates further uncertainty
- The complexity of the IJB governance arrangements has been highlighted by Audit Scotland as an ongoing concern, in particular the lack of clarity around decision-making. The MSG Review of Integration Report acknowledged the challenging environment in which Integration Authorities are operating and made specific proposals around governance and accountability arrangements to be implemented during 2019/20

- A shortage of key professionals including General Practitioners, District Nurses, Mental Health Officers, Psychologists and Care at Home Staff is a current recruitment and retention challenge for Renfrewshire HSCP. Potential impacts include negative effects on:
    - the sustainability of, access to, and quality of services
    - the resilience and health of our existing workforce as they attempt to provide the required level of services with reduced resources
    - the additional cost of using bank and agency staff.

Renfrewshire's Financial Planning Strategy

Given this budget gap, going forward we need to consider the type and level of service required, and that it can be delivered safely and sustainably. We must continue to strive to deliver both a balanced budget and accessible, high quality and safe services. After many years of budget reductions, it is fair and reasonable to state that these dual objectives cannot be assured.

Two key national documents, The Scottish Government's Medium-Term Framework for Health and Social Care, and Audit Scotland's Health and Social Care Integration Review (February 2018), both highlight the need for integrated finance and financial planning to be a core component in shifting the balance of care.

Framed by these two key documents, our Financial Plan reflects the economic outlook beyond 2018/19. It focuses on a medium-term perspective centred on financial sustainability; acknowledging the uncertainty around key elements including the potential scale of savings required, and the need to redirect resources to support the delivery of key priorities set out in our Strategic Plan.

Critical to its delivery is:

1. The implementation of the MSG's proposals for integrated service and financial planning to enable us to deliver and focus on the gaps identified in the Audit Scotland report, and the required environment to deliver the Scottish Government's medium-term strategy; and
2. Delivery of our local medium-term financial strategy.

Ministerial Strategic Group

The recent Ministerial Strategic Group's Review of Progress with Integration of Health and Social Care (February 2019) report highlights integrated finance and financial planning as one of six key features which support integration. The report highlights a number of proposals to ensure "money must be used for maximum benefit across health and social care and to confirm arrangements are in place to support the Scottish Government's Medium-Term Framework for Health and Social Care":

I. Health Boards, Local Authorities and IJBs should have a joint understanding of their respective financial positions as they relate to integration.

II. Delegated budgets for IJBs must be agreed timeously.

III. Delegated hospital budgets and set aside requirements must be fully implemented.

IV. Each IJB must develop a transparent and prudent reserves policy.

V. Statutory partners must ensure appropriate support is provided to IJB S95 Officers.

VI. IJBs must be empowered to use the totality of resources at their disposal to better meet the needs of their local populations.

Locally, Health Boards, Local Authorities and Integration Joint Boards have carried out a self-evaluation to collectively evaluate their current position in relation to the findings of the MSG review. Based on the outcome of this evaluation, an Action Plan will be developed. Actions relating to integrated finance and financial planning will be led by the Chief Officer and Chief Finance Officer, working with the Scottish Government and partner organisations.

Medium Term Financial Strategy

Stemming future demand

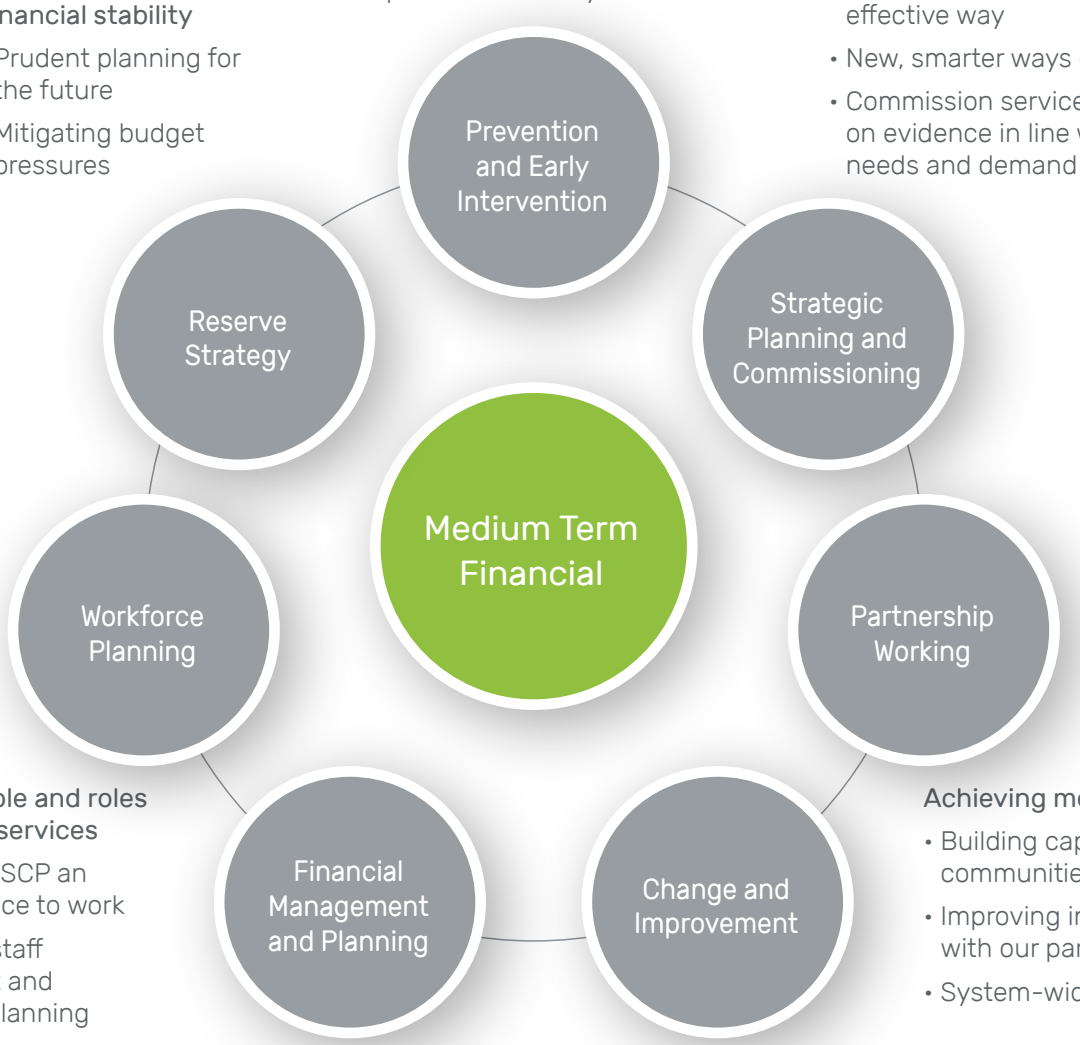
- Creating healthier communities that require less intervention
- Tackling inequalities that create pressure in the system

Aligning our resource to outcome

- Plan and commission our services in the most cost effective way
- New, smarter ways of working
- Commission services based on evidence in line with future needs and demand

Financial stability

- Prudent planning for the future
- Mitigating budget pressures



The right people and roles to deliver our services

- Making the HSCP an attractive place to work
- Investing in staff development and succession planning
- Supporting attendance at work

Achieving more together

- Building capacity in our communities
- Improving interfaces with our partners
- System-wide working

Better value

- Financial management in line with MSG Review
- Robust financial planning process
- Good governance
- Monitoring pressures

Enabling and manging change

- Integrated working and shifting the balance of care
- Delivering on our staturtory requirements and national policy
- Supporting service reviews and redesign
- Delivering safe and sustainable services within budget

Appendix 1

Renfrewshire Integration Joint Board Scorecard 2017/18

National Outcome 1	People are able to look after and improve their own health and wellbeing and live in good health for longer					
Performance Indicator	16/17 Value	17/18 Value	18/19 Value	Target	Direction of Travel	Status
Exclusive breastfeeding at 6-8 weeks	23.1%	23.4%	Qtr.3 24.4%	21.4%	↑	✓
Number of Alcohol brief interventions	779	549	306	-	-	Data only

National Outcome 2	People are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community					
Performance Indicator	16/17 Value	17/18 Value	18/19 Value	Target	Direction of Travel	Status
Percentage of clients accessing out of hours home care services (65+)	89%	89%	89%	85%	–	✓
Average number of clients on the Occupational Therapy waiting list	340	302	349	350	↓	✓
People newly diagnosed with dementia have a minimum of 1 year's post-diagnostic support	100%	100%	100%	100%	–	✓
Number of unscheduled hospital bed days; acute specialties	128,961	130,409	144,712	123,820	↓	●
Number of emergency admissions	22,448	19,681	18,958	18,000	↑	▲
Percentage of long term care clients receiving intensive home care (national target: 30%)	27%	28%	28%	30%	–	▲
Number of delayed discharge bed days	3,205	4,680	6,085	3,200	↓	●
Homecare hours provided - rate per 1,000 population aged 65+	460	459	444	-	-	Data only
Percentage of homecare clients aged 65+ receiving personal care	99%	99%	99%	-	-	Data only
Population of clients receiving telecare (75+) - Rate per 1,000	29.13	39.47	40.17	-	-	Data only
Percentage of routine OT referrals allocated within 9 weeks	-	-	Baseline 52%	-	-	Data only
Number of adults with a new Anticipatory Care Plan	1,847	257	185	-	-	Data only

✓ Target achieved ▲ Warning ● Alert Data only

↑ Improvement ↓ Deterioration – No change

Renfrewshire Integration Joint Board Scorecard 2017/18

National Outcome 3	People who use health and social care services have positive experiences of those services, and have their dignity respected					
Performance Indicator	16/17	17/18	18/19	Target	Direction of Travel	Status
	Value	Value	Value			
Percentage of deaths in acute hospitals (65+)	40.3%	41.9%	42.7%	42%	↓	▲
Percentage of deaths in acute hospitals (75+)	39.2%	40.7%	41.6%	42%	↓	✓
Percentage of patients who started treatment within 18 weeks of referral to Psychological Therapies	100%	100%	94%	90%	↓	✓
Child and Adolescents Mental Health (CAMHS) - % of patients seen within 18 weeks	100%	100%	82.5%	100%	↓	●
A&E waits less than 4 hours	89.5%	84.9%	89.5%	95%	↑	▲
Percentage of staff who have passed the Fire Safety LearnPro module	-	67%	45.6%	90%	↓	●
Percentage of Primary Care Mental Health Team patients referred to first appointment offered within 4 weeks.	95%	79%	86.5%	100%	↑	●
Number of routine sensitive inquiries carried out	319	178	249	-	-	▂▄▆
Number of referrals made as a result of the routine sensitive inquiry being carried out	16	8	1	-	-	▂▄▆

✓ Target achieved ▲ Warning ● Alert ▂▄▆ Data only

↑ Improvement ↓ Deterioration — No change

Renfrewshire Integration Joint Board Scorecard 2017/18

National Outcome 4	Health and social care services are centred on helping to maintain or improve the quality of life of service users					
Performance Indicator	16/17	17/18	18/19	Target	Direction of Travel	Status
	Value	Value	Value			
Reduce the rate of pregnancies for those under 16 years of age (rate per 1,000 population)	3.9	3.1	2.4	3.1	↑	✓
At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation (See Note 1)	89.6%	85.1%	Data recording issue	80%	↓	✓
Uptake rate of child health 30-month assessment	82%	89%	93%	80%	↑	✓
Percentage of children vaccinated against MMR at 5 years	96.4%	97.0%	97.2%	95%	↑	✓
Percentage of children vaccinated against MMR at 24 months	96.2%	95.5%	96.0%	95%	↑	✓
Reduction in the rate of alcohol related hospital stays per 1,000 population	9.9	9.0	7.7	8.9	↑	✓
Emergency admissions from care homes	538	519	576	242	↓	●
Percentage of paediatric Speech & Language Therapy wait times triaged within 8 weeks	100%	100%	100%	100%	–	✓
Alcohol and Drugs waiting times for referral to treatment. % seen within 3 weeks	94.1%	84.9%	71.5%	91.5%	↓	●
Reduce drug related hospital stays - rate per 100,000 population	179.6	156.1	2018/19 data not available until 2020	170	↑	✓
Reduce the percentage of babies with a low birth weight (<2500g)	5.9%	7.0%	Qtr. 3 6.4%	6%	↑	▲
Percentage of children seen within 18 weeks for paediatric Speech & Language Therapy assessment to appointment	47%	73%	63%	100%	↓	●
Emergency bed days rate 65+ (rate per 1,000 population)	297	263	262	-	-	
Number of readmissions to hospital 65+	2,032	1,337	1,368	-	-	

1. Antenatal Care
   There has been a delay with the data from ISD for this indicator and unfortunately the data is still unavailable at year end 2018/19.

Renfrewshire Integration Joint Board Scorecard 2017/18

National Outcome 5	Health and social care services contribute to reducing health inequalities					
Performance Indicator	16/17	17/18	18/19	Target	Direction of Travel	Status
	Value	Value	Value			
Smoking cessation - non smokers at the 3 month follow up in the 40% most deprived areas	197	201	165	139	↑	✓
Exclusive breastfeeding at 6-8 weeks in the most deprived areas	13.6%	14.5%	17.7%	19.9%	↑	●
Number of staff trained in sensitive routine enquiry	-	-	94	-	-	Data only
Number of staff trained in Risk Identification Checklist and referral to MARAC.	-	-	133 (Mental Health, Addictions, Children's Services Staff)	-	-	Data only

National Outcome 6	People who provide unpaid care are supported to reduce the potential impact of their caring role on their own health and wellbeing					
Performance Indicator	16/17	17/18	18/19	Target	Direction of Travel	Status
	Value	Value	Value			
Number of carers accessing training	233	242	229	220	↓	✓
Number of adult support plans completed for carers (age 18+)	-	-	93	-	-	Data only
Number of adult support plans refused by carers (age 18+)	-	-	78	-	-	Data only
Number of young carers' statements completed	-	-	78	-	-	Data only

✓ Target achieved ▲ Warning ● Alert Data only

↑ Improvement ↓ Deterioration — No change

Renfrewshire Integration Joint Board Scorecard 2017/18

National Outcome 7	Health and social care services contribute to reducing health inequalities					
Performance Indicator	16/17	17/18	18/19	Target	Direction of Travel	Status
	Value	Value	Value			
Suicide - rate per 100,000	16	23	Annual figure. Due Autumn 2019	-	-	
Number of Adult Protection contacts received	2,578	2,830	2,723	-	-	
Total Mental Health Officer service activity	200	200	723	-	-	
Number of Chief Social Worker Guardianships (as at position)	107	117	113	-	-	
Percentage of children registered in this period who have previously been on the Child Protection Register	12%	23%	24%	-	-	

National Outcome 8	People who work in health and social care services are supported to continuously improve the information, support, care and treatment they provide and feel engaged in the work they do					
Performance Indicator	16/17	17/18	18/19	Target	Direction of Travel	Status
	Value	Value	Value			
% of Health Care Support Worker staff with mandatory induction completed within the deadline	100%	100%	100%	100%	—	
% of Health Care Support Worker staff with standard induction completed within the deadline	100%	100%	80%	100%	↓	
% of health staff with completed TURAS profile/PDP	68.9%	75.8%	48.7%	80%	↓	
Improve the overall iMatter staff response rate	65%	59%	64%	60%	↑	
% of complaints within HSCP responded to within 20 days	-	76%	81%	70%	↑	
Sickness absence rate for HSCP NHS staff	5.6%	5.5%	5.3%	4%	↑	
Sickness absence rate for HSCP Adult Social Work staff (work days lost per FTE)	3.65	4.34	4.13	2.79 days	↓	
No. of SW employees in the Managing Team and Individual Performance Development process, with a completed IDP	543	909	1,000	-	-	

Renfrewshire Integration Joint Board Scorecard 2017/18

National Outcome 9	Resources are used effectively in the provision of health and social care services, without waste					
Performance Indicator	16/17	17/18	18/19	Target	Direction of Travel	Status
	Value	Value	Value			
Formulary compliance	79.5%	79.7%	78.5%	78%	↓	✓
Prescribing cost per treated patient	New indicator	£83.70	£83.23	£86.63	↑	✓
Total number of A&E attendances	57,244	56,681	61,175	56,119	↓	▲
Care at Home costs per hour (65 and over)	£23.56	£22.40	Annual Indicator Due early 2020	-	-	
Direct Payment spend on adults 18+ as a % of total social work spend on adults 18+	3.7%	4.25%	Annual Indicator Due early 2020	-	-	
Net residential costs per week for older persons (over 65)	£360	£414	Annual Indicator Due early 2020	-	-	
Prescribing variance from budget	0.83% underspent	3.95% over budget	0.5% over budget	-	-	

✓ Target achieved ▲ Warning ● Alert Data only

↑ Improvement ↓ Deterioration — No change

Appendix 2a

Renfrewshire Health & Wellbeing Profile – Scottish Public Health Observatory

Domain	Indicator		Period	Number	Measure	Type	National Average
Life Expectancy & Mortality	1	Life expectancy (Males)[18]	2015	n/a	76.4	yrs	77.1
	2	Life Expectancy (Females)[18]	2015	n/a	80.2	yrs	81.1
	3	All-cause mortality among the 15-44 year olds[12]	2017	72	118.8	sr4	105.8
Behaviours	4	Estimated smoking attributable deaths [3, 13, 16]	2014	347	377.8	sr4	366.8
	5	Smoking prevalence (adults 16+)[3, 14]	2016	50	20.0	%	20.2
	6	Alcohol-related hospital stays[15]	2018	1,472	853.4	sr4	675.7
	7	Alcohol-related mortality[17]	2017	40	23.3	sr4	22.1
Mental Health	8	Population prescribed drugs for anxiety/depression/psychosis	2017	35,024	19.9	%	18.0
	9	Deaths from suicide[17]	2017	23	13.8	sr4	14.2
Social Care & Housing	10	Children looked after by local authority[3]	2017	659	19.4	cr2	14.0
Economy	11	Population income deprived	2017	23,450	13.3	%	12.3
	12	Working age population employment deprived	2017	13,725	12.1	%	10.6
	13	Children Living in Poverty	2016	5,675	16.94	%	16.66
Crime	14	Domestic Abuse[3]	2017	2,230	126.8	cr9	108.1
Women's & Children's Health	15	Teenage pregnancies[12]	2016	144	29.9	cr2	37.7
	16	Women smoking during pregnancy[12]	2017	228	13.8	%	17.3
	17	Child dental health in primary 1	2017	1,268	70.09	%	70.39
	18	Child dental health in primary 7	2017	1,188	68.71	%	71.15
	19	Child obesity in primary 1	2017	1,430	76.72	%	76.48

Source: ScotPHO

Key

%	Percent
cr2	Crude rate per 1,000 population
cr9	Crude rate per 10,000 population
sr4	Age-sex standardised rate per 100,000 populations to ESP2013.
Yrs	Years

Notes

3. Data available down to council (local authority) area only.
12. Three-year average number and 3-year average annual measure.
13. Indicator based on HB boundaries prior to April 2014.
14. Two-year combined number, and 2-year average annual measure.
15. All 6 diagnosis codes used in the analysis.
16. Two-year average number and 2-year average annual measure.
17. Five-year average number and 5-year average annual measure.
18. Three year average for health boards, local authorities and Scotland. Five year average intermediate geographies.

Appendix 2b

Paisley Health & Wellbeing Profile – Scottish Public Health Observatory

Domain	Indicator		Period	Number	Measure	Type	National Average
Life Expectancy & Mortality	1	Life expectancy (Males)[18]	2015	n/a	75.49	yrs	77.1
	2	Life Expectancy (Females)[18]	2015	n/a	79.47	yrs	81.1
	3	All-cause mortality among the 15-44 year olds[12]	2017	35.3	135.41	sr4	105.8
Behaviours	4	Estimated smoking attributable deaths [3, 13, 16]	2014	N/A	N/A	N/A	366.8
	5	Smoking prevalence (adults 16+)[3, 14]	2016	N/A	N/A	N/A	20.2
	6	Alcohol-related hospital stays[15]	2018	758	1,079.5	sr4	675.7
	7	Alcohol-related mortality[17]	2017	19.4	27.86	sr4	22.1
Mental Health	8	Population prescribed drugs for anxiety/depression/psychosis	2017	15,650	21.49	%	18.0
	9	Deaths from suicide[17]	2017	10.6	15.08	sr4	14.2
Social Care & Housing	10	Children looked after by local authority[3]	2017	N/A	N/A	N/A	14.0
Economy	11	Population income deprived	2017	11,145	15.31	%	12.3
	12	Working age population employment deprived	2017	6,825	14.16	%	10.6
	13	Children Living in Poverty	2016	2,550	19.08	%	16.66
Crime	14	Domestic Abuse[3]	2017	N/A	N/A	N/A	108.1
Women's & Children's Health	15	Teenage pregnancies[12]	2016	43	22.46	cr2	37.7
	16	Women smoking during pregnancy[12]	2017	99.33	13.85	%	17.3
	17	Child dental health in primary 1	2017	469	65.69	%	70.39
	18	Child dental health in primary 7	2017	463	67.39	%	71.15
	19	Child obesity in primary 1	2017	559	78.18	%	76.48

Source: ScotPHO

Key

%	Percent
cr2	Crude rate per 1,000 population
cr9	Crude rate per 10,000 population
sr4	Age-sex standardised rate per 100,000 populations to ESP2013.
Yrs	Years

Notes

3. Data available down to council (local authority) area only.
12. Three-year average number and 3-year average annual measure.
13. Indicator based on HB boundaries prior to April 2014.
14. Two-year combined number, and 2-year average annual measure.
15. All 6 diagnosis codes used in the analysis.
16. Two-year average number and 2-year average annual measure.
17. Five-year average number and 5-year average annual measure.
18. Three year average for health boards, local authorities and Scotland. Five year average intermediate geographies.

Appendix 2c

Renfrewshire North, West & South Health & Wellbeing Profile – Scottish Public Health Observatory

Domain	Indicator		Period	Number	Measure	Type	National Average
Life Expectancy & Mortality	1	Life expectancy (Males)[18]	2015	n/a	76.82	yrs	77.1
	2	Life Expectancy (Females)[18]	2015	n/a	81.26	yrs	81.1
	3	All-cause mortality among the 15-44 year olds[12]	2017	36.67	106.6	sr4	105.8
Behaviours	4	Estimated smoking attributable deaths [3, 13, 16]	2014	N/A	N/A	N/A	366.8
	5	Smoking prevalence (adults 16+)[3, 14]	2016	N/A	N/A	N/A	20.2
	6	Alcohol-related hospital stays[15]	2018	714	691.3	sr4	675.7
	7	Alcohol-related mortality[17]	2017	20.8	20.11	sr4	22.1
Mental Health	8	Population prescribed drugs for anxiety/depression/psychosis	2017	20,362	19.58	%	18.0
	9	Deaths from suicide[17]	2017	11.6	11.71	sr4	14.2
Social Care & Housing	10	Children looked after by local authority[3]	2017	N/A	N/A	N/A	14.0
Economy	11	Population income deprived	2017	12,305	11.83	%	12.3
	12	Working age population employment deprived	2017	6,900	10.51	%	10.6
	13	Children Living in Poverty	2016	2,550	19.08	%	16.66
Crime	14	Domestic Abuse[3]	2017	N/A	N/A	N/A	108.1
Women's & Children's Health	15	Teenage pregnancies[12]	2016	47.33	16.53	cr2	37.7
	16	Women smoking during pregnancy[12]	2017	106	10.99	%	17.3
	17	Child dental health in primary 1	2017	799	72.97	%	70.39
	18	Child dental health in primary 7	2017	725	69.58	%	71.15
	19	Child obesity in primary 1	2017	871	75.81	%	76.48

Source: ScotPHO

Key

% Percent

cr2 Crude rate per 1,000 population

cr9 Crude rate per 10,000 population

sr4 Age-sex standardised rate per 100,000 populations to ESP2013.

Yrs Years

Notes

3. Data available down to council (local authority) area only.
12. Three-year average number and 3-year average annual measure.
13. Indicator based on HB boundaries prior to April 2014.
14. Two-year combined number, and 2-year average annual measure.
15. All 6 diagnosis codes used in the analysis.
16. Two-year average number and 2-year average annual measure.
17. Five-year average number and 5-year average annual measure.
18. Three year average for health boards, local authorities and Scotland. Five year average intermediate geographies.

Appendix 3

Benchmarking

Summary and Results

We have measured Renfrewshire's performance against the other Health and Social Care Partnerships within the Greater Glasgow and Clyde area (East Dunbartonshire, East Renfrewshire, Glasgow City, Inverclyde and West Dunbartonshire) and also within our 'Family Group', as determined by Healthcare Improvement Scotland. Our Family Group consists of Stirling & Clackmannanshire, Dumfries & Galloway, Falkirk, Fife, South Ayrshire, South Lanarkshire, Stirling and West Lothian. Councils are arranged in 'family groups' so the comparisons are similar in terms of the type of population (e.g. relative deprivation and affluence) and the type of area (e.g. urban, semi-rural, rural). The point of comparing like with like is more likely to lead to useful learning and improvement.

We have used the most recent National Core Suite of Integration Indicators data (Appendices 3a and b) and the most up to date data from the ScotPHO Health and Wellbeing Profiles (Appendices 3c and 3d). These present a range of indicators to give an overview of health and its wider determinants at a local level and are updated quarterly, annually and bi-annually depending on the frequency of the data.

Results highlighted in pink are the same as the Scottish average; green is better than the Scottish average; orange is less than the Scottish average; while blue highlights the best Group result.

National Core Integration Indicators – Family Group – Appendix 3a

As at December 2018, Renfrewshire has the best Group result for two indicators:

- Readmission to hospital within 28 days
- Number of days people aged 75+ spend in hospital when they are ready to be discharged, per 1,000 population.

Renfrewshire has better results than the Scottish average for five indicators:

- Percentage of people with positive experience of the care provided by their GP
- Emergency bed day rate per 100,000 population for adults
- Falls rate per 1,000 population aged 65+
- Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections
- Percentage of adults with intensive care needs receiving care at home.

Health and Wellbeing Profile Indicators – Family Group – Appendix 3c

Renfrewshire's results are below the Scottish average in all but two indicators, deaths from suicide (rate per 100,000 population) and child healthy weight in primary 1.

Health and Wellbeing Profile Indicators – Greater Glasgow & Clyde HSCPs – Appendix 3d

Renfrewshire's results are better than the Scottish average for child healthy weight in primary 1 and deaths from suicide, with both rates just fractionally higher than the GG&C average.

Appendix 3a

National Core Integration Indicators Benchmarking - HSCP Family Group

	Indicator	Scotland	Renfrewshire	Stirling	Clack'shire	Dumfries & Galloway	South Ayrshire	South Lanarkshire	West Lothian	Fife	Falkirk
1	Percentage of adults able to look after their health very well or quite well	93	93	94	93	93	94	92	92	94	92
2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	81	79	84	77	85	82	81	80	82	83
3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	76	73	73	74	80	77	69	77	74	76
4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	74	71	76	77	83	85	74	76	75	72
5	Total % of adults receiving any care or support who rated it as excellent or good	80	76	79	75	85	85	78	84	81	81
6	Percentage of people with positive experience of the care provided by their GP practice	83	84	86	87	86	88	81	75	81	81
7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	80	79	81	76	86	87	82	82	80	78
8	Total combined % carers who feel supported to continue in their caring role	37	36	38	39	40	36	32	42	32	37
9	Percentage of adults supported at home who agreed they felt safe	83	81	88	83	87	85	82	85	84	84
10	Percentage of staff who say they would recommend their workplace as a good place to work	INDICATOR UNDER DEVELOPMENT									
11	Premature mortality rate per 100,000 persons; by calendar year	425	473	360	410	381	380	431	410	427	427
12	Emergency admission rate per 100,000 population for adults	12,201	12,440	9,805	11,778	13,218	17,824	14,467	11,758	13,212	12,203
13	Emergency bed day rate per 100,000 population for adults	130,828	118,646	105,552	125,754	135,300	159,165	118,211	105,569	119,780	136,689
14	Readmission to hospital within 28 days	102	88	100	106	93	125	97	107	114	118

Appendix 3a continued

National Core Integration Indicators Benchmarking - HSCP Family Group

	Indicator	Scotland	Renfrewshire	Stirling	Clack'shire	Dumfries & Galloway	South Ayrshire	South Lanarkshire	West Lothian	Fife	Falkirk
15	Proportion of last 6 months of life spent at home or in a community setting	88%	88%	88%	87%	88%	87%	88%	88%	89%	86%
16	Falls rate per 1,000 population aged 65+	23	22	21	20	19	24	23	19	27	23
17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	82%	87%	92%	97%	81%	80%	83%	85%	86%	86%
18	Percentage of adults with intensive care needs receiving care at home	61	62	66	68	65	65	62	67	50	63
19	Number of days people aged 75+ spend in hospital when they are ready to be discharged, per 1,000 population	792	211	539	647	565	1,269	956	1,300	557	1,132
20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	24%	25%	23%	24%	26%	28%	24%	23%	26%	24%

Same as Scottish average
Better than Scottish average
Best result of Group
Worse than Scottish average

NB: Indicators 12, 13, 14, 15, 16, 19 and 20 show data for the 2018 calendar year, while data for indicators 11, 17 and 18 data is for the financial year 2018/19

Appendix 3b

National Core Integration Indicators Benchmarking - Greater Glasgow and Clyde HSCPs

	Indicator	Scotland	Renfrewshire	Glasgow City	East Renfrewshire	East Dunbartonshire	West Dunbartonshire	Inverclyde
1	Percentage of adults able to look after their health very well or quite well	93	93	90	94	96	91	91
2	Percentage of adults supported at home who agreed that they are supported to live as independently as possible	81	79	82	74	84	81	80
3	Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	76	73	80	64	86	80	77
4	Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	74	71	77	60	84	79	79
5	Total % of adults receiving any care or support who rated it as excellent or good	80	76	79	77	84	81	83
6	Percentage of people with positive experience of the care provided by their GP practice	83	84	86	84	90	85	83
7	Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	80	79	80	76	83	79	77
8	Total combined % carers who feel supported to continue in their caring role	37	36	38	37	41	40	40
9	Percentage of adults supported at home who agreed they felt safe	83	81	85	82	87	89	84
10	Percentage of staff who say they would recommend their workplace as a good place to work	INDICATOR UNDER DEVELOPMENT						
11	Premature mortality rate per 100,000 persons; by calendar year	425	473	614	301	313	514	567
12	Emergency admission rate per 100,000 population for adults	12,201	12,440	12,957	10,368	11,298	13,788	14,757
13	Emergency bed day rate per 100,000 population for adults	130,828	118,646	135,669	114,744	111,003	129,319	155,146
14	Readmission to hospital within 28 days	102	88	96	79	73	91	92

Appendix 3b continued

National Core Integration Indicators Benchmarking - Greater Glasgow and Clyde HSCPs

	Indicator	Scotland	Renfrewshire	Glasgow City	East Renfrewshire	East Dunbartonshire	West Dunbartonshire	Inverclyde
15	Proportion of last 6 months of life spent at home or in a community setting	88%	88%	88%	86%	89%	89%	87%
16	Falls rate per 1,000 population aged 65+	23	22	30	24	25	27	25
17	Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	82%	87%	86%	84%	81%	89%	87%
18	Percentage of adults with intensive care needs receiving care at home	61	62	55	63	67	70	63
19	Number of days people aged 75+ spend in hospital when they are ready to be discharged, per 1,000 population	792	211	417	162	361	294	106
20	Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	24%	25%	25%	22%	22%	22%	25

Same as Scottish average
Better than Scottish average
Best result of Group
Worse than Scottish average

NB: Indicators 12, 13, 14, 15, 16, 19 and 20 show data for the 2018 calendar year, while data for indicators 11, 17 and 18 data is for the financial year 2018/19

Appendix 3c

Health and Wellbeing Profile Indicators Benchmarking - HSCP Family Group

	Indicator	Scotland	Renfrewshire	Stirling	Clack'shire	Clack'shire & Stirling	Dumfries & Galloway	South Ayrshire	South Lanarkshire	West Lothian	Fife	Falkirk
1	Alcohol related hospital stays*	675.7	853.4	419.5	614.3	489.1	476.7	758.1	706.6	600.2	651.9	543.7
2	Alcohol related mortality*	20.2	23.3	16.5	19.7	17.7	11.8	14.1	21.9	18.4	17.3	16.4
3	Babies exclusively breastfed at 6-8 weeks (%)	29.7	22.2	38.4	19.4	28.3	25.8	21.2	21.7	27.3	27.5	20.3
4	Child healthy weight in Primary 1 (%)	76.5	76.7	78.5	75.6	77.3	74.9	78.0	77.0	75.5	76.0	77.0
5	Deaths from suicide*	13.3	13.2	10.5	21.7	14.6	12.0	10.9	11.6	11.5	14.8	16.9
6	Drug related hospital stays*	146.9	162.6	119.8	116.8	119.2	138.7	192.2	118.5	142.1	188.7	100.8
7	Life expectancy females	81.1	80.2	82.3	80.6	N/A	81.8	80.8	80.7	80.8	81.2	80.6
8	Life expectancy males	77.1	76.4	78.7	76.7	N/A	77.8	77.5	76.8	78.3	77.6	77.3
9	Healthy birth weight (%)	83.5	82.4	84.2	82.4	83.5	82.2	79.9	83.0	81.5	83.3	84.7
10	Patients with emergency hospitalisations	7,601.0	8,504.2	6,415.6	7,004.4	6,606.2	7,482.7	9,451.2	8,423.3	8,118.5	7,407.5	7,389.3
11	Population prescribed drugs for depression/anxiety/ psychosis (%)	18.5	19.9	15.9	21.2	17.8	18.7	20.8	20.6	18.9	19.2	19.7

Same as Scottish average
Better than Scottish average
Best result of Group
Worse than Scottish average

* rate per 100,00 population

Appendix 3d

Health and Wellbeing Profile Indicators Benchmarking - Greater Glasgow & Clyde HSCPs

	Indicator	Scotland	GG&C	Renfrewshire	Glasgow City	East Renfrewshire	East Dunbartonshire	West Dunbartonshire	Inverclyde
1	Alcohol related hospital stays*	675.7	990.8	853.4	1,232.8	413.3	468.9	1,065.1	1,050.2
2	Alcohol related mortality*	20.2	27.6	23.3	34.9	12.9	11.9	27.4	31.1
3	Babies exclusively breastfed at 6-8 weeks (%)	29.7	26.7	20.9	25.9	40.3	32.7	17.4	15.1
4	Child healthy weight in Primary 1 (%)	76.5	77.5	76.7	75.8	83	80.0	79.4	77.7
5	Deaths from suicide*	13.3	13.0	13.2	14.0	9.6	10.4	13.4	14.5
6	Drug related hospital stays*	146.9	197.7	162.6	242.1	57.9	65.1	197.3	304.4
7	Life expectancy females	81.1	80.1	80.2	78.9	83.5	83.5	78.8	80.1
8	Life expectancy males	77.1	75.3	76.4	73.4	80.1	80.1	74.7	75.6
9	Healthy birth weight (%)	83.5	85.1	82.4	85.9	85.0	84.4	84.7	85.7
10	Patients with emergency hospitalisations*	7,601.0	8,594.5	8,504.2	9,404.2	6,762.1	7,212.1	8,499.6	8,753.0
11	Population prescribed drugs for depression/anxiety/ psychosis (%)	18.5	19.9	19.9	20.4	16.2	17.5	21.8	22.0

Same as Scottish average
Better than Scottish average
Best result of Group
Worse than Scottish average

* rate per 100,00 population

Brighter futures

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