Annual Performance Report 2017/18

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

Brighter futures

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Message from David Leese, Chief Officer

Our aim is to improve the health and wellbeing of the people of Renfrewshire. We will do this by working in partnership to treat the person as well as the condition and to deliver the right service, at the right time and in the right place.

Welcome to Renfrewshire Health and Social Care Partnership's Annual Performance Report 2017/18.

Now in our second year as a Partnership, we will use the report to measure our performance against a set of National Outcomes and Performance Indicators and to help plan and improve our services going forward. We report regularly on our progress and these reports, along with our Annual Performance Reports, can be found on the Renfrewshire HSCP website at: https://goo.gl/i7Uyd7

Key achievements

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

- A major communications 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 a wide range of health and care services. We hope to reduce demand on A&E services and GPs through this work to keep people out of hospital and well supported in their own homes and communities
- The maturing of our six GP clusters in Renfrewshire (two in Paisley and four covering the rest of Renfrewshire). Activity includes supporting local care homes to appropriately minimise use of hospital services and reduce admissions and readmissions. We are also working with high users of health and care services to optimise how their needs are met, promoting preventative and anticipatory care planning and reducing reliance on unscheduled care
- A Joint Inspection of Adult Health and Social Care Services in Renfrewshire took place between October and December 2017. This proved to be a positive process with good staff engagement and the Care Inspectorate and Healthcare Improvement Scotland agreed with our self assessment that Quality Indicators 1 and 6 were Level 4 – Good. The report highlighted that the Partnership is making significant progress on improving residents' health and social care services. See more detail on the joint inspection on page 10.
- We exceeded our target for reducing alcohol related hospital stays for the period April 2017 to March 2018 at a rate of 8.3 per 1,000 population aged 16+ (target 8.9). This is the lowest rate achieved since January 2009. Maintaining this will be challenging, but it is a positive improvement.

- A successful 'test of change' took place in 2017/18 where District Nurses delivered flu vaccinations to housebound patients in partnership with 14 GP practices. This programme will be extended to all 29 Renfrewshire GP practices in 2018/19
- Community Connectors is a link worker model that was introduced into three GP practices in Renfrewshire in 2016/17 to test how to more appropriately connect a range of people into the right services. The aim was to relieve pressure on GPs and to provide information and support to patients for issues that were not medical in nature, and to help people take responsibility for their own health and wellbeing. Community Connectors will now be rolled out in all GP practices in Renfrewshire over the next three years. Find out more about how they help patients in our Case Study on page 18.

Tell us what you think

We really appreciate your feedback. Responses to our feedback questionnaire on last year's report were positive and we have taken on board suggestions in shaping 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 2017/18 report.

Finally, I would like to thank all HSCP staff and volunteers for their continued hard work, dedication and professionalism, and for going the extra mile when most needed. We faced some real challenges through the year when our services were tested – for example during the period of adverse weather in February and March 2018, our staff were exceptional in ensuring the health and social care needs of local people continued to be met.

David Leese

David Leese
Chief Officer
Renfrewshire Health & Social Care Partnership

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

In order to deliver our vision, our Strategic Plan describes the themes and high level priorities which direct the Partnership over the three year period 2016-19. Our three strategic priorities are:

- Improving health and wellbeing
- The right service, at the right time, in the right place
- Working in partnership to treat 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.

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. We also have a number of smaller working groups which enable members to have a voice in influencing and improving health and social care service delivery.

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

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.

Outcome 1	People are able to look after and improve their own health and wellbeing and live in good health for longer.
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.
Outcome 3	People who use health and social care services have positive experiences of those services, and have their dignity respected.
Outcome 4	Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.
Outcome 5	Health and social care services contribute to reducing health inequalities.
Outcome 6	People who provide unpaid care are supported to look after their own health and wellbeing, including reducing any negative impact of their caring role on their own health and wellbeing.
Outcome 7	People using health and social care services are safe from harm.
Outcome 8	People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.
Outcome 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 2016-19 and Financial Statement.

We aim to continuously build on our commitment to community engagement and participation, creative learning, equalities, diversity and inclusion, and adapt 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 (p14-22): for those who want to see how the Partnership makes a difference in the lives of individuals and families and highlights more outcome based performance.

Care Groups (p34-59): for those who are interested in particular services including addictions, learning disabilities, carers, and mental health.

National/Local Outcomes (p83-94): 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. 2017/18 has been a financially challenging year and we have detailed our financial position and how we have delivered best value whilst having to make difficult budget decisions.

Renfrewshire HSCP has lead Partnership responsibility for Podiatry and Primary Care Support across NHS Greater Glasgow and Clyde. This report features some of the excellent work provided by these services for the largest NHS Board in Scotland.

As we move into our third year of integration, we continue to highlight the significant benefits of joint working and show that our services provide high quality, effective care and support to the people of Renfrewshire.

Benchmarking

In 2018/19 we plan to establish relationships with other Health and Social Care Partnerships to compare Renfrewshire's performance with similar HSCP areas identified by Health Improvement Scotland (HIS). Renfrewshire is in a 'family group' with Clackmannanshire and Stirling, Dumfries and Galloway, South Ayrshire, South Lanarkshire, West Lothian, Fife and Falkirk. We will identify a number of key indicators and compare our performance against these areas. By sharing good practice and learning, we hope to improve performance where possible.

Joint Inspection of Adult Health and Social Care Services in Renfrewshire

Scottish Ministers have asked the Care Inspectorate and Healthcare Improvement Scotland to report on the effectiveness of the Strategic Plans prepared by integration authorities, from April 2017.

At this early stage in the integration of health and social care the aim is to ensure the building blocks are in place to plan, commission and deliver high quality services in a co-ordinated and sustainable way, namely:

- A shared vision
- Leadership of strategy and direction
- A culture of collaboration and partnership
- Effective governance structures
- A needs analysis on which to plan and jointly commission services
- Robust mechanisms to engage with communities
- A plan for effective use of financial resources
- A coherent integrated workforce plan, which includes a strategy for continuous professional development and shared learning.

The purpose of this inspection is to help Renfrewshire Health and Social Care Partnership to answer the question “How well does the organisation plan and commission services to achieve better outcomes for people?”

To do this, the inspectors assess the vision, values and culture across the Partnership, including leadership of strategy and direction, operational and strategic planning arrangements (including progress towards effective joint commissioning) and improvements the Partnership is making in both health and social care, in respect of services provided for all adults.

The joint inspection took place between October and December 2017. In preparation for the inspection, the Partnership undertook a self-evaluation across the following Quality Indicators identified by the Care Inspectorate and Healthcare Improvement Scotland:

- Quality Indicator 1 - Key performance outcomes
  – 1.1 Improvements in Partnership performance in both health and social care
- Quality Indicator 6 – Policy development and plans to support improvement in service
  – 6.1 Operational and strategic planning arrangements
  – 6.5 Commissioning arrangements
- Quality Indicator 9 – Leadership and direction that promotes partnership
  – 9.1 - Vision, values and culture across the Partnership
  – 9.2 - Leadership of strategy and direction.

The Partnership self-evaluated each of the Quality Indicators at 'Level 4 – Good', using the Care Inspectorate/Healthcare Improvement Scotland's six point scale below:

Level 6	Excellent	Outstanding or sector leading
Level 5	Very good	Major strengths
Level 4	Good	Important strengths with areas for improvement
Level 3	Adequate	Strengths just outweigh weaknesses
Level 2	Weak	Important weaknesses
Level 1	Unsatisfactory	Major weaknesses

The self-evaluation together with supporting evidence and examples of good practice were submitted to the Inspection Team on 27 October 2017. Following this, inspectors carried out a series of onsite scrutiny sessions with staff, partners, providers, carers and service users.

In addition, a staff survey was undertaken by the inspectors, the results of which have informed the inspection report. The results of the survey were presented to the Health and Social Care Senior Management Team on 10 November 2017. At that time the response rate (34%) was the highest received by the inspection team nationally and it was also noted the overall response to the questions was more positive than the national average.

On 18 April 2018, the Care Inspectorate and Healthcare Improvement Scotland published their findings from the inspection in the report 'Joint Inspection (Adults) -the Effectiveness of Strategic Planning in Renfrewshire'.

The report notes that Renfrewshire Health and Social Care Partnership is making significant progress on improving residents' health and social care services. It also agrees with the self-assessment that Quality Indicators 1 and 6 are Level 4 – Good. In advance of the Inspection, the Partnership was advised that Quality Indicator 9 would not be given a formal grade, however comments on this indicator have been provided within the report.

On the whole, the report is positive and highlights the following:

Key Performance Outcomes

The Partnership has a robust, structured approach to monitoring progress in performance. Regular reports are produced and reviewed by senior managers and the Integration Joint Board (IJB). Exception reports are also produced for the IJB.

Areas for further development include gathering more feedback from our service users and benchmarking our performance against other Partnerships across the country.

Strategic Planning and Commissioning Arrangements

The Partnership has completed a joint strategic needs analysis, supporting the development of its joint strategic plan and related plans. It has also developed a range of early intervention and support services for adults and their carers.

Areas for further development include working with the local community and other stakeholders to develop a cross-sector Market Facilitation Plan and develop joint robust quality assurance systems.

Leadership and Direction that supports Partnership

The Partnership has a clear vision, which is understood and shared by all grades of staff. There is a strong commitment to the delivery of health and social care services in line with this vision.

Members of the senior management team are highly visible, and supportive of frontline staff. Joint working is promoted, and a culture of integrated working is evident. The joint working is contributing to the delivery of positive outcomes for people experiencing health and social care services.

An area identified for further development was carrying out a training needs analysis with IJB members and developing a structured programme of sessions for members.

Next Steps

The Integration Joint Board has agreed an improvement plan and the actions identified will be driven forward by the HSCP. An update will be provided as part of the Annual Performance Report 2018/19.

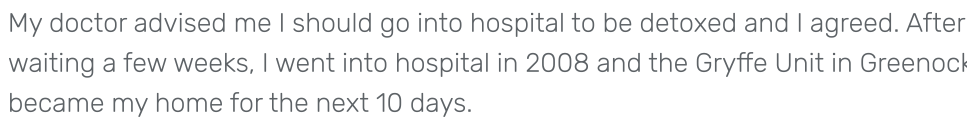
The full Joint Inspection (Adults) -the Effectiveness of Strategic Planning in Renfrewshire report is available at: https://goo.gl/CCknjm

Case Studies

The following case studies show how the HSCP and its partners make a difference in the lives of individuals and families.

Addictions

My life was out of control. Alcohol was my best friend, but it was killing me. My doctor told me to change my ways or I would be dead within five years, but it still took me three years to ask my GP for help.



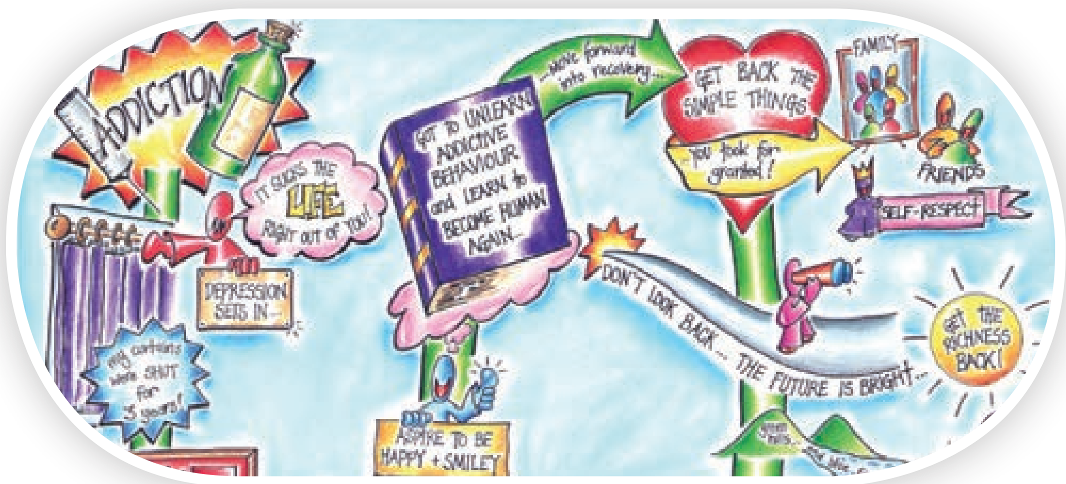
My doctor advised me I should go into hospital to be detoxed and I agreed. After waiting a few weeks, I went into hospital in 2008 and the Gryffe Unit in Greenock became my home for the next 10 days.

After my detox I attended the Alcohol Problems Clinic (APC) at Dykebar Hospital three times per week. This is where I joined a group set up specifically for women. I attended on a regular basis but then the group stopped meeting which left a big gap for me. This is when I decided, along with some other women from the group, to set up Route 66 and continue to offer support to women who were affected by alcohol. The group continues to meet at the Renfrewshire Council for Alcohol (RCA) Trust in Paisley.

Through Route 66 I found out about Renfrewshire Alcohol and Drug Partnership (ADP) and together we came up with the idea of opening a Recovery Café in Paisley. So with the help of the ADP and other volunteers, the Sunshine Recovery Café was born. The Café has been running for five years and has supported hundreds of people who are affected by addiction. Due to its success, our hard work was recently acknowledged by Renfrewshire Health and Social Care Partnership (HSCP) and NHS Greater Glasgow and Clyde when we won the 'Chairman's Award for Excellence'.

As a result of my own life experience, I was asked to join a Planning Group set up by the HSCP. This was a great opportunity for me to help others in my community. I was also asked to be on the organising committee of the Conversation Café event held in 2016 by the ADP. This was an empowering time for me. I gave a speech to over 100 people, all of whom listened to my story and gave me a big round of applause afterwards. My daughter was also there and said "I'm very proud of you, mum". This is what motivates me to move forward in my journey and keep helping others who are in a similar situation.

In 2016, I applied and was accepted to do the Peer2Peer certificate which meant attending university to study for a professional development award. I was also given the opportunity to accept a paid placement within the Torley Unit (previously called the Alcohol Problems Clinic), which was fantastic. I was treated like any other member of staff. They did not judge me even though I had come through this service at the beginning of my own recovery journey many years before.



I spent nine months at the Torley Unit, working with many different people at different stages of their recovery. I shared my story and they shared theirs. This allowed me to build trust and connections in my role. People with addictions have a lot of respect for peer workers as they know they have been through similar experiences to them in their own addiction.

My placement at the Torley Unit came to an end which gave me the confidence to successfully apply for a Peer Support Worker post at Leverndale Hospital. This post took me out of my comfort zone as I was working with people who have addiction and mental health issues.

The best thing I ever did was admit I had an alcohol problem and from there my journey in recovery began. Today I'm 9 years 5 months in Recovery and I enjoy my life. Alcohol today is my biggest enemy but Recovery is my Life.

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

Care and Repair

Bridgewater Housing Association in Erskine provides the Care and Repair service on behalf of Renfrewshire Council, providing advice, assistance and practical support to owner occupiers and private tenants who are older or have disabilities.

An Occupational Therapy assessment was made to Care & Repair to adapt a ground floor toilet at the home of a 7 year old boy with cerebral palsy. Despite his condition, he is fiercely independent and loves to play football. After a long and frustrating search by his parents to find a football team that would allow him to take part, a Scottish Premier League club welcomed him into their team.

When he went to the toilet, he had to use a platform with handrails on both sides to lift him high enough for the WC. This equipment was donated by a Cerebral Palsy Charity. The platform then had to be dragged by one of his parents to the other side of the room to allow him to wash his hands. It was decided after consultation with the OT that as well as installing a wet floor shower area, we should re-position the wash hand basin next to the WC so he could access both from his platform. Due to the size of the room we were also able to form a large showering area he was able to use almost without any assistance, after being provided with a specialist shower chair by another charitable organisation.

His parents have another two children and while Dad works full time and Mum works part time, money is still very tight. The minimum grant available is 80% and we hoped a means test would result in this percentage increasing. Unfortunately it did not and the family were faced with paying a shortfall of £780, which was unaffordable. After some discussion we agreed to make a contribution of £500 from our own Hardship Fund (funded by donations from clients and businesses) to reduce their contribution.

The whole process took four months and the family could not be happier with the outcome. Mum said:

"We appreciate all the help we received so much. The adaptation has made such a difference to our son's life. He is becoming much more independent which has made him so much happier in himself."

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.**

Rehabilitation and Enablement Services

Mrs T, in her late 70s, was referred to the Renfrewshire Rehabilitation and Enablement Services (RES) Team from the Royal Alexandra Hospital Stroke Outreach physiotherapy service.

Mrs T required further physio rehab following a stroke, which had resulted in a severe loss of mobility and function on her left side. Prior to the stroke, Mrs T had lived with her husband in a cramped first floor flat.

Already aware of unrealistic expectations from Mrs T and her husband, both of whom expected her to be able to walk on her own unaided; they also seemed unaware of the high falls risk posed by her very poor balance. Indeed at the point of referral, two months post stroke, Mrs T had shown minimal improvement in function, balance and mobility. Initial review involved negotiations regarding physiotherapy input being dependent upon functional improvement within agreed timescales which Mrs T and her husband both accepted.

Over the period of rehabilitation, Mrs T's sitting and dynamic balance did not improve and she continued to require maximum support from one person to walk short distances with her walking frame (her husband and family were encouraged to be present during rehab sessions to witness firsthand the amount of support she required and to be aware of the lack of improvement). Her balance also remained erratic and she was not safe to walk with her husband due to his health problems. Younger family members were taught how to walk with her over short distances.

Further input then focused on liaising with the Occupational Therapist from the Housing Service when as a result she was moved to a wheelchair accessible ground floor flat; with her carers providing equipment for transfers and an electric wheelchair provided by Westmarc; and her husband and family to allow her to get out and about with ease, without the days of planning it had previously required.

Although Mrs T and her husband's initial goals/expectations were not met, they were delighted with the improved independence and quality of life achieved. This also highlights the benefits of joint working in terms of improving outcomes for patients and their families.

Outcome 3

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

Community Connectors

Ms M, in her late 50s, had major heart surgery four years ago and, after losing her job, was suffering from low mood and low self-esteem.

A protracted legal battle in relation to her job which resulted in financial hardship led to her being unable to see any future for herself in the job market. She visited her GP who referred her to the Link Worker attached to the practice – initially to try to support her with the low mood and to help her gain some structure to her days.

The Link Worker successfully worked with Ms M to increase her confidence and self-esteem and as a result Ms M referred herself to the Recovery Across Mental Health (RAMH) counselling service. This service enabled her to cope with the changes in her life and, after a period of time, Ms M also felt confident enough to refer herself to the RAMH employability service. This has resulted in Ms M now enjoying volunteering with a local third sector organisation.

Ms M has stated that she feels well supported by her peers and is happy in her volunteering role. She has reported reduced anxiety and increased self-esteem and confidence and will receive support from the RAMH employability service for as long as is required.

Before being referred to the Link Worker, Ms M visited her GP 17 times in one year. After her referral, she visited her GP five times in a year, and saw the Link Worker on six occasions.

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.**

Transition from Children's to Adult Services

Mr O is a young person who was looked after and accommodated from the age of 15. It was quickly identified that it would be likely that Mr O would need support into adulthood due to learning difficulties.

However, historically there had been poor engagement with education and health services and as such there had been no formal assessment of his ability to understand and retain information, make good decisions for himself, and safely manage his finances. At the age of 16, during a short stay within a secure residential setting, Mr O was referred to the Renfrewshire Learning Disability Service (RLDS) who allocated a Clinical Psychologist. This allowed a formal assessment to take place which confirmed that Mr O met the referral criteria for Adult Services.

Immediately following this assessment an Adult Services social worker was allocated and this started the process of planning for Mr O's eventual transition to adult services. This Social Worker became an integral part of Mr O's care team for the remainder of his stay in residential care. The opportunity to co-work this case for the 12 months prior to Mr O's 18th birthday resulted in effective joint planning and information sharing, and enabled Mr O to develop good working relationships with workers that would take over his support in the longer term.

As part of this, the RLDS social worker arranged for a formal capacity assessment to take place and this has subsequently led to the local authority obtaining Guardianship and Appointeeship. These are essential elements of supporting Mr O to transition out from his residential childcare setting and into his own tenancy whilst managing many of the risks. Mr O continues to receive support from RLDS and Throughcare Services to allow him to live as independently as possible.

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

Young Carer

Jaimie is a young carer of 15 and looks after his mother who has cancer, heart disease and arthritis. Although Jaimie was known to the Carers' Centre, he had not attended for a while.

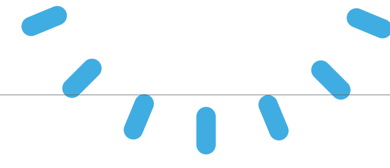
The Education/Home Link Worker was notified by a family therapist that Jaimie would benefit from a break from caring and spending time with other young people.

Over a period of months, increased caring for his mother had impacted negatively on Jaimie's health and wellbeing and affected his attendance at school. The Young Carers' Development Worker met with Jaimie to identify his needs and support him to access appropriate support. He resumed attending the Young Carers' Groups and was successful in accessing funding for respite. In August 2017, Jaimie went on a respite break with the Ocean Youth Trust for five days. In October, Jaimie won a 'Positive about Youth Award – Carers' Award'.

With the support of a councillor and Renfrewshire Council's Education Department, Jaimie was supported to access a college place. However, he felt anxious about leaving his mum for full days. A tutor was provided to support Jaimie with school work and allowed him to continue with a reduced caring role for his mum and stay on at school.

Jaimie appreciates the support he received from services. He was able to talk about his worries and fears in a safe place and felt understood, supported and valued. He recognises the importance of looking after his own health and wellbeing while still providing a caring role for his mum. Jaimie has noticed that when he is happy, his mother is happier too. The Young Carers' Development Worker continues to support Jaimie to explore his own needs and make further positive changes in his life.

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



Family Nurse Partnership (FNP)

Melissa was referred by her midwife to FNP in early pregnancy. She was 18 years old and living with her mother and sister in an overcrowded council flat. When met by her Family Nurse (FN), Melissa was trying to end her relationship with Paul who was known to criminal justice for violent crimes.

The couple had also used illicit drugs and there had been an episode of domestic abuse involving Melissa.

Melissa's parents separated when she was 12 years old. Following this, she was known to social services due to non-attendance at school; use of solvents; and being out with parental control, resulting in a compulsory supervision order.

At the point of engagement Melissa had left her college course due to her pregnancy and was dependent on benefits. While the family home was clean and comfortable, all three members of the family smoked and there was a high level of second hand smoke in the environment. While smoking around 10 cigarettes per day in pregnancy, Melissa also had a high intake of caffeine drinks and a poor diet. Her mother and sister were also keen to support her and take part in FNP visits.

As the programme progressed, Melissa began to trust the family nurse more and showed a high level of interest in programme materials, for example "how to build a baby's brain", and a therapeutic relationship was established. At around 28 weeks pregnant, Melissa stopped smoking and her mother and sister both smoked outside the family home. As her nutritional knowledge grew she was proud to discuss the positive changes she had made to her caffeine and dietary intake.

During the programme it became evident that Melissa had some issues with reading and numeracy and she and her sister supported each other to attend local supports for this.

Just as Melissa's baby was born, her mother was diagnosed with cancer, which clearly removed her ability to support Melissa and the baby, and brought further financial difficulties. Throughout this difficult time Melissa prioritised the baby's needs and showed a high level of bonding and attachment.

It became clear as the baby reached toddlerhood that Melissa was becoming more independent in her maternal role. While she enjoyed family support, she wished to progress her own development by working and getting her own home. The family nurse gave support for housing and a nursery placement for the toddler. Melissa got a job part time in a shop and remained smoke free throughout the programme.

Achievements

Working with the Family Nurse Partnership has achieved significant outcomes for Melissa and her daughter. Melissa has put her child at the centre when making decisions around safe extended family contact and has been able to maintain supportive family relationships.

She can now identify risk factors in relationships and protect herself and her child from domestic and drug abuse.

The family has been supported through challenging times and threat of eviction via appropriate referral, and Melissa has now secured her own tenancy and has a job.

The best thing about working with Melissa is the trust she has gained in health professionals. She can identify the positive changes she has made and the increase in her self-confidence.

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

A week in the life of RHSCP

Reducing Inequalities

Significant inequalities exist across Renfrewshire's communities. We are committed to placing equality at the heart of everything we do to achieve the best outcomes for everyone.

The focus of our effort has been on early intervention and prevention, supporting our staff and working together with our statutory, community and third sector partners.

Early Intervention and prevention

Early intervention and prevention are vital and our work has included the following:

- Community Connectors: in Primary Care we tested a Social Prescribing model initially in three GP practices, which was then expanded to eight practices due to demand and positive feedback. This model enabled the GP to have time to focus on medical issues and give patients more time to discuss underlying social needs with a Link Worker, signposting them to local support available
- Financial: staff from our Mental Health and Addiction Services are able to refer their patients to a specialist financial inclusion/welfare advice service which aims to support patients from both Mental Health and Addictions to help mitigate the impacts of welfare reform
- Falls Prevention: our work with Roar Connections for Life supports the intervention work on falls and we also promote a similar falls prevention approach in our work with nursing homes
- Cancer screening: we collaborated with Cancer Research UK and NHSGGC Breast Screening UK to target specific cancer screening interventions which aim to educate and highlight the importance of screening in areas where rates are particularly poor and also increase uptake of these services
- Mental Health - Addressing Stigma and Discrimination: we led the Renfrewshire Anti Stigma Alliance Group (RASA), providing an opportunity for agencies to come together in response to the stigma, injustice and discrimination barriers faced by residents living in Renfrewshire. In 2017 RASA organised a 'Walk a Mile' event with over 1,000 participants taking part. The event increased awareness of stigma and discrimination and provided an opportunity to encourage open discussion about mental health issues, targeting the general population as well as specific groups; such as young and older people

- Visual Impairment: we supported the Renfrewshire Visually Impaired Forum to produce an educational DVD for staff to enhance their knowledge to provide the best experience for those patients

Equipping our Staff

We support our staff by providing a wide range of training courses and development opportunities. Many courses cover guidance and awareness training when working with vulnerable people who may be covered by protected characteristics. Some examples of our staff training courses include:

- Financial Harm Awareness and the links to Adult Support and Protection
- Technology Enabled Care Service Awareness Training
- Autism, Learning Disability and Dementia Awareness
- Person Centred Planning
- Anti Stigma Training (Renfrewshire): Understanding Mental Health
- Anti-Racist Practice in Social Work
- Domestic Abuse
- Various Welfare Rights and Benefits courses.

Equality training courses are also available through our e-learning systems in addition to a specific course for staff carrying out Equality Impact Assessments.

The Housing First Initiative, which is now in its fourth year in Renfrewshire, provides intensive support to previously homeless people with complex needs. Turning Point Scotland provides intensive support for up to 20 homeless applicants to help ensure they move in to and sustain their tenancies, and avoid making further homelessness applications.

Working Together

The Health and Social Care Partnership is committed to working in partnership with a wide range of statutory, voluntary and community organisations to achieve better outcomes for everyone. We work to maintain and strengthen existing partnerships and build new partnerships with individuals and organisations as we mainstream equality in the HSCP.

Our activities through Community Planning arrangements include our leadership of initiatives funded through the Council's Tackling Poverty Programme and include:

- The promotion of mental health and resilience through school counselling in all 11 secondary schools across Renfrewshire. To date they have supported over 418 young people, with anxiety/stress, bereavement/loss and family issues the most frequently presented issues. Initial evaluation of the service has demonstrated an increase in the overall health and wellbeing of pupils attending the counselling service
- Peer education, run in conjunction with Active Communities, has trained 274 pupils from S3-S6 as peer educators. Topics within the programme include mental health, physical activity, drugs and alcohol, sexual health and self esteem, and young people report increased knowledge of health inequalities
- The embedding of a financial inclusion service for new mums and their families providing associated outcomes such as reduced stress for families and improved budgeting
- The Digital Participation Project: increasing digital participation for two of Renfrewshire's most digitally excluded groups: older people and people with disabilities. It is a partnership project with Renfrewshire Council's Disability Resource Centre (DRC) and the Renfrewshire charity 'Roar: Connections for Life'. Funded through Renfrewshire Council's Tackling Poverty Initiative, the project aims to increase digital inclusion in a variety of ways including reducing social isolation, better access to services, improved communications, and opportunities for education/skills development. The project has been put forward for a COSLA (Convention of Scottish Local Authorities) Excellence Award in 2018.

Quality, Care and Professional Governance

Quality, Care and Professional Governance

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.

Renfrewshire HSCP's supporting governance arrangements continue to ensure health and social care systems are working to a shared understanding and definition for Quality, Care & Professional Governance.

A review of the HSCP governance arrangements was undertaken in early 2018 to ensure that HSCP structures going forward are efficient and effective, and to avoid areas of duplication and overlap.

Following this review it was proposed that:

- A new Renfrewshire HSCP Quality, Care and Professional Governance Operational Procedures and Guidelines Group be introduced to provide a governance forum to discuss, develop and review local operational procedures and guidelines associated with Adult Services
- The work of the Professional Executive Group is incorporated into existing Governance groups of which professional representatives are already a member.

In the HSCP's first Annual Quality, Care and Professional Governance report, March 2017 (https://goo.gl/1ujF0F.), a number of specific commitments were made that have or are currently being implemented. A few examples are included in the following table:

Renfrewshire HSCP Children's Services took part in the 'What matters to you?' day on 6 June 2017. This Scotland-wide campaign aims to encourage and support meaningful conversations between people who provide health and social care and the people, families and carers who receive care.

Commitment - Training	Update on progress made
Staff to be invited to take part in Significant Clinical Incident (SCI) Master class/shadowing opportunities to be arranged.	A number of staff had the opportunity to shadow SCI reviews. Sessions are also available for SCI Master classes via the Clinical Risk Department.
Roll out further programme of Root Cause Analysis Training.	A schedule of training dates has been confirmed for the year.
Staff to be invited to undertake Risk Management/Register Development Session	A session took place in March 2017 which over 20 staff attended.
Commitment - Guidance	**Update on progress made**
Develop guidance to support the process of completing and quality assuring a Rapid Alert for Social Work Significant Incidents.	Staff involved in commissioning/conducting SCI investigations must follow a series of principles and key requirements.
Develop guidance around Large Scale Investigations.	Work is ongoing at both a local and national level to develop guidance.
Review process in line with Duty of Candour.	New Duty of Candour regulations began on 1 April 2018. This means health and social care organisations have a legal requirement to inform people (or families/carers acting on their behalf) when they have been harmed (physically or psychologically) as a result of the care or treatment they have received. An NHSGGC Short Life Working Group developed a Policy and Procedure (Duty of Candour Compliance). An e-learning resource is also being developed by NHS Education for Scotland.
Commitment - Patient/Service User and Carer Feedback	**Update on progress made**
Create a group of volunteers.	A recruitment process is underway to expand the number of volunteers within Renfrewshire HSCP. The aim is to improve access to quality health and social care services, learn from feedback and implement action plans on areas identified for improvement.
Roll out programme of Patient Experience initiatives.	The HSCP has extended this work by linking with a local volunteer to gain valuable insight into patient/service users and carers' experience. The Care at Home Service has invited the volunteer into their service to talk to the people they care for about their experiences, treatment, involvement and care. The recommendations have been incorporated into the Care at Home Review/Work Plan. The volunteer has also worked with the Family Nurse Partnership (FNP) to gather the views of clients in the first group in Renfrewshire, East Renfrewshire and Inverclyde about their journey and the impact of the programme on themselves and their child. This work builds on a programme of work previously undertaken within District Nursing, Rehabilitation & Enablement, Podiatry Services and GP Practices.

Examples of incident management/investigation/reporting improvements include:

- Analysis sessions are carried out anually to identify recurring themes and ensure actions are put in place following SCIs
- There are 9 SAFETALK and 7 ASIST courses planned for 2018 to deliver suicide awareness training to Mental Health front line staff. We will implement the suicide prevention policy for schools with Children's Services
- A process is in place to share learning across all HSCP Governance Groups and NHSGGC Primary Care and Community Clinical Governance Forum.

Feedback

Renfrewshire HSCP values and listens to the views of patients, service users and carers capturing their experiences so we can learn from them.

Some examples include:

- Patient conversations with in-patients in mental health wards twice yearly. Dates are planned for the year in advance and patients and their carers are invited to an informal discussion about their experiences in the ward. After each meeting, feedback is provided on a poster which describes the positive comments, any concerns raised and what was done in response. These visits are carried out by the Service Manager, Professional Nurse Advisor and a representative from the service user organisation - Mental Health Network
- Renfrewshire HSCP Children's Services, including the Family Nurse Partnership took part in the 'What matters to you?' day on 6 June 2017. This Scotland-wide campaign aims to encourage and support meaningful conversations between people who provide health and social care and the people, families and carers who receive care
- The Podiatry Service implements the 'Tell me what matters to you' approach in their daily practice
- 'Just to Say' cards are promoted in outpatient areas
- Feedback from Renfrew Community Immunisation Clinic in June 2017
- Annual feedback surveys in the Community Mental Health Team.

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 A&E 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 within scope. For 2017/18, the set aside budget for unscheduled acute services in Renfrewshire was £32.3m.

Our priorities in 2017/18 have been to address local and national targets.

Locally, we are progressing our joint work plan with acute colleagues in the RAH and primary care services. Key achievements include:

1. Development of a 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. A survey in the A&E department to understand why patients use this service, and if alternatives would be more appropriate.
3. Better use of information about frequent service users to help community and primary care services work in a more preventative manner with these patients.
4. Targeted support to specific care homes with higher than average admission rates to hospital to help them support people to remain in the community.
5. Early work has begun on an improved pathway for people with respiratory disease to help them manage their own care and avoid hospital admission where possible.

2017/18
showed a decrease in emergency admissions and unscheduled bed days

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 and community services.

2017/18 data showed a decrease in emergency admissions and unscheduled bed days. Delayed discharges rose in the early part of 2017/18, but are now back at 2016/17 levels and A&E attendances remain constant.

During 2017/18, we have had a major communication drive to provide information to people in Renfrewshire about the best health and care service for their individual need. Our Know Who to Turn to campaign has used public events, our website and social media to publicise health and care services and to ensure that people know about the wide range of available services. We hope to reduce demand on A&E services and GPs through this work and direct people to the best service for their need.

This year has also seen the maturing of our six GP clusters in Renfrewshire (two in Paisley and four covering the rest of Renfrewshire). Clusters have developed improvement plans with a focus on reducing our reliance on unscheduled care. Activity includes supporting local care homes to appropriately minimise use of hospital services and reduce admissions and readmissions. We are also working with high users of health and care services to optimise how their needs are met, promoting preventative and anticipatory care planning and reducing reliance on unscheduled care.

Our Performance by Care Group

Population Health and Wellbeing

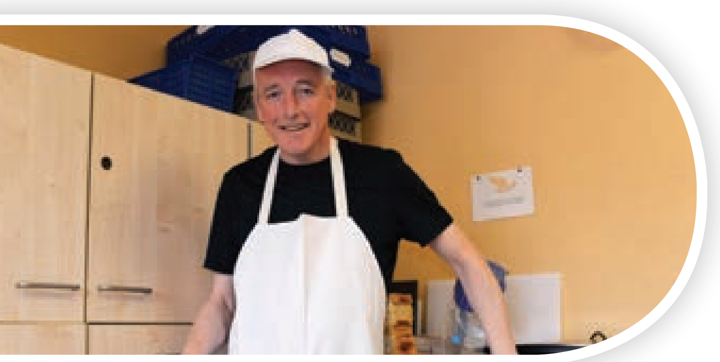
We continue to promote health and wellbeing, self-care, prevention and early intervention to enable Renfrewshire's population to live healthy and good quality lives. We have targeted our interventions and resources to narrow inequalities and build strong, resilient communities.

The Renfrewshire Health and Wellbeing Profile, produced by the Scottish Public Health Observatory, is attached at Appendix 2. The Profile uses a number of indicators on life expectancy, mortality, behaviours, mental health and economy to show Renfrewshire's data against the national averages.

Examples of this work include:

- The Community Link Team creating an information portal, Well in Renfrewshire (WiRe) in partnership with the national ALISS (a local information system for Scotland) project. It aims to make it easier for people to find local groups and resources that can support their health and wellbeing and create more choice for people with Self Directed Support budgets. The team engages with a wide range of groups to connect them with each other and with HSCP and Council users. To date, feedback has been very positive.

The team also worked with GP practices to support them to access available resources in their local area.



In promoting equality, two local Equality Impact Assessment training sessions were delivered for staff. Training is available, as well as an integration network, for people from black and minority ethnic backgrounds, to support them to have equal access to services and equal opportunities to contribute in their community

- A successful Mental Health Arts Festival in October 2017 saw a range of groups and individuals with lived experience of mental health issues show how creativity can support mental health and wellbeing. Various events took place to raise awareness amongst the general public
- A new drop-in Smoking Cessation Service was added to our existing services. The new session at the Renfrew Health and Social Work Centre commenced in January 2018. The new service was promoted at a recent GP practice event in the Centre. This additional drop in service supports more people in Renfrewshire to stop smoking
- Work is also underway to raise awareness of the new regulations for smoke free hospital grounds which will make it illegal to smoke within 15 metres of hospital buildings. This is in addition to a non legislative NHS policy of having all hospital grounds smoke free.

142 **participants attended Understanding Mental Health training delivered by the Health Improvement Team**

Sexual Health and Wellbeing

Sandyford Sexual Health Service (SHS) is a service for the whole of NHS Greater Glasgow and Clyde, hosted by Glasgow City HSCP.

The Service's vision is that the population should enjoy good and positive sexual health and wellbeing. When people do need support, care or treatment they can easily access specialist sexual health services. The focus is on the prevention of poor sexual health, early intervention and supported self-management.

A review of the Service began in 2017, which aims to improve the use of existing resources and release efficiencies through service redesign, with consideration of team structures, skill mix, localities and patient pathways; encourage those who could be self-managing to be supported differently; and ensure Sandyford Services are accessible and targeting the most vulnerable groups.

The direction of travel was set out in a paper to the Glasgow City Integration Joint Board in March 2018 which can be found at https://goo.gl/SEU4Xw

A final paper will be submitted for approval following further engagement.

During 2017 the Sandyford Sexual Health Service provided a range of services in Renfrewshire; 6,484 clients attended; 4,866 female clients and 1,618 male clients.

According to the Scottish Index of Multiple Deprivation (SIMD) - 51.7% of Sandyford clients with Renfrewshire postcodes resided in areas which are classed as being in SIMD 1 or 2, the most deprived areas.

Deprivation Index for Sandyford Clients from Renfrewshire in 2017

	SIMD 1	SIMD 2	SIMD 3	SIMD 4	SIMD 5
2017	34.4%	17.3%	20.9%	13.4%	13.8%

Providing long acting reversible contraception (LARC) methods is a marker of quality in reproductive health care. 1,291 women resident in Renfrewshire of reproductive age (15 – 49) had a LARC method fitted at Sandyford during 2017. This is a slight increase from the 1,266 who had a LARC fitted in 2016.

56 **Active free condom sites across Renfrewshire at the end of 2017. 82,479 condoms were ordered for distribution by services in Renfrewshire during 2017**

Child and Maternal Health

30-32 Month Assessment

Our Children's Services commenced delivery of the 30-32 month development assessments in 2015. The current uptake of assessments has increased from 82% at March 2017 to 89% of eligible families at March 2018. Within this group, 83% of infants have achieved their developmental milestones, an increase of 4% on the 2017 figure. For children where difficulties are identified, there is an intervention pathway in place to support behavioural and communication needs.

Childhood Immunisation

Implementation of the community based immunisation clinics has now rolled out to all areas within Renfrewshire. In some of our clinics, families have the opportunity to speak to a Dental Health Support Worker or Nursery Nurse to discuss issues such as oral health and feeding. We have also seen a reduction in the number of 'Did Not Attends' (DNAs) in our immunisation clinics, which were evaluated in June 2017 in 'What Matters to You' with positive feedback:

> **Great service! Very helpful staff that helped with queries on feeding and general baby health. I am made to feel welcome every time I visit.**

> **All in one clinic is useful and gets everything done in one day – it saves time!**

> **The staff are friendly and make you feel at ease. They help you as much as they can.**

> **I like being able to have the baby weighed and the immunisation at the same time. I wouldn't change a thing.**

MMR is an effective combined vaccine that 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 and NHS Greater Glasgow and Clyde (NHSGGC) exceeded this target for those aged 5 at December 2017. Unfortunately at 24 months, the rates in both Renfrewshire and across NHSGGC were below the 95% target. The March 2018 data is not yet available but we hope to see an increase in this rate when it is next reported.

MMR % Uptake

Age	March 2017	June 2017	Sept 2017	Dec 2017
24 months Renfrewshire	96.2%	97%	96.3%	94%
24 months NHSGGC	**94.8%**	95.3%	95.4%	94.7%
5 years Renfrewshire	96.4%	97.5%	97.3%	97.9%
5 years NHSGGC	96.8%	96.2%	97.2%	96.8%

Breastfeeding

An internal audit of Renfrewshire HSCP UNICEF Baby Friendly Standards took place in October 2017. The results showed, of the 20 standards relating to staff knowledge, none fell below the 80% threshold.

Infant feeding training has been delivered to a wide range of staff, students and volunteers in 2017/2018. This will help to provide consistency and best practice in the information parents receive in relation to breastfeeding, bottle feeding and weaning.

As part of our work to increase public acceptability and awareness of breastfeeding a social media campaign was piloted in May and June 2017. Four campaign messages were promoted through Facebook and Twitter. The total Facebook reach was 2,316 and the total Twitter impressions and reach was 5,306 and 123 respectively.

Health Visitors

Renfrewshire has seen an increase in the number of new Health Visitors who are now well embedded within Teams. There are planned dates for further uptakes of new Health Visitors for September 2018 and January 2019. This has led to a reduction in the size of caseloads for Health Visitors which allows for more focus on the most vulnerable children.

Specialist Children's Services

There have been a number of service developments across Specialist Children's Services in 2017/18:

Paediatric Speech and Language Therapy (SLT) successfully completed their 'Drop in Clinics' pilot and have now rolled the clinics out across Renfrewshire. These clinics offer quick advice and sign-posting to children and their parents/carers, as well as pre-referral Speech and Language communication activities for families to try. This may prevent the need for further full referral to SLT. Early advice is also available to reassure families and reduce anxiety at an earlier stage than previously possible. Any child who does require full assessment will be accepted on to the waiting list from the clinics. An audit of the impact of the clinics is planned for 2018. SLT waiting times for assessment are consistently within the 8 week target. The longest waiting time from referral to treatment was 17 weeks at March 2018, just below the 18 week target. This is an improvement from 25 weeks at March 2017.

Speech and Language Therapy 'Drop in Clinics' are now available throughout Renfrewshire; feedback from families and other agencies has been very positive and has helped reduce service waiting times.

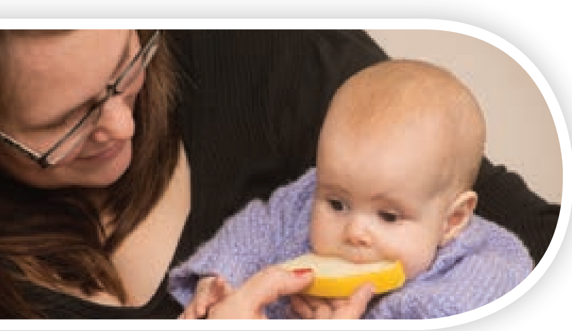
Occupational Therapy has successfully launched its 'digital platform'. This provides an immediate single point of access to advice, strategies and self-help support via the NHSGGC Kids Scotland website prior to a need for direct referral to Occupational Therapy. Links to the platform will be sent to all referrers and to children and families who enquire about the service. This facility will be rolled out across all Specialist Children's Teams. Occupational Therapy waiting times have consistently met the 18 week Referral to Treatment (RTT) target. The longest wait at March 2017 was 15 weeks and this has reduced to 10 weeks at March 2018.

Paediatric Speech and Language Therapy and Occupational Therapy (Referral to Treatment) Waiting Times

Referral to Treatment	Date	Longest Number of Weeks Wait	Date	Longest Number of Weeks Wait
SLT	March 2017	25 weeks	March 2018	17 weeks
Occupational Therapy	March 2017	15 weeks	March 2018	10 weeks

New Autism Spectrum Disorder (ASD) assessment pathways have been in place since 1 October 2017. These pathways aim to provide a better route for assessment of pre-school and school age children. Work is now underway to increase the number of clinicians with expertise in ASD diagnosis to improve response times.

Renfrewshire Child and Adolescent Mental Health Service (CAMHS) has continued to benefit from the addition of the Allied Health Professionals to the service, which assists with throughput and capacity with complex cases. The CAMHS Service Improvement Plan was refreshed at the beginning of 2018 with full team engagement and became live in April 2018. Regular reviews of the plan have been scheduled throughout the year.



Primary Care and Long Term Conditions

New GP Contract

GPs now work together in Clusters. The new GP Contract will change how we work with GPs in Renfrewshire. The aim is to improve patient access, address health inequalities and improve population health.

Key priorities include:

- Additional professional roles such as physiotherapists and mental health support
- Urgent Care (e.g. Advanced Practitioners, Nurses and Paramedics carrying out home visits and unscheduled care)
- Developing and increasing Pharmacy Services and support
- Community Treatment and Care Services (e.g. minor injuries and dressings, phlebotomy, ear syringing and suture removal)
- Vaccination services (e.g. immunisations and vaccinations)

This will mean GPs can spend longer with patients and provide better care. Patients in Renfrewshire will also benefit from access to Link Workers, who will offer support to address a wide range of issues affecting patients' health and wellbeing and offer support and opportunities for improving self-management.

Primary Care Improvement Plan

Every Health and Social Care Partnership will produce a Primary Care Improvement Plan (PCIP) which takes account of local priorities, population needs and existing services and builds on local engagement. This work will be ongoing throughout 2018/19.

All Long Term Conditions

Long term conditions are a group of illnesses that include diabetes, COPD (chronic obstructive pulmonary disease), asthma and CHD (coronary heart disease, heart failure and hypertension). The crude discharge rate per 100,000 population is monitored in Renfrewshire and across NHS Greater Glasgow and Clyde.

The crude hospital discharge rate per 100,000 population for all long term conditions in Renfrewshire was 3,226.8 in 2017. This is similar to the rate in 2016 (3,253.7) and just above the NHSGGC rate of 3,159.2. Although discharge rates for Asthma, Coronary Heart Disease, Heart Failure and Hypertensive Disease, and Diabetes are at similar levels in 2016 and 2017, there has been an 8.3% decrease in discharge rates for COPD.

Crude Hospital Discharge Rate Per 100,000 Population

	2013	2014	2015	2016	2017	Renf % increase/ decrease 2016–17
All LTCs	2,280.6	2,704.5	2,931.8	3,253.7	Renf: 3,226.8 GGC: 3,159.2	-0.8%
Asthma	182.3	176.2	218.1	219.8	Renf: 222.7 GGC: 214.0	+1.3%
COPD*	581.9	707.7	773.7	901.7	Renf: 827.1 GGC: 1,090.3	-8.3%
CHD**	1,298.4	1,605.9	1,712.7	1,866.5	Renf: 1,915.9 GGC: 1,624.7	+ 2.6%
Diabetes	217.9	214.7	227.3	265.7	Renf: 261.1 GGC: 230.2	-1.7%

*COPD – Chronic obstructive pulmonary disease & bronchiectasis

** CHD – Coronary Heart Disease, Heart Failure & Hypertensive Disease

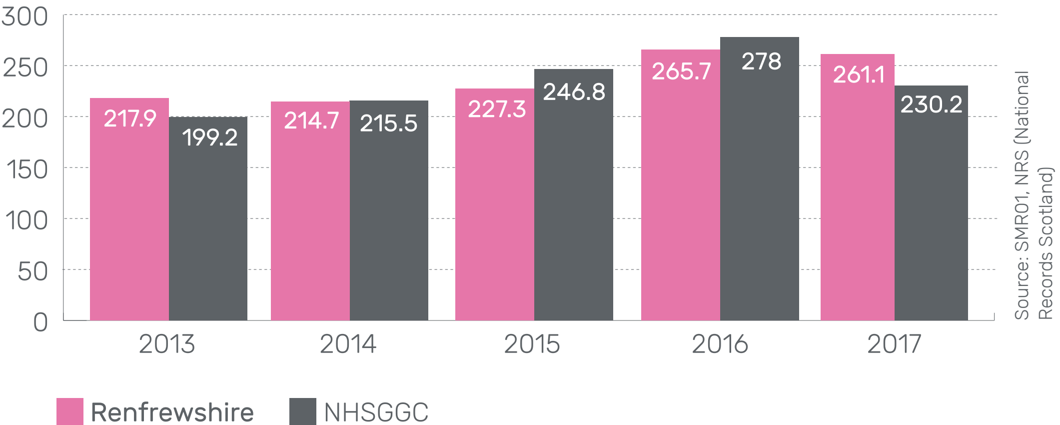
SMR01, NHS SharePoint

Diabetes

The Renfrewshire Integrated Diabetes Interface Group continues to prioritise diabetes awareness and health inequalities. The Group has developed a Work Plan and key actions and messages are communicated to the wider workforce through targeted meetings and newsletters. The Group audit care in a variety of ways and circulate the results of these audits to staff and practices. The work of the Group has achieved the following:

- Reduced length of patient waiting times for secondary care return appointments at the diabetic clinic from 10 weeks to 7 weeks
- Increased the number of diabetics on statin treatment
- Increased self-care for people with diabetes by promoting My Diabetes, My Way
- Reduced house visits by District Nurses by rationalising patients' insulin regimes and rationalised prescribing of diabetic test strips
- A series of education meetings for GPs and Practice Nurses.

Diabetes – Crude Hospital Discharge Rate per 100,000 Population



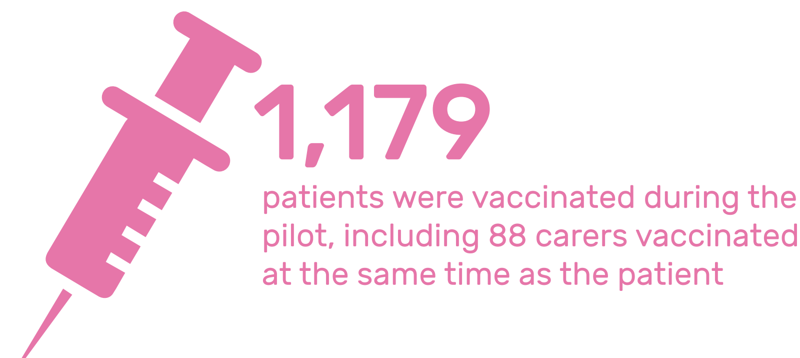
Flu Vaccination

Uptake rates of seasonal flu vaccine in Renfrewshire are similar to the rates for NHSGGC and above the Scottish average.

Seasonal Flu Vaccine Uptake Averages - as at week 15, 2018 (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	75.1%	45.5%	58.3%	63.7%
NHSGGC	73.9%	45.6%	54.2%	64.1%
Scotland	73.6%	44.8%	48.1%	61.8%

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 (DN) vaccinated 369 housebound patients during the months of October 16 to February 17. The complicated process in place required, prior to any vaccine being administered, the DN to confirm this had not been carried out by the GP and obtains the vaccine from the surgery. The vaccination programme for 14 Practices this year was completed centrally. A total of 1,179 patients were vaccinated during the pilot, including 88 carers vaccinated at the same time as the patient. This programme will be rolled out to all Renfrewshire GP Practices in 2018.

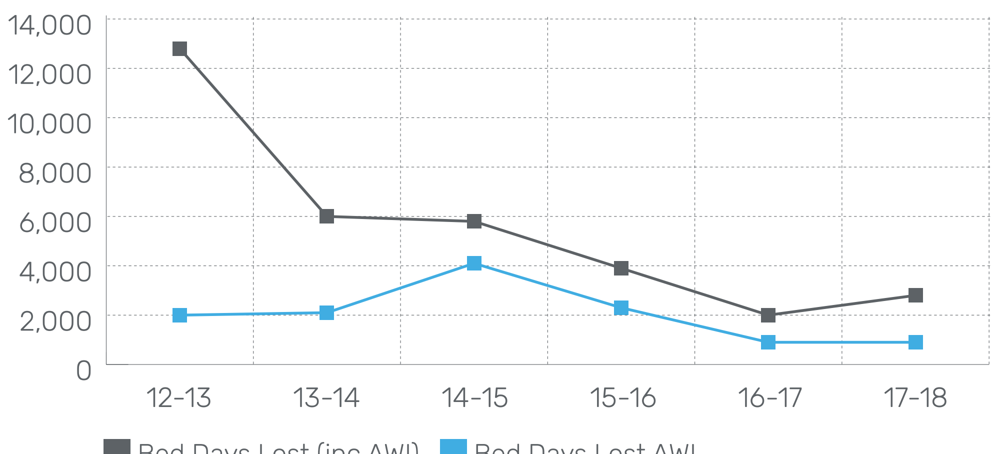


Older People

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 and it has been a challenge to maintain this level in 2017/18 with a 42% increase in bed days lost to delayed discharges (including Adults with Incapacity). There has however been a slight decrease in bed days lost to delayed discharges for Adults with Incapacity from 664 to 652 (1.8%).

Lost bed days >65 years: 2012/13 – 2017/18



	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Bed days lost (inc AWI)	12,698	5,835	5,325	3,633	1,910	2,712
Bed days lost AWI	2,050	2,288	4,301	2,624	664	652

Renfrewshire HSCP continues to perform well with regards to delayed discharges. The figures show a temporary rise as a consequence of a couple of reasons. The main one being a reduction in the capacity of the Nursing Home estate due to embargos on new placements in a number of providers, following poor inspection outcomes and Adult Support and Protection events. This position has since eased and a new provider has opened a care home in Paisley, extending the options available to families. Peaks in demand, such as that arising from the high levels of respiratory illness over winter also impacts on performance. This is due to the increase in the numbers referred, as well as, increased illness amongst the workforce, resulting in reduced capacity in the Care at Home Service.

Dementia

850,000 people in the UK live with dementia. This figure includes 93,000 in Scotland, with approximately 2,750 of those living in Renfrewshire. It is anticipated that this will increase to around 4,400 people by 2030; an increase of 60%.

The Renfrewshire Dementia Strategy Group has developed a work plan to ensure the required actions and outcomes of the national strategy are achieved. This aims to ensure that in-patient and community services, across statutory, independent and third sector agencies, develop person centred services that assist people with dementia to live as independently as possible and that they are treated with dignity and respect.

Recent developments include:

- Waiting times for an appointment to the diagnostic service averaged at 4 weeks over 2017/18
- All people who received a diagnosis of dementia were offered Post Diagnostic Support, in line with the Local Delivery Plan, which ensures they receive at least one years' support from a named link worker
- A service user and carer experience review of Post Diagnostic Support was completed by the Mental Health Service, helping to make the service more person centred
- Fast track mental health assessment with the aim of preventing hospital admission and allowing appropriate care at home
- The introduction of an Older People's Mental Health Clinical Nurse Specialist who offers expert advice and support to the wards in the Royal Alexandra Hospital.

The service is currently planning a facilitators' pack to assist local communities to build a Dementia Friendly Community Project within Renfrewshire.

A review of the first year of the Older People's Mental Health Liaison Service has shown a 42% decrease in people being transferred from care homes into Older People's Mental Health NHS wards.

Post Diagnostic Support Service Review

The recent review of the Post Diagnostic Support Service showed that the guidance on rights and signposting was valuable to clients. Clients felt staff had the right skills, knowledge and abilities, and treated people with dignity and respect. Home visits work well and clients gave positive feedback on the support they had received. Some issues were raised around capacity and waiting times, however the recruitment of a second link worker should see waiting times reduce.

Client Feedback

The link worker is at the end of a phone; I feel I can phone for anything

The service has provided me with guidance. My other half is always included in discussions

The worker visited my home and was extremely caring and professional

It is a bewildering and frightening time for the family; however the support I was given was invaluable

My daughter received a lot of support and I was given details of local groups I could attend and people I could contact. I attended a few groups that the worker recommended.

Falls Prevention

Falls and fragility fractures remain a concern, particularly in the context of an ageing population. 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.

The Strategy was implemented across Renfrewshire in December 2016 and focused on joint working across the Health and Social Care Partnership, Acute Services and with a range of agencies in the third and independent sectors.

Early identification and intervention has contributed to a reduction in Renfrewshire's population aged 65 and over admitted to hospital following a fall-related injury. The figure has decreased from 20.5 per 1,000 population in 2015/16 to 17 in 2017/18

During 2017/18 work focused on two main areas:

- Delivering Positive Steps training to a range of frontline 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
- Developing and implementing clear pathways 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:

- Care Home Falls Prevention and Management Group, with a specific aim to minimise the risks of falls for residents
- Community Falls Prevention and Management Group comprising of members from the third and independent sectors
- Partnership working with the Scottish Ambulance Service to reduce any unnecessary transfers to hospital for individuals who experience a fall at home, but sustain no injury.

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 highest vacancy rates are in our own HSCP residential care homes. Further work will be taken forward to assess how appropriate this model of care is. 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.

519 **Admissions from care homes to the Royal Alexandra Hospital (RAH) in 2017/18; 7.2% above the target of 484.**

Current issues for the HSCP include:

- The care sector (care at home and care homes) has difficulty recruiting and retaining staff
- We have access to a limited number of places for people under 65
- Beds for people with acquired brain injury or with specific learning disabilities are not always locally available
- Demand for care at home (24/7 availability) is increasing
- A Renfrewshire Care Home Partnership Group was established to reduce levels of preventable admissions to hospital.

Housing

Renfrewshire Digital sessions are now being implemented across all 12 Renfrewshire Council sheltered and amenity housing complexes. Using a bank of technology, older individuals are supported to gain a variety of digital skills such as: online banking; use of email; use of Alexa and Google Home; online games; and creating newsletters, all of which will help users to find information and stay in touch with family, friends and the wider community.

A review of our Older People's Services will be carried out in 2018/19. A Planning Group with service user representation will be established.

Learning and Physical 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. There is a large space that is used to grow fruit and vegetables and also acts as a sensory garden.

Within the DRC there are two voluntary groups that service users have set up: Renfrewshire Arts Forum and the Dirty Feet Dance Company. In addition, the Renfrewshire Sports Development Committee is a group that engages service users in sporting activities including bowling and archery. Some participants who learned to sail have gone on to win medals in national competitions.

Everyone accessing the Service is reviewed at regular intervals and has their goals and aims updated accordingly. Some service users have gone on to run groups within the Service, such as the movie and photography groups. One example of their work looked to improve access to country parks and waterways. The group made videos and sent them to the appropriate agencies. As a result of their work, access was improved and organisations changed how they designed facilities.

Members of the Service are also invited to take part in consultations, most recently feeding back their thoughts and views on the newly proposed social security changes proposed by the Scottish Government. This ensured service users felt involved in something that directly affected them.

A review of the service is now underway to ensure the HSCP has modern, 'fit for purpose', flexible, outcome focused services for people with learning disabilities in Renfrewshire.

National Involvement Network

Work has continued to ensure service user engagement and involvement remains a high priority. Groups have been established to support the development of a 'participation network'.

Dementia

Dementia post diagnostic support has been offered to all Learning Disability clients with a diagnosis of dementia. Allocated workers support clients in the first 12 months post diagnosis and to date, 100% performance has been achieved.

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. The Autism Connections Team is supporting all service staff to work within the NHS Education for Scotland (NES) training framework.

Inclusive Communication Strategy

Speech and Language Therapists from the Community Team have rolled out a proactive approach across the Learning Disabilities Service with the introduction of individual communication profiles. Joint working and focused approaches have greatly enhanced the quality of communication for service users with staff, carers, family and friends.

A successful 'Have Your Say' day was held in Johnstone Town Hall and was attended by over 50 service users. The focus was on supporting service users to contribute to strategic development and this will be taken forward at the first meeting of the Participation Network Group.

Physical Disabilities

The Self Directed Support (SDS) model has been further developed and is now established as a business as usual process which ensures a needs based approach to resource allocation and involves service users and their carers in the co-production of their support plan. The outcomes of the Self-Evaluation Assessment will result in a number of work streams to improve information, communication and processes.

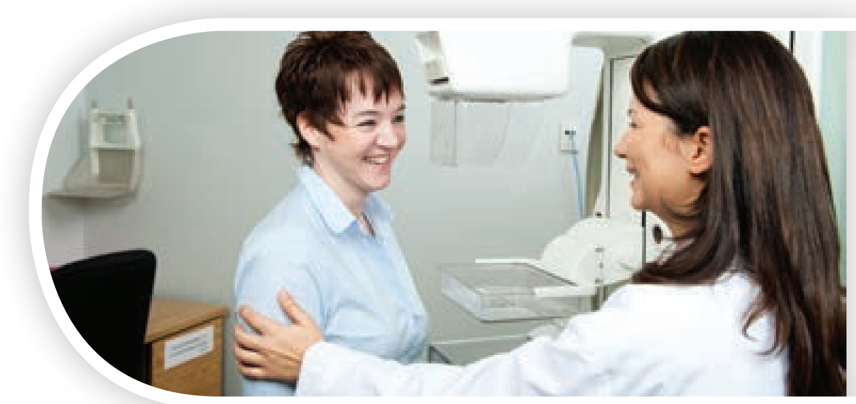
As more people are allocated and work to manage their SDS budget, we need to respond to what services are available and delivered. We also need to measure the effect this might have on services where the impact of SDS is to reduce the funding available to them and/or the level of demand on them.

Self-directed support (SDS) allows people to choose how their support is provided, and gives them as much control as they want of their individual budget.

Work with Housing providers to identify opportunities for collaboration at both strategic and operational levels is ongoing.

Breast Screening

In 2017/18 the Health Improvement Team successfully bid for funding to address health inequalities with the aim of improving access and increasing the breast screening uptake rate for women with disabilities. The project commenced in July 2018.



Mental Health

NHS Greater Glasgow and Clyde 5 year Mental Health Strategy

HSCPs in NHSGGC are working together to develop a whole system five-year Strategy for Mental Health. This is based on a number of reasons and drivers including:

- The adult mental health system being under unsustainable pressure with 3% annual growth demand and bed occupancy frequently operating over 100%. There is no prospect of these pressures easing in the short to medium term
- Implementing conventional cost efficiencies and seeking modest incremental change will not be sufficient to meet financial targets while maintaining safe and effective services
- There is some scope for system-wide pooling and consolidation of resources, including performance improvement, pathway redesign and innovative forms of support
- Cross-system interdependencies are strong and complex, and need to be coordinated in a GGC-wide context.

Key next steps include:

- Heads of Service responsible for Mental Health Services will continue to work together across the NHSGGC area to progress the development of the Strategy
- This work will include finalising the unscheduled care review for adult mental health, including mental health liaison, crisis and out of hours services and bed modelling
- Chief Finance Officers for all HSCPs will be engaging in the near future to form the financial framework
- Develop a local HSCP action plan following the approval of the GGC wide Mental Health Strategy

Assertive Outreach Team

The Community Mental Health Assertive Outreach Team which became operational in September 2015 was reviewed and evaluated by the Mental Health Network in September/October 2017.

Some of the comments received as part of the review process included:

This team are really committed to supporting people like me. For that, I am truly grateful.

Assistance and encouragement is given on all levels.

Comments from staff included:

We have been able to reduce hospital admissions for people with a long term history of frequent admissions. We have been able to work with people to review medication and get a treatment plan that works better for them.

We are able to look deeper into individual needs and support small lifestyle changes that can make a big difference.

Waiting Times

There are two Primary Care Mental Health Service waiting time indicators: the first is the percentage of patients referred to first appointment offered within 4 weeks which has reduced from 95% at March 2017 to 79% at March 2018. There are factors that have influenced performance in this area and reduced capacity to meet the demand on service and the completion of assessments within 28 days, including:

- 12% increase in service demand in 2017
- increased short term sickness absence of staff within the service
- adverse weather conditions in February and March 2018

The second waiting times target in Primary Care Mental Health, is the percentage of patients referred for first treatment appointments within 9 weeks which increased to 98% at March 2018 from 96% at year end 2016/17.

Doing Well

Over the past three years, the Primary Care Mental Health Team (Doing Well) has introduced a self-referral route to the service. One positive aspect of this has been the decrease in clients attending a GP to be referred. The number of self-referrals to the service has increased from 207 in 2013/14 to 1,237 in 2017/18. This self referral route has successfully redirected work away from GP surgeries.

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 records audited in February 2018, SRE took place in 83% of the cases.

100% **of patients started treatment for Psychological Therapies within the target of 18 weeks from referral**

Mental Health Inpatient Service - Welfare Commission

Inspectors from the Mental Welfare Commission praised patient care at three Older People's Mental Health wards in Renfrewshire in February 2018:

- Ward 39 at the Royal Alexandra Hospital
- North ward at Dykebar Hospital
- East ward at Dykebar Hospital

Staff were praised for the atmosphere on wards, high levels of communication with relatives and carers, and ensuring they were involved in care decisions, and personal care plans for all patients.

Palliative care initiatives were also commended on both Arran and East Wards at Dykebar Hospital.

Alcohol and Drugs

PhotoVoice

In partnership with Alcohol Focus Scotland and the University of Edinburgh, a group of individuals with lived experience of addiction were given the opportunity to take part in a unique concept called 'Photovoice'. Participatory photography was used to enable participants to reflect and explore the reasons and experience that guided their chosen images. Participants were trained in photography and then assisted to capture images within their local community which reflected their experience of addiction. As a result of the project, participants were able to learn skills enabling them to communicate their experience of services which will feed into the review of alcohol and drug services. An exhibition showcasing their work was also held earlier this year. Some examples included:

"It's a vicious cycle- every day I got up and drank alcohol - I was going round in circles and I kept wondering how to get off it and get myself help. The building behind this sign is Dykebar hospital where I did get help."

"Spiralling to rock bottom depicts the beauty of the staircase but also how alcohol can suck you in, taking you to the abyss and the unknown below"
(The Lighthouse - Glasgow)

"Emptiness and how alcohol can strip you of everything"
(Museum of Modern Art - Glasgow)

"HELP is there... pick up that phone"
(River Clyde - Glasgow)

Reduction in alcohol related hospital stays

We have exceeded our target for reducing alcohol related hospital stays for the period April 2017 to March 2018 at a rate of 8.3 per 1,000 population aged 16+ (target 8.9). This is the lowest rate achieved since the recording of this indicator in January 2009. The rate was 9.6 at September 2017. Maintaining this will be challenging, but it is a good improvement (23.8% reduction) from a rate of 10.9 at September 2014.

Alcohol and Drug Waiting Times

The target for the percentage of people seen within three weeks for alcohol and drug services is 91.5%. Our performance has reduced from 96.9% at June 2017 to 87.3% at December 2017. To improve performance in waiting times, a nursing post has been recruited to increase the capacity of assessment appointments. This will be further enhanced by the use of nurse bank hours to clear the backlog of assessments. The outcome of the recent review of Addiction Services will be published shortly and a work plan developed to address key areas.

Naloxone

Renfrewshire Alcohol and Drug Partnership (ADP) continues to implement the National Naloxone Programme which aims to prevent drug related deaths. Naloxone is a potentially lifesaving drug which can temporarily reverse the symptoms of overdose. Specialist staff offer training on how to administer Naloxone and basic lifesaving skills including Cardio-pulmonary Resuscitation (CPR). Current performance in relation to the provision of Naloxone has exceeded the local improvement target of 30% coverage of problem drug users. This means that Naloxone is being offered to all individuals as part of their assessment, as well as family members and key partners, to administer as required. Most recent performance shows that 32% of problem drug users have been trained and received a supply of Naloxone.

An independent review of Addiction Services will inform a change programme over the next three years and shape our service model to remain person-centred, and recovery and outcome focused when meeting future care needs.

Carers

The Carers' (Scotland) Act 2016 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.

Adult Carers' Support Plans
The Act means local authorities (the area in which the cared for person lives) must offer and prepare Adult Carers' Support Plans. Arrangements are in place within Renfrewshire to support this delivery.
Young Carers' Statements
The Act places a duty on on the Health Board for pre-school children, and the Local Authority for non-pre-school children, to offer and prepare Young Carers' Statements. These detail young carers' identified needs and proposed personal outcomes. A dedicated Young Carers' Resource Worker will work across Children's Services and within Renfrewshire Carers' Centre to support this delivery.
Eligibility Criteria for Adult Carers
Renfrewshire's Adult Carer Eligibility Criteria was approved by the Integration Joint Board (IJB) on 26 January 2018. The 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' Strategies
Following a period of consultation, an Adult Carers' Strategy will be published in April 2019. In 2017/18 Renfrewshire's Children's Services Partnership produced a Young Carers' Strategy. The Partnership carried out extensive consultation with local young carers who receive support at Renfrewshire Carers' Centre. The overwhelming feedback was that they want to be able to enjoy the same activities and have the same experiences as their friends who are not carers. They want professionals to see beyond their caring role and to understand their lives as children and young people first.

Young Adult Carers

Five Young Adult Carers attended a 6-week Eat Better, Feel Better course at Our Place, Our Families. The course taught young adults basic cooking skills; how to cook nutritious meals; and the nutritional values and portions of the meals. The Course also offered the carers an opportunity to socialise with other carers and meet new people.

Feedback included:

- I'm now cooking a range of different and healthier food
- I've become more confident with cooking
- We eat more as a family
- We cook more homemade meals

43 training courses were delivered by the Carers' Centre to 242 carers in 2017/18

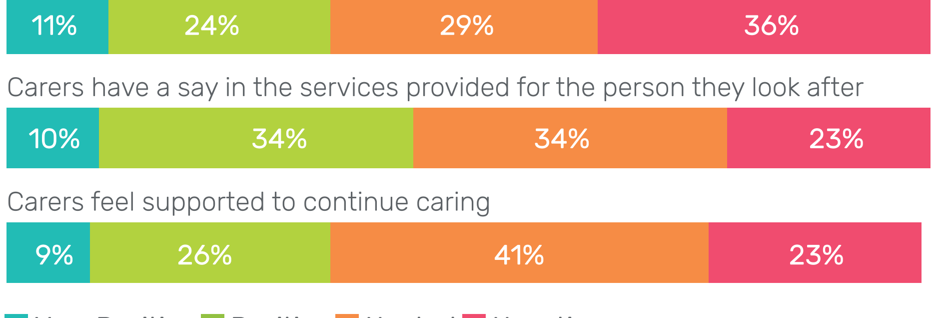
106 new carers were identified during 2017/18

Health & Care Experience Survey 2017/18 – Carers' Results

Results on the caring questions in the 2017/18 Health and Care Experience Survey showed 35% of carers felt supported to continue caring. We continue to work with practitioners and the Carers' Centre to improve the experience of carers in Renfrewshire.

Health & Care Experience Survey 2017/18

Caring has not had a negative impact on carers' health and wellbeing



Full report: http://www.isdscotland.org/Products-and-Services/Consultancy/Surveys/Health-and-Care-Experience-2017-18

Effective Organisation

iMatter

iMatter is a team based, employee engagement questionnaire which was introduced by the Scottish Government in January 2015 with a three year roll out plan. Renfrewshire HSCP implemented iMatter as part of our Organisational Development and Service Improvement Strategy and our staff undertook the survey in January 2017.

The Benefits

- Gives staff the chance to feed back on specifics and to influence change and improvement in the workplace
- Helps managers understand the 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 59%, which while slightly down on last year's 66%, is still significantly higher than staff surveys in the years before iMatter. Staff gave positive responses at a level equal to or higher than last year's results.

This does not mean we are complacent however, and next steps include adding new actions to work plans that will contribute to improving the areas where we have achieved the lowest scores. Further evaluation and monitoring will continue throughout 2018.

Sickness Absence

Sickness absence and a healthy workforce remain a priority for the HSCP and will be subject to continued performance monitoring and evaluation of work to ensure absence performance is improved and best practice is applied across the HSCP.

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 the 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 2017/18 was 2.36 days per full time equivalent employee.

The sickness absence level for NHS staff at the end of March 2018 in Renfrewshire was 5.49%, a slight increase on the February 2018 figure of 5.3% but marginally lower than the March 2017 figure of 5.6%. The highest rate in 2017/18 was 7.4% in January 2018, while the lowest rates of 4.9% were seen in April and May 2017.

Absence Rate (%)	Jun 2017	Sep 2017	Dec 2017	Mar 2018
Health	5.37%	5.15%	6.21%	5.49%

Adult Social Work absence is expressed as a number of work days lost per full-time equivalent (FTE) employee. At March 2018, the rate was 4.34 days per employee against a target of 2.36 days.

Absence Rate (Work Days Lost)	Jun 2017	Sep 2017	Dec 2017	Mar 2018
Adult Social Work	2.36	3.88	5.13	4.34

Supporting Attendance Activity

Planned actions to improve sickness absence performance 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 care services, when positive feedback was received from the inspectors on the HSCPs 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. 30 leaders will commence this training in 2018/19
- Developing our Strategic Planning Group (SPG) to be able to play an active role in 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 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.

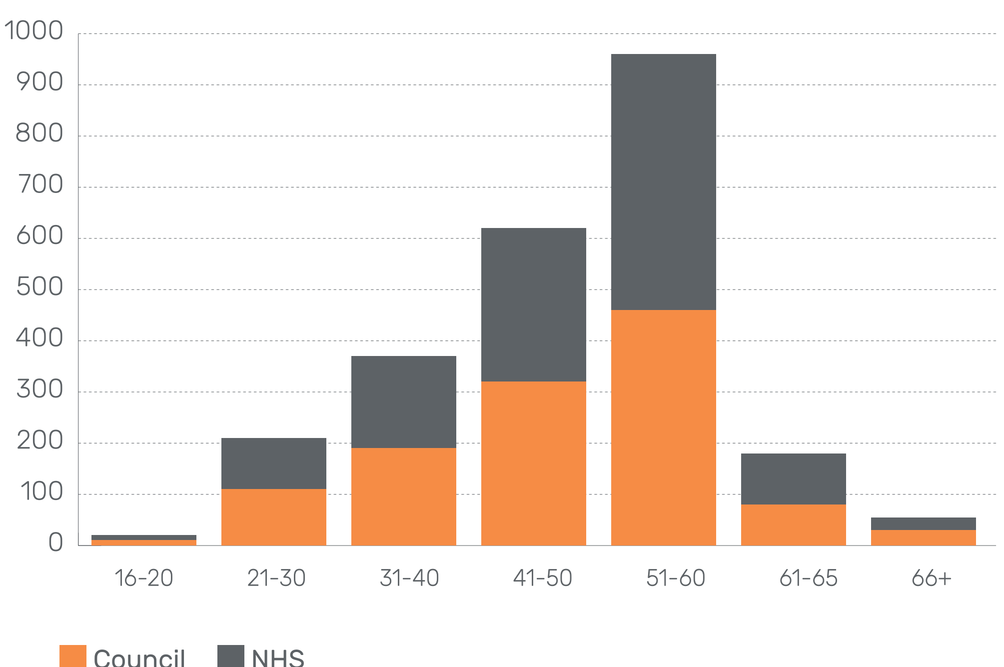
2017/18 saw the implementation and embedding of:

- Governance arrangements to ensure health and social care systems are working to a shared understanding and definition for workforce
- Professional Governance and reporting mechanisms to the HSCP Senior Management Team (SMT); Integration Joint Board (IJB) ; and Joint Staff Partnership Forum (JSPF); and
- Links to operational and professional structures and networks, in particular the Participation, Engagement and Communication Group, and the Quality, Care and Professional Governance Groups.

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:

- 43.3% of the combined HSCP workforce is over 50 years old
- 47.7% of the Council workforce is over 50 years old with the NHS figure at 38.9%
- 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
- 10% of the workforce is in the 21-30 age band, with just 6 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.

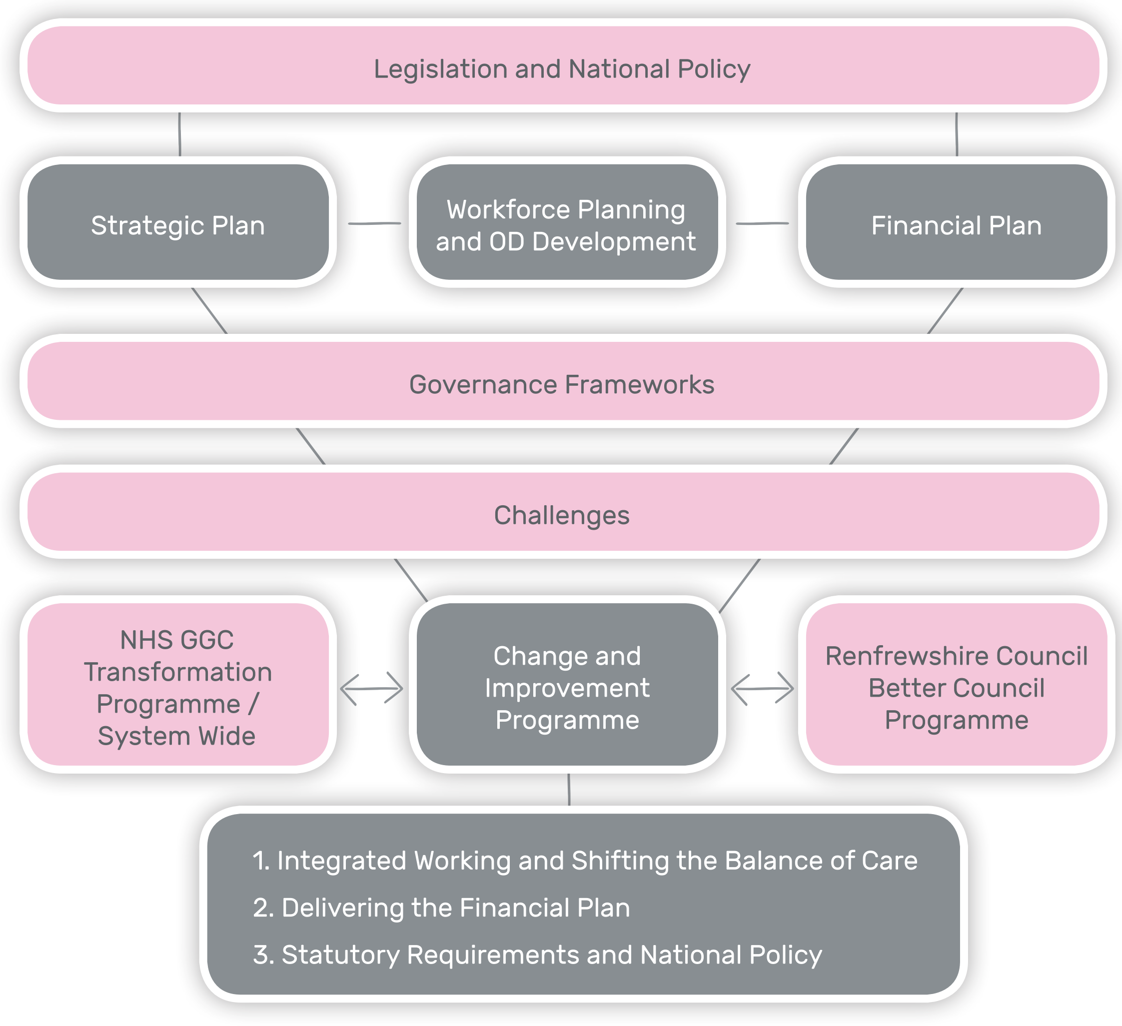
2,412 **people work in Renfrewshire HSCP**

Change Programme: Our approach to change

This Programme provides a structured approach to manage change, optimise the use of change and improvement approaches and develop and share best practice to deliver on this vision.

The Change and Improvement Programme has been established in support of the Integration Joint Board's Vision and to enable the delivery of our Strategic, Workforce and Financial Plans and in line with the national direction set out in the National Clinical Strategy and Health and Social Care Delivery Plan – see diagram 1. This Programme provides a structured approach to manage change, optimise the use of change and improvement approaches and develop and share best practice to deliver on this vision.

Diagram 1: Change and Improvement Programme



As illustrated opposite, the Change and Improvement Programme is being delivered through three work streams:

Optimising Joint and Integrated Working and Shifting the Balance of Care – to proactively develop our health and social care services, maximising the opportunities joint and integrated working offer, with service redesign informed by a strategic commissioning approach. This in turn will support the financial sustainability of the Partnership and deliver the savings required to address the IJB's budget shortfall.

Delivery of the Financial Plan – to deliver approved health and social care savings in line with the HSCP's established financial planning process. This robust process ensures all proposals are subject to a comprehensive impact assessment including alignment with our Strategic Plan; statutory requirements including the Equalities Act; and Quality, Care and Professional Standards.

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.

The IJB approve this programme on an annual basis. Thereafter regular updates are brought to the IJB to report on progress and to seek approval for any new change and improvement work, including further savings proposals, to be included within this evolving programme.

A number of highlights from the 2017/18 Change and Improvement Programme include:

- An independent review of Addictions Services which will help inform a change programme over the next three years and shape our service model to be person-centred, and recovery and outcome focused when meeting future care needs
- Progressing our joint Unscheduled Care Action Plan with colleagues in the Royal Alexandra Hospital, as part of the wider NHSGGC Unscheduled Care Programme
- New measures to review enhanced observations of patients (within Mental Health) and ensure therapeutic interventions are delivered where possible. There has been a marked reduction in the special observation levels. The average monthly spend for months 1 to 8 was £121k, reducing to an average monthly spend of £77k for months 9 and 10. We anticipate this downward trend will continue throughout 2018/19 and beyond

- A review to identify service pressures and determine root causes of the drivers and challenges which impact on the delivery of Care at Home Services
- Concluding the tender process to procure a system to support the management and delivery of both internal and external Care at Home Services. A number of Health and Social Care Partnerships are now operating an Electronic Scheduling and Monitoring Service and are reporting significant benefits in using this type of system. It is anticipated the preferred supplier will be approved by July 2018
- Implementation of the provisions in the Carers' Act, designed to support carers' health and wellbeing, which came into force on 1 April 2018
- Compliance with the new Duty of Candour regulations which commenced on 1 April 2018. The duty will create a legal requirement for health and social care organisations to inform people (or their families/carers acting on their behalf) when they have been harmed (physically or psychologically) as a result of the care or treatment they have received
- Implementation of the recommendations arising from the HSCP's recent evaluation of the Self-Directed Support (SDS) system in Renfrewshire
- Continue to support Renfrewshire GP clusters, including the development of Cluster Quality Improvement Plans
- Service Improvement through the local Diabetes Interface Group, which aims to improve the experience and clinical outcomes for people living with diabetes across Renfrewshire; and
- The establishing of a Respiratory Pathways Interface Group to consider 'tests of change' that will impact positively on reducing COPD admissions/ bed days. The group will specifically look at improving pathways, promoting self-management and anticipatory care planning.

We are progressing our joint Unscheduled Care Action Plan with colleagues in the Royal Alexandra Hospital, as part of the wider NHS Greater Glasgow and Clyde Unscheduled Care Programme.

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.

Podiatry

Podiatrists are health care specialists in treating 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 employs approximately 200 podiatrists in around 60 clinical locations spread across the six Health and Social Care Partnerships. The Podiatry Service currently provides care to around 40,000 patients across the NHSGGC Board area, representing 3.4% of the population.

During 2017/18, the Podiatry Service launched the 'Positively Podiatry' initiative to communicate the positive contribution podiatry makes to the health and social care system.

This reflects the service improvements delivered since April 2012, when the Podiatry Service commenced its ongoing whole system redesign. The impact of this has delivered the following significant improvements in clinical and organisational outcomes and service performance:

- Waiting times are now consistently less than four weeks with over 95% of referrals being seen within 4 weeks - an improvement of 444% since 2012
- Over 90% of diabetic foot ulcers are treated within two working days, in spite of a 105% increase in referrals. This has been evidenced to improve amputation rates and life expectancy for individuals with diabetes
- The service has made a total of £795k in direct savings (recurrent) – or around 11.5% over six years
- Sickness absence within the Podiatry Service has reduced from an annual average of 5.8% to 2.8%. This represents an improvement in staff attendance of 43.8% over the period of the redesign.

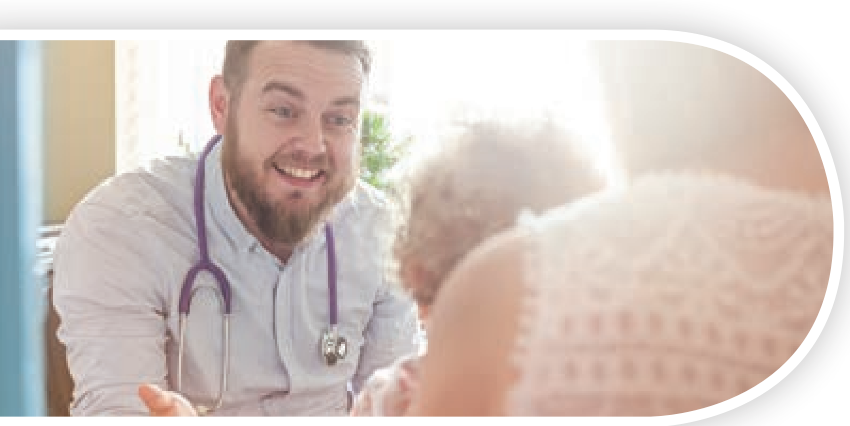
Primary Care Support

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 preparation for the new GP Contract, the Primary Care Support Team has been liaising with the Scottish Government. Local preparation included collaborative working with the Local Medical Committee, GP sub-committee, HSCP Chief Officers and reporting to IJB and Board meetings.

Over the next three years, every practice within NHS Greater Glasgow & Clyde (NHSGGC) should be supported by expanded teams of HSCP and NHS Board employed health professionals. This will create a skilled multidisciplinary team surrounding Primary Care, and support the role of the General Practitioners (GPs) as the expert medical generalist.



Primary Care Improvement Plans

All Health and Social Care Partnerships are developing Primary Care Improvement Plans (PCIPs) which take account of local priorities, population needs and existing services. This work will continue throughout 2018/19, supported by the PCS Team who provide advice and oversight on funding arrangements, and ensure effective governance arrangements are in place.

Inspection of Services

Renfrewshire Health and Social Care Partnership commission a number of 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:

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

Through a proactive approach, our Contract Performance Management Team ensures externally contracted organisations are person centred, safe, effective and sustainable. Services are visited 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

Renfrewshire Health and Social Care Partnership directly provide a number of services subject to a rolling programme of inspection from the Care Inspectorate. Inspection assures people that services are working well and highlights areas for improvement. This is carried out by independent inspectors who look at 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.

As at May 2018, our directly provided services attained the following grades for care as detailed below:

Service Name	Quality of Care & Support	Quality of Environment	Quality of Staffing	Quality of Management & Leadership
Hunterhill Care Home	4	4	4	4
Montrose Care Home	5	6	5	4
Renfrew Care Home	5	5	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

Six Point Grading System

6: Excellent 5: Very Good 4: Good 3: Adequate 2: Weak 1: Unsatisfactory

Financial Performance and Best Value

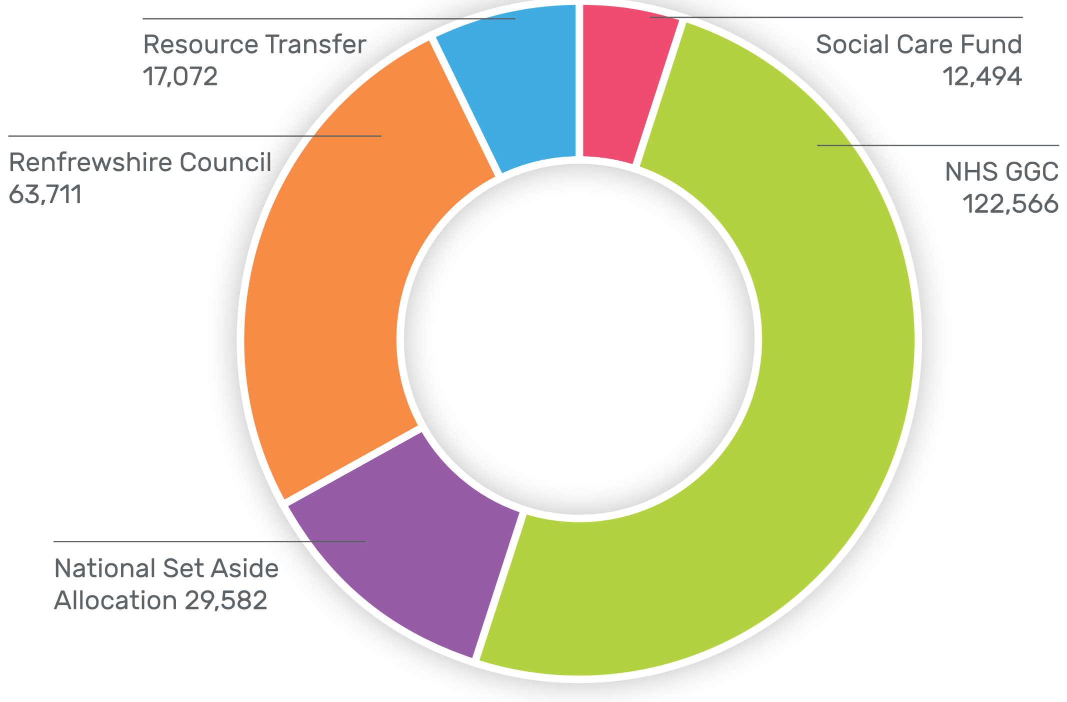
The financial position for public services continues to be challenging, with the IJB operating within ever increasing budget restraints and pressures which were reflected in the IJB's Financial Plan and regular monitoring reports by the Chief Finance Officer (CFO) to the IJB.

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 2018/19.

Resources Available to the IJB 2017/18

The resources available to the IJB in 2017/18 to take forward the commissioning intentions of Renfrewshire Health and Social Care Partnership in line with the Strategic Plan totalled £245.425m. The chart below provides a breakdown of where this funding came from:

Funding Sources in 2017/18



Included within the funding available is a 'Large Hospital Services' (Set Aside) budget totalling £29.582m. This is a notional allocation in respect of those functions delegated by the Health Board and 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.

Over recent financial years a number of pressures on health and social care services have had to be addressed due to reduced levels of public sector funding. These pressures include:

- The move to the Scottish Living Wage
- Increasing 'employer' costs due to: the introduction of the Apprenticeship Levy; increases in national insurance contributions; and costs associated with the new requirement for all new starts to be automatically enrolled in pension schemes
- Increasing cost of medication
- Impact of: an ageing population; increased number of people with dementia; and an increase in the number of people with complex needs.

In order to facilitate transformational change, additional funding was provided by the Scottish Government to support integration and the focus on shifting the balance of care to community-based services. In 2016/17, the Scottish Government directed £250m from the national health budget to Integration Authorities for Social Care, and in 2017/18 a further £110m was allocated on the same basis. Renfrewshire IJB's share of this funding was c£12.5m, which was allocated to a range of adult social care services including: the payment of the living wage for all social care workers; reducing the level of charges to service users; investment in the Care at Home service; and meeting the costs of increasing demand across all areas.

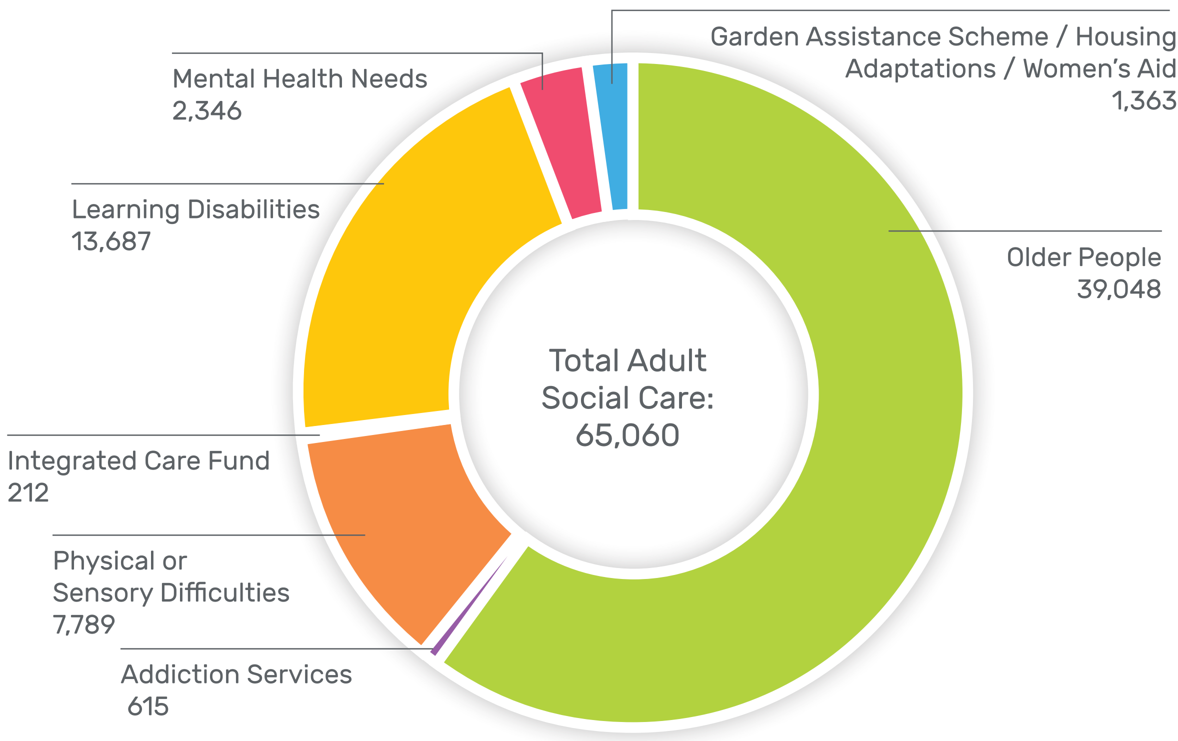
Summary of Financial Position

Budget Monitoring throughout 2017/18 has shown the IJB projecting a break-even position subject to the drawdown of reserves to fund any shortfalls, and the transfer of specific ring-fenced monies (including Scottish Government funding for Health Visitors and the Primary Care Improvement Fund) and agreed commitments to ear marked reserves. At the close of 2017/18, as anticipated, the IJB showed an overspend of £2.052m. The IJB approved the drawdown of reserves throughout 2017/18, in order to deliver a breakeven position. This leaves an overall reserves balance of £3.442m which will be carried forward to manage pressures in future years in support of our Strategic Plan priorities.

Adult Social Care

The diagram below shows the final outturn position across each Adult Social Care client group for Renfrewshire HSCP in 2017/18:

Adult Social Care Spend 2017/18, £000s



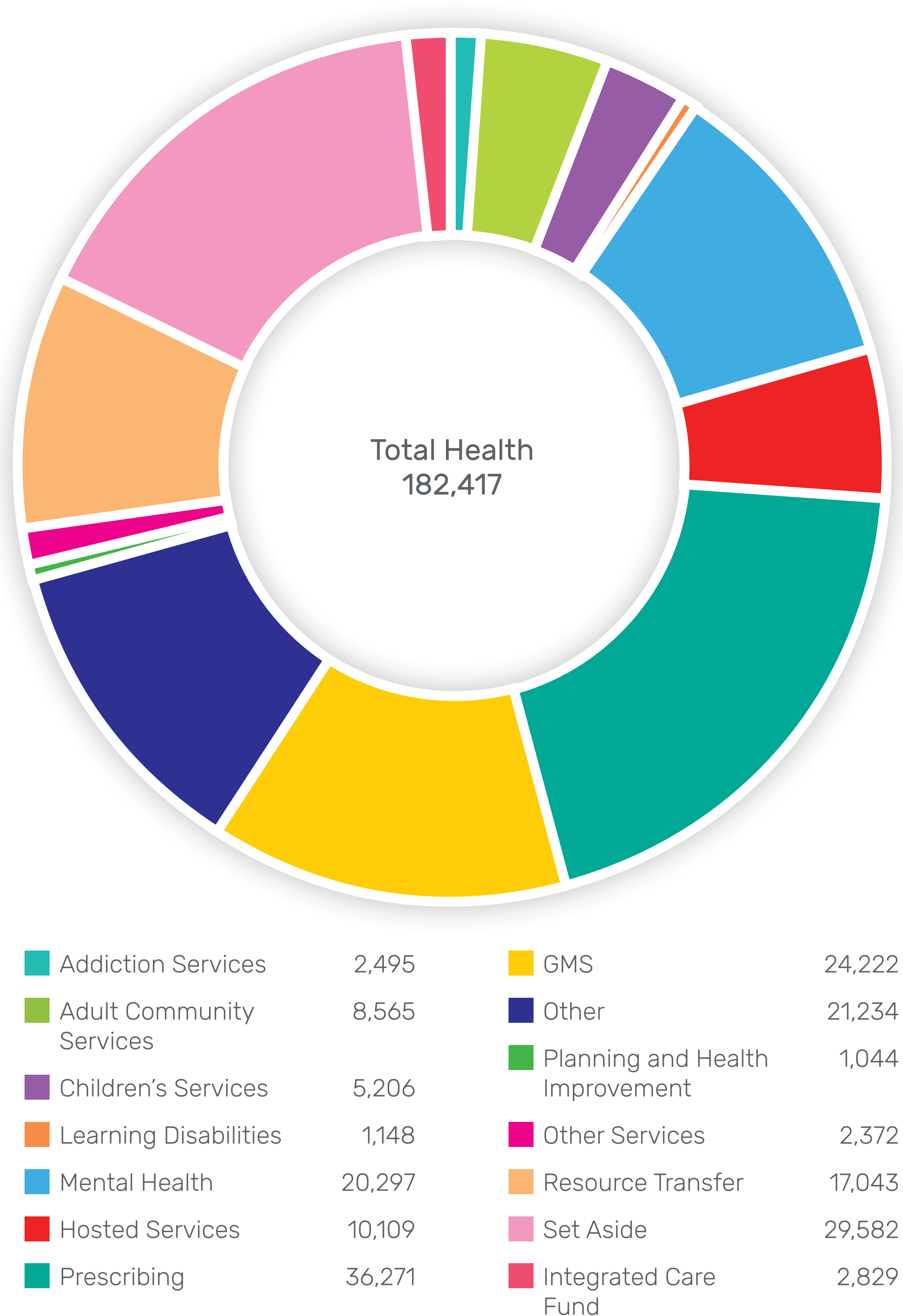
Adult Social Care delegated services saw continued pressure throughout 2017/18 including:

- Pressure within the Care at Home service reflecting a growing elderly population who are living longer with more complex needs. Despite additional recurring resources of £747k allocated from Renfrewshire Council's additional budget made available for 2017/18, along with the draw down from reserves of £1.519m, the year end position of Care at Home was an overspend of £427k
- Pressures within the Adult Placement Budget, mainly due to the levels of increasing demand; Living Wage associated costs; and the growing impact of SDS.

Health Budget

The table below shows the final outturn position across each delegated Health service client group for Renfrewshire HSCP in 2017/18.

Delegated Health Spend 2017/18, £000s



Addiction Services	2,495	GMS	24,222
Adult Community Services	8,565	Other	21,234
Children's Services	5,206	Planning and Health Improvement	1,044
Learning Disabilities	1,148	Other Services	2,372
Mental Health	20,297	Resource Transfer	17,043
Hosted Services	10,109	Set Aside	29,582
Prescribing	36,271	Integrated Care Fund	2,829

A breakeven position was reported to the IJB throughout 2017/18 (subject to the draw-down of general reserves and transfer of ring fenced balances at the year end to ear marked reserves). The final outturn position, inclusive of the draw down of reserves and net of the ear marked reserves of £2.958m, was a breakeven. The main themes of which are:

- An under spend of £458k in Adult Community Services due to turnover across the Rehabilitation and District Nursing services, and an under spend in relation to external charges for Adults with Incapacity (AWI) bed usage;
- Under spends within Addiction Services, Planning and Health Improvement, the Integrated Care Fund and Children's Services reflecting staff turnover including planned vacancies in respect of the reduction in Speech and Language Therapy funding from 2018/19, and use of non-recurring monies to maximise the transfer to ear marked reserves; and
- An under spend of £418k in Renfrewshire Hosted Services due to vacant administrative posts in the Primary Care Screening Service, and an under spend within Podiatry due to a combination of staff turnover and maternity/ unpaid leave, some of which were covered by bank staff.

These under spends offset an overspend in Mental Health Services of £1.263m due to the significant costs (overtime, agency and bank costs) associated with patients requiring enhanced levels of observation across all ward areas. In order to fund the continuing pressure associated with special observations, base budget realignments from other areas of the Partnership budget were identified as part of the overall HSCP 2018/19 budget realignment exercise (as requested by the IJB), and transferred to Mental Health to create a recurring budget to fund these costs.

Going forward into 2018/19 the main pressure on the delegated Health budget is likely to be on Prescribing as the current risk sharing arrangement across NHSGGC ceased on 31 March 2018. The main challenge to the prescribing budget relates to additional premiums paid for drugs on short supply (there are currently an unprecedented number of drugs on short supply for which significant premium payments are being made), along with the impact of increased volume and general price increases.

Financial Outlook, Risks and Plans for the Future

Looking into 2018/19 and beyond, it is anticipated that the public sector in Scotland will continue to face a very challenging short and medium term financial outlook.

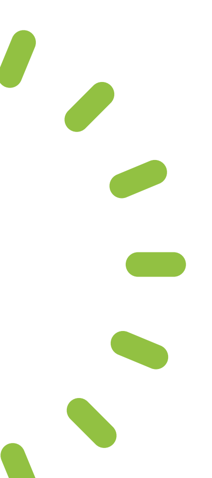
Financial Outlook

There is significant uncertainty over the scale of this likely reduction in available funding. It is therefore important to be clear that within current models of working, the reduction in budgets available will require further recurring savings to be made.

Taking into account a range of scenarios, current projections for the period 2018/19 to 2020/21 include a wide range of assumptions in respect of key cost pressures and demand, highlighting a potential budget gap for the HSCP within a range of £16m to £21m for this period. Subject to clarification over the coming months and years, the Chief Finance Officer (CFO) recommends the IJB adopts a financial planning assumption to deliver savings of up to £6.4m per annum in the years 2018/19-20/21.

The current budget gap does not take into account potential additional funding for any pressures from either the Scottish Government or our partner organisations. In addition, it does not include potential costs in relation to:

- Changes to the GP contract
- Impact of the Carers' Scotland Act (2016)
- Impact of the extension of free personal care to adults under the age of 65; and
- Unintended consequences of our partner organisations' changes in activity from 2018/19 onwards.



An ongoing assessment and update of key assumptions will be required 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.

Risks and Uncertainties

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. There is consequently no current expectation of additional monies to be delegated to the IJB in 2017/18.

There are a number of key strategic risks and uncertainties for the IJB:

- 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
- 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
- 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

The most significant financial risks facing the IJB are:

- The Health Board is required to determine an amount set aside for integrated services provided by large hospitals. In 2016/17 and 2017/18, this did not operate fully as the guidance required. There are a number of risks associated with the set aside budget which may mean the IJB will not be able to deliver the Scottish Government's expectations in relation to the commissioning of set aside services
- From 2018/19, the current risk sharing arrangement with NHSGGC for prescribing will change. This creates a new risk for IJBs as the increased cost of drugs that have a short supply is projected to create an additional financial pressure over 2018/19 in the region c£0.85m to c£1.7m

- A number of new statutory requirements such as the Carers' Act, the Living Wage and the National Dementia Strategy are anticipated to create additional financial pressures for the Renfrewshire IJB over 2018/19, some of which cannot yet be fully quantified. Without the IJB 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 that care can be more person centred. Furthermore, the current social care management system requires to be replaced within the next three years and all telecare equipment (used to support our most vulnerable service users in their home) must be upgraded from analogue to digital by 2025. These developments alone are projected to create a pressure of circa £2m.

Going Forward

This budget gap will need the IJB to consider what type and level of service is required and can safely and sustainably be delivered. We must work to deliver both a balanced budget and also continue to deliver accessible, high quality, safe and effective services. After many years of budget reductions, it is fair and reasonable to state that these dual objectives cannot be assured.

The Chief Officer, Chief Finance Officer and the HSCP Senior Management Team will work with key stakeholders to continue to critically appraise and challenge current models of service delivery to ensure resources are focused on areas of greatest need, delivering the best outcomes to clients. That said, almost all the delegated services we manage have already been subject to constructive review and redesign over recent times with productivity gains and cost efficiencies taken from every service, using where available evidence of best and safe practice, and effective service models.

The IJB's three-year Financial Plan reflects the economic outlook beyond 2018/19, adopting a strategic and sustainable approach linked to the delivery of priorities in our Strategic Plan. These priorities will continue to provide a focus for future budget decisions, where the delivery of core services must be balanced with the resources available.

Our Financial Plan, underpinned by a robust financial planning process, focuses on a medium-term perspective. It is 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. In addition, it is important the IJB works towards creating sufficient reserves to protect it during the course of the financial year. Audit Scotland will continue to closely monitor the IJB's position to ensure unallocated general working balances remain at an appropriately prudent level.

Appendix 1

Health & Care Experience Survey 2017/18

The survey was sent to 20,694 people registered with GP practices in the area.

The survey asks about people's experiences of accessing and using primary care services and was widened in 2013/14 to include aspects of care, support and caring to support the principles underpinning the integration of health and care in Scotland outlined in the Public Bodies (Joint Working) (Scotland) Act 2014.

A copy of the survey is available at: https://goo.gl/HFAmCS

4,074 people in Renfrewshire sent in feedback on their experiences. This is a 5% increase on the 2015/16 response rate. Of the people that answered questions about themselves:

- 42% were male and 58% were female
- 9% were aged 16-34; 8% were aged 35-44; 24% were aged 55-64; and 42% were aged 65 and over
- 49% did not have any limiting illness or disability

The survey was commissioned by the Scottish Government as part of the Scottish Care Experience Survey Programme, which aims to use the public's experiences of health and care services to improve those services. The survey was managed by the Scottish Government in partnership with Information Services Division (ISD) of NHS National Services Scotland.

The results of the survey will be used by GP practices, Health Boards, Health and Social Care Partnerships and the Scottish Government to improve the quality of health and care services in Scotland.

This section provides the results for those questions which align to the Health and Social Care Indicators.

The difference between the percent positive score for Renfrewshire HSCP and the Scottish average is shown in the final column.

Summary of Results

I am able to look after my own health	93%	-0
Service users are supported to live as independently as possible	79%	-2
Service users have a say in how their help, care or support is provided	73%	-3
Service users' health and care services seem to be well coordinated	71%	-3
Rating overall help, care or support services	77%	-3
Rating of overall care provided by GP practice	84%	+1
The help, care or support improves service users' quality of life	79%	-1
Carers feels supported to continue caring	36%	-2
Service users feel safe	81%	-2

Appendix 2

Renfrewshire Health & Wellbeing Profile – Scottish Public Health Observatory

Domain		Indicator	Period	Number	Measure	Type	National Average
Life Expectancy & Mortality	1	Life expectancy (Males)[18]	2011	n/a	75.3	yrs	76.6
	2	Life Expectancy (Females)[18]	2011	n/a	80.4	yrs	80.8
	3	All-cause mortality among the 15-44 year olds[12]	2014	70	116.5	sr4	98.2
Behaviours	4	Estimated smoking attributable deaths [3, 13, 16]	2014	347	377.8	sr4	366.8
	5	Smoking prevalence (adults 16+)[3, 14]	2014	N/A	20.1	%	20.2
	6	Alcohol-related hospital stays[15]	2015	1,618	945.3	sr4	664.5
	7	Alcohol-related mortality[17]	2013	46	27.0	sr4	22.1
Mental Health	8	Population prescribed drugs for anxiety/depression/psychosis	2015	33,807	19.4	%	18.0
	9	Deaths from suicide[17]	2012	26	15.3	sr4	14.2
Social Care & Housing	10	Children looked after by local authority[3]	2014	681	18.9	cr2	14.0
Economy	11	Population income deprived	2015	23,450	13.4	%	12.3
	12	Working age population employment deprived	2015	13,725	12.2	%	10.6
	13	Children Living in Poverty	2012	6,090	15.7	%	15.3
Crime	14	Domestic Abuse[3]	2015	2,151	123.2	cr9	108.1
Women's & Children's Health	15	Teenage pregnancies[12]	2013	171	34.8	cr2	37.7
	16	Women smoking during pregnancy[12]	2014	273	16.6	%	17.3
	17	Child dental health in primary 1	2015	1,181	67.9	%	69.9
	18	Child dental health in primary 7	2015	1,079	66.2	%	67.9
	19	Child obesity in primary 1	2015	156	9.0	%	9.9

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

DASHBOARD – Summary of Red, Amber and Green Measures as at March 2018

The summary chart shows 46 measures for information only; there are no specific targets for these measures.

Of the 45 measures that have performance targets, 58% show green (on or above target); 18% show amber (within 10% variance of target); and 24% show red (more than 10% variance of target).

National outcome	Red	Amber	Green	Data Only	Total	Movement
1. People are able to look after and improve their own health and wellbeing and live in good health for longer	0	2	4	1	7	No change
2. People are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community	1	1	5	14	21	One 🔴 to ✅ One 🔺 to ✅
3. People who use health and social care services have positive experiences of those services, and have their dignity respected	1	2	4	5	12	No change
4. Health and social care services are centred on helping to maintain or improve the quality of life of service users	4	2	5	5	16	One 🔴 to ✅ One 🔴 to 🔺 Three ✅ to 🔴 One 🔺 to ✅ One ✅ to 🔺
5. Health and social care services contribute to reducing health inequalities	2	0	1	4	7	No change
6. People who provide unpaid care are supported to reduce the potential impact of their caring role on their own health and well-being	1	0	0	2	3	One ✅ to 🔴
7. People who use health and social care services are safe from harm	0	0	2	3	5	No change
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 with the work they do	2	1	3	4	10	No change
9. Resources are used effectively in the provision of health and social care services, without waste	0	0	2	8	10	No change
Total:	11	8	26	46	91	

Appendix 4

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.					
PI code & name	15/16 Value	16/17 Value	Latest 17/18 Value	Target	Direction of Travel	Status
National Indicators						
HSCP/CI/HCES/01 Percentage of adults able to look after their health very well or quite well	93%	Survey. Next data expected in 2018	93%	-	-	Data only
Local Indicators						
HSCP/HI/ANT/01 Breastfeeding exclusive for 6-8 weeks	20.8%	23.1%	Sep 17: 21.7%	21.4%	↓	OK
HSCP/HI/LS/01 Increase in the number of people who assessed their health as good or very good	2014 77%	Survey. Next data expected 2017/18	Survey. Next data expected in 2018	80%	↓	Warning
HSCP/HI/LS/02 Increase the percentage of people participating in 30 mins of moderate physical activity 5 or more times a week	2014 53%	Survey. Next data expected in 2018	Survey. Next data expected in 2018	32%	↑	OK
HSCP/HI/LS/03 Reduce the percentage of adults who smoke	2014 19%	Survey. Next data expected in 2018	Survey. Next data expected in 2018	23%	↑	OK
HSCP/HI/LS/04 Reduce the percentage of adults that are overweight or obese	2014 49%	Survey. Next data expected in 2018	Survey. Next data expected in 2018	55%	↑	OK
HSCP/HI/MH/01 Increase the average score on the short version of the Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS)	2014 53.4	Survey. Next data expected in 2018	Survey. Next data expected in 2018	57	↓	Warning

↑ Improvement ↓ Deterioration — No change

Appendix 4

Renfrewshire Integration Joint Board Scorecard 2017/18

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.					
PI code & name	**15/16**	**16/17**	**Latest 17/18**	**Target**	**Direction of Travel**	**Status**
	Value	**Value**	**Value**			
National Indicators						
HSCP/CI/HCES/02 Percentage of adults supported at home who agree that they are supported to live as independently as possible	81%	Survey. Next data expected 2017/18	79%	-	-	
HSCP/CI/HCES/03 Percentage of adults supported at home who agreed that they had a say in how their help, care or support was provided	81%	Survey. Next data expected 2017/18	73%	-	-	
HSCP/CI/HCES/15 Proportion of last 6 months of life spent at home or in a community setting	87.5%	87%	89%	-	-	
HSCP/CI/HCES/18 Percentage of adults with intensive care needs receiving care at home	63%	62%	Annual figure. Not yet available	-	-	
HSCP/CI/HCES/19 Number of days people spend in hospital when they are ready to be discharged, per 1,000 population	287	107	192	-	-	
Local Indicators						
The total number of patients delayed (at census point) (Acute and Mental Health)	-	Total: 5 Acute: 5 (1<72hrs; 4>72hrs) MH: 0	Mar 18: Total: 6 Acute: 6 (2<72hrs; 4>72hrs) MH: 0 (0>72hrs)	-		
The total number of delayed discharge episodes at month end (Acute and Mental Health)	-	Total: 38 Acute: 37 MH: 1	Mar 18: Total: 50 Acute: 45 MH: 5	-		
The total number of bed days occupied by delayed discharge patients (month end) (Acute and Mental Health)	-	Total: 313 Acute: 282 MH: 31	Mar 18: Total: 353 Acute: 221 MH: 132	-		
HPBS14b1 Number of Private Sector Housing Grants awarded to disabled tenants to adapt private homes	108	217	189	-	↓	

PI code & name	15/16	16/17	Latest 17/18	Target	Direction of Travel	Status
	Value	Value	Value			
HPCHARTER22 Percentage of approved applications for medical adaptations completed during the year	96%	96%	100%	99%	↑	OK
HPCHARTER23 The average time (in days) to complete medical adaptation applications	44	40	33.57	–	–	Data only
HSCP/AS/ACP/02 Number of adults with an Anticipatory Care Plan	977	1,847	257	220	↓	OK
HSCP/AS/DEM/02 People newly diagnosed with dementia will have a minimum of 1 year's post-diagnostic support (female & male)	100%	100%	100%	100%	—	OK
HSCP/AS/HC/01.1 Percentage of clients accessing out of hours home care services (65+)	87%	89%	89%	85%	—	OK
HSCP/AS/HC/02 Percentage of long term care clients receiving intensive home care (National Target: 30%)	31%	27%	28%	30%	—	Warning
HSCP/AS/HC/07 Total number of homecare hours provided as a rate per 1,000 population aged 65+	501	460	459	–	–	Data only
HSCP/AS/HC/09 Percentage of homecare clients aged 65+ receiving personal care	98%	99%	99%	–	–	Data only
HSCP/AS/HC/11 Percentage of homecare clients aged 65+ receiving a service during evening/overnight	64%	66%	66%	–	–	Data only
HSCP/AS/HC/16 Total rate of clients receiving telecare (75+) per 1,000 population	20.71	29.13	39.47	–	–	Data only
HSCP/AS/OT/01 Percentage of clients on the OT waiting list allocated a worker within 4 weeks (Social Work Service)	20%	15%	22%	70%	↑	Alert
HSCP/AS/OT/04 The average number of clients on the Occupational Therapy waiting list	297	340	302	350	↑	OK

Alert Warning OK Data only

↑ Improvement ↓ Deterioration — No change

Appendix 4

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.					
PI code & name	15/16 Value	16/17 Value	Latest 17/18 Value	Target	Direction of Travel	Status
National Indicators						
HSCP/CI/HCES/04 Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated	77%	Survey Next data: 2017/18	71%	-	-	
HSCP/CI/HCES/05 Percentage of adults receiving any care or support who rate it as excellent or good	79%	Survey Next data: 2017/18	77%	-	-	
Local Indicators						
HSCP/AS/AE/01 A&E waits less than 4 hours	88.6%	89.5%	Oct 17: 85.8%	95%		
HSCP/AS/MORT/01 Percentage of deaths in acute hospitals (65+)	42.8%	41.3%	Dec 17: 42.2%	48.2%		
HSCP/AS/MORT/02a Percentage of deaths in acute hospitals (75+) SIMD 1	43.0%	40.4%	Dec 17: 40.9%	45%		
HSCP/CS/MH/01 Child and Adolescents Mental Health (CAMHS) - % of patients seen within 18 weeks	100%	100%	Apr 18: 100%	100%		
HSCP/EQ/EDT/02 Number of staff trained in Equality and Diversity Training	161	117	118	-	-	
HSCP/HI/SI/01 Number of routine sensitive inquiries carried out	-	71% of an audit of 319 (August and February audits combined.)	178 (56%) from 320 audited records; 95/120 Mental Health, 83/200 Children's Services	-	-	

PI code & name	14/15	15/16	Latest 16/17	Target	Direction of Travel	Status
	Value	Value	Value			
HSCP/HI/SI/02 Number of referrals made as a result of the routine sensitive inquiry being carried out	13	16	8	-	-	Data only
HSCP/MH/PCMHT/03 Percentage of Primary Care Mental Health Team patients referred to first appointment offered within 4 weeks	88%	95%	79% (87 < 4/52) (24 > 4/52)	100%	Deterioration	Alert
HSCP/MH/PCMHT/04 Percentage of patients referred to first treatment appointment offered within 9 weeks	98%	96%	98% (94 < 9/52) (2 > 9/52)	100%	No change	Warning
HSCP/MH/PT/01 Percentage of patients who started treatment within 18 weeks of referral to Psychological Therapies	99.8%	100%	100%	90%	No change	OK

Alert Warning OK Data only

Improvement Deterioration No change

Appendix 4

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.					
PI code & name	15/16	16/17	Latest 17/18	Target	Direction of Travel	Status
	Value	Value	Value			
National Indicators						
HSCP/CI/HCES/06 Percentage of people with positive experience of the care provided by their GP practice	88%	Survey. Next data: 2017/18	84%	-	-	
HSCP/CI/HCES/07 Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.	80%	Survey. Next data: 2017/18	79%	-	-	
HSCP/CI/HCES/17 Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	91%	86%	88%	-	-	
Local Indicators						
HSCP/AS/ANT/04 At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation	88.3%	89.6%	Sep 17: 85.8%	80%	↓	
HSCP/AS/HA/03 Emergency admissions from care homes	477	538	Dec 17: 388	363	↓	
HSCP/AS/HA/04 Emergency bed days rate 65+	302	297	263	-	-	
HSCP/HI/ADS/01 Alcohol brief interventions	1,036	761	Dec 17: 384	-	-	
HSCP/HI/ADS/06 Reduce the estimated prevalence of problem drug use amongst 15-64 year olds (percentage of total population age 15-64)	2.41 (14/15)	Data expected in 2018	Data expected in 2018	1.86	↓	
HSCP/HI/ADS/07 Drug related hospital discharge rate per 100,000	154.1	180.8	Annual figure. Not yet available	130	–	
HSCP/HI/ADS/08 Alcohol and Drugs waiting times for referral to treatment. % seen within 3 weeks	99.6%	93.3%	Dec 17: 87.3%	91.5%	↑	

PI code & name	15/16	16/17	Latest 17/18	Target	Direction of Travel	Status
	Value	Value	Value			
HSCP/HI/ANT/03 Reduce the rate of pregnancies for those under 16 years of age (rate per 1,000 population)	3.9	3.9	3.1	5	Improvement	OK
SOA13CHP.04 Reduction in the rate of alcohol related hospital admissions per 1,000 population	9.8	9.9	Dec 17: 8.9	8.9	Improvement	OK
SOA13CHP.11 Reduce the percentage of babies with a low birth weight (<2500g)	6.8%	5.8%	Dec 17: 6.8%	6%	Deterioration	Alert
HSCP/CS/AX/01 Uptake rate of 30-month assessment	83%	82%	89%	80%	Improvement	OK
HSCP/CS/SPL/01 Percentage of paediatric Speech & Language Therapy wait times triaged within 8 weeks	100%	100%	100%	100%	No change	OK
HSCP/CS/SPL/02 Percentage of children seen within 18 weeks for paediatric Speech & Language Therapy assessment to appointment	67%	47%	73%	95%	Improvement	Alert

Alert Warning OK Data only

Improvement Deterioration No change

Appendix 4

Renfrewshire Integration Joint Board Scorecard 2017/18

National Outcome 5	Health and social care services contribute to reducing health inequalities.					
PI code & name	15/16 Value	16/17 Value	Latest 17/18 Value	Target	Direction of Travel	Status
National Indicators						
HSCP/CI/HCES/11 Premature mortality rate. European age-standardised mortality rate per 100,000 for people aged under 75	463	491	Annual figure. Not yet available	-	-	Data only
Local Indicators						
HSCP/HI/AD/01 Smoking cessation - non smokers at the 3 month follow up in the 40% most deprived areas	254	197	148**	228	Deterioration	Alert
HSCP/HI/ANT/04 Breastfeeding at 6-8 weeks in most deprived areas	12.9%	13.6%	Sep 17: 14.5%	19.9%	Improvement	Alert
HSCP/HI/EQ/FI/04 Number of referrals to Financial Inclusion and Employability Services	1,997	935	1,107	-	-	Data only
HSCP/HI/EQIA/03 Number of quality assured EQIAs carried out	1	6	4 EQIAs plus 6 rapid EQIAs carried out on finance and service redesign proposals	-	-	Data only
HSCP/HI/GBV/01 Number of staff trained in Gender Based Violence	63	38	92	-	-	Data only
HSCP/HI/LE/01 Reduce the gap between minimum and maximum life expectancy (years) in the communities of Renfrewshire (Bishopton and Ferguslie)	14.8	14.8	7.1*	15.3	Improvement	OK

Alert Warning OK Data only

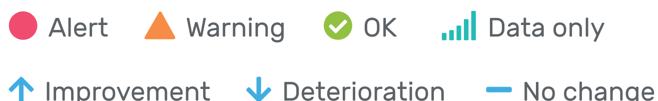
Improvement Deterioration No change

* This figure relates to new geographic boundaries and cannot now be compared to the previous figure of 14.8 years.
** Data incomplete for Quarter 4, Jan-Mar 2018

Appendix 4

Renfrewshire Integration Joint Board Scorecard 2017/18

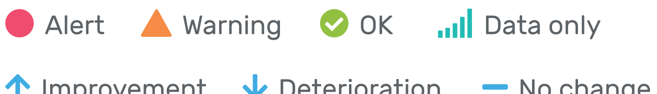
National Outcome 6	People who provide unpaid care are supported to reduce the potential impact of their caring role on their own health and well-being.					
PI code & name	15/16 Value	16/17 Value	Latest 17/18 Value	Target	Direction of Travel	Status
National Indicators						
HSCP/CI/HCES/08 Percentage of carers who feel supported to continue in their caring role (National Survey)	39%	Survey. Next data available 2018	35%	-	-	▁▂▃▅▇
Local Indicators						
HSCP/AS/AS/19 Number of carers' assessments completed for adults (18+)	80	64	49	70	↓	●
HSCP/AS/AS/20 Number of carers' self assessments received for adults (18+)	56	29	15	-	-	▁▂▃▅▇



Appendix 4

Renfrewshire Integration Joint Board Scorecard 2017/18

National Outcome 7	People who use health and social care services are safe from harm.					
PI code & name	**15/16**	**16/17**	**Latest 17/18**	**Target**	**Direction of Travel**	**Status**
	Value	**Value**	**Value**			
National Indicators						
HSCP/CI/HCES/09 Percentage of adults supported at home who agree they felt safe.	84%	Survey. Next data: 2017/18	81%	-	-	
HSCP/CI/HCES/16 Falls rate per 1,000 population aged 65+	21	16	Information available late 2018	-	-	
Local Indicators						
SOA13SW.06 Reduction in the proportion of adults referred to Social Work with three or more incidents of harm in each year	6.4%	5.8%	Information available late 2018	12%	–	
SOA13SW.08 Reduction in the proportion of children subject to 2 or more periods of child protection registration in a 2 year period	2%	3%	5%	6%		



Improvement   Deterioration   No change

Appendix 4

Renfrewshire Integration Joint Board Scorecard 2017/18

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 with the work they do.					
PI code & name	**15/16**	**16/17**	**Latest 17/18**	**Target**	**Direction of Travel**	**Status**
	Value	**Value**	**Value**			
National Indicators						
HSCP/CI/HCES/10 Percentage of staff who say they would recommend their workplace as a good place to work.	80%	-	Indicator under development	-	-	Data only
Local Indicators						
RSW/H&S/01 No. of planned SW Health & Safety Audits undertaken (both internal and 3rd party)	1	0	0	-	-	Data only
SWPERSOD07b No. of SW employees, in the MTIPD process, with a completed IDP	609	493+50 on new pilot IDP = 543	909	-	-	Data only
HSCP/CS/H&S/01 % of health staff with completed eKSF/PDP	61.1%	68.9%	75.8%	80%	↑	Warning
HSCP/CS/H&S/02 Health sickness absence rate	7.0%	5.6%	5.5%	4%	↑	Alert
HSCP/AS/SW/01 Absence and sickness rates for Social Work Adult Services Staff (work days lost per FTE)	3.68	3.65	4.34	2.36 days	↓	Alert
HSCP/CS/H&S/03 % of Health Care Support Worker staff with mandatory induction completed within the deadline	-	100%	100%	100%	—	OK
HSCP/CS/H&S/04 % of Health Care Support Worker staff with standard induction completed within the deadline	100%	100%	100%	100%	—	OK
HSCP/CS/H&S/05 Improve the overall iMatter Employee Engagement Index rating and staff response rate.	-	65%	59%	-	-	Data only
HSCP/CORP/CMP/01 % of complaints within HSCP responded to within 20 days	-	-	76%	70%	—	OK

Alert   Warning   OK   Data only

↑ Improvement   ↓ Deterioration   — No change

Appendix 4

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.					
PI code & name	15/16 Value	16/17 Value	Latest 17/18 Value	Target	Direction of Travel	Status
National Indicators						
HSCP/CI/HCES/12 Emergency admission rate (per 100,000 population)	14,410	13,865	11,072	-	-	Data only
HSCP/CI/HCES/13 Emergency bed day rate (per 100,000 population)	128,062	125,377	118,611	-	-	Data only
HSCP/CI/HCES/14 Readmission to an acute hospital within 28 days of discharge per 1,000 admissions	104	96	75	-	-	Data only
HSCP/CI/HCES/20 Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	21%	21%	21%	-	-	Data only
Local Indicators						
RSW/ILGB/SW1 Care at home costs per hour (65 and over)	£15.47	£23.56	2017/18 information available early 2019	-	-	Data only
RSW/ILGB/SW2 Direct Payment spend on adults 18+ as a % of total social work spend on adults 18+	2%	3.7%	2017/18 data available early 2019	-	-	Data only
RSW/ILGB/SW3 Net Residential Costs Per Week for Older Persons (over 65)	£369	£360	2017/18 data available early 2019	-	-	Data only
HSCP/AC/PHA/01 Prescribing variance from budget	1.07% over budget	0.83% underspent	3.95% over budget	-	-	Data only
HSCP/AC/PHA/02 Formulary compliance	79.1%	79.5%	79.66%	78%	No change	OK
HSCP/AC/PHA/03 Prescribing cost per treated patient	New indicator	New indicator	£83.70	£86.63	No change	OK

Alert Warning OK Data only

Improvement Deterioration No change

What do you think?

Please take a few minutes to tell us what you think about this Annual Report by completing this short questionnaire. This can be found online at https://goo.gl/gcltUS

1. How do you rate the design and layout of the Annual Report?

☐ Very good ☐ Fairly good ☐ Average ☐ Poor

2. How easy is it to read and understand?

☐ Very easy ☐ Fairly easy ☐ Not very easy ☐ Not at all easy

3. How useful is it in informing you about the work of your Health & Social Care Partnership?

☐ Very useful ☐ Fairly useful ☐ Not very useful ☐ Not at all useful

4. Which sections did you find particularly useful?

5. What other information would you like to see in a future Annual Report?

6. Other comments

Thank you for your feedback

Alternatively you can print and complete the questions on this page and return to

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