Renfrewshire
Health & Social Care
Partnership

Strategic Plan 2019-2022

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

Brighter futures

Contents

All supporting documents are available on the Renfrewshire Health and Social Care website at www.Renfrewshire.HSCP.scot/StrategicPlan

These include: Renfrewshire's Integration Scheme, Market Facilitation Plan, Performance Reports, Annual Reports, NHS Board Public Health Strategy 'Turning the Tide through Prevention, the Housing Contribution Statement, NHS transformation programme Moving Forward Together, the Audit Scotland Integration Report, NHS Digital Data and Information Strategy, and the Glossary

1. Introduction

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

1.1 This three year Strategic Plan sets out the vision and future direction of community health and adult social work services in Renfrewshire. It covers the period from April 2019 to March 2022 and describes how we will deliver the nine national outcomes. It is not a description of every activity the HSCP carries out, but seeks to highlight how we will continue to work with partners to deliver real improvements to Renfrewshire's health within local and national policy direction.

1.2 This is our second three-year Strategic Plan. Our Annual Performance reports note the progress we have made against our performance indicators and also use case studies to bring to life some of our activity. The last three years have been financially challenging for Renfrewshire HSCP. Our budget is made up of contributions from Renfrewshire Council and from NHS Greater Glasgow and Clyde, determined as part of their budget setting processes. Over the last year, we have commenced an ambitious service review programme covering Care at Home, Older People's Services, Learning Disability Day and Respite Services, Charging and Addictions Services. These reviews will conclude during 2019/20. We have scrutinised all spend areas to ensure that our leadership and management arrangements are effective, joint wherever possible and as lean and fit for purpose as they can be. We have also worked to remove duplication and ensure we are delivering value for money. In managing our resources we have focused on strategic and operational change and improved ways of working – we have not simply sought budget reductions in all areas. We have managed to achieve financial balance each year but have found this increasingly challenging. Our Set Aside budget for Unscheduled Care in hospital settings has remained a notional budget. We have made significant progress in reducing our reliance on unscheduled care, but have not yet seen funding released from acute services to enable further progress.

1.3 Under the Public Bodies (Joint Working) (Scotland) Act 2014, Renfrewshire Council and NHS Greater Glasgow and Clyde established Renfrewshire Integration Joint Board. Full details of this and of the delegated functions can be found in our Integration Scheme on Renfrewshire HSCP's website www.Renfrewshire.HSCP.Scot

1.4 The last three years have seen the development of a number of key national and local policies and strategies which will shape our services in the years ahead. These include the National Clinical Strategy, the Health and Social Care Delivery Plan and the Audit Scotland Report.

There has been a significant shift towards prevention and early intervention, recognising that 'more of the same' is unsustainable. A collaborative approach across West of Scotland Health Boards is being taken to develop regional planning and a longer term approach to the future of care. NHS Greater Glasgow and Clyde's transformation programme Moving Forward Together (MFT) describes a tiered model of services where people receive care as near home as possible, travelling to specialist centres only when expertise in specific areas is required. MFT explores the potential of using digital technology to a far greater extent and promotes maximising the utilisation of all resources, with a drive to ensure all practitioners are working to the top of their professional abilities. It recommends supported self care and better links between primary and secondary care. These principles are taken forward in the NHS Board's Public Health Strategy, 'Turning the tide through prevention', which will directly shape our health improvement activity and partnership work over the next three years.

1.5 The new GP contract, supported by the Primary Care Improvement Fund, has reiterated our ambition to deliver the right service, at the right time, in the right place. Our Primary Care Improvement Plan in Renfrewshire describes how we will support GPs to be able to be 'expert generalists' in working with the most complex patients in our communities. Exciting new developments have started as we transform our vaccination programme, extend and improve phlebotomy services, ensure general practice has the right support from pharmacists, advanced nurse practitioners and Allied Health Professional (AHP) staff, and introduce Community Link Workers to every practice.

1.6 Over the last three years, we have started to develop our HSCP Market Facilitation Plan. We will use this to inform and shape our internal and external commissioning processes. The Market Facilitation Plan describes demographic and workforce challenges in the context of national policy and notes how this will affect the services we commission in the future. It also helps to inform providers to enable them to respond to future procurement opportunities.

1.7 An important aspect of improving health and social care outcomes is keeping people safe and well in their communities through the provision of good housing and appropriate housing related support. Renfrewshire's Local Housing Strategy 2016-21 is the key statutory strategic plan for the area and sets out the direction for housing and housing related activity across all tenures. A Housing Contribution Statement has been developed by Renfrewshire Council and local housing associations.

1.8 This Strategic Plan has been produced in partnership with service users, carers, staff and the Third Sector. Workshops have taken place over the last six months to ensure that all stakeholders have been given the opportunity to get involved.

2. Outcomes and Our Approach

2.1 National Outcomes

Scotland's national health and wellbeing outcomes aim to ensure that Health Boards, Local Authorities and Health and Social Care Partnerships are clear about their shared priorities by bringing together responsibility and accountability for their delivery. They provide a strategic framework for the planning and delivery of health and social care services and this suite of outcomes, together, focus on improving the experiences and quality of services for people using those services, carers and their families.

The 9 national outcomes are as follows:

The 9 Health and Wellbeing National Outcomes

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

2.2 The three strategic priorities identified in our last Strategic Plan remain the principles which direct our work in Renfrewshire HSCP.

1. Improving Health and Wellbeing.
2. Providing the right service, at the right time, in the right place.
3. Working in partnership to support the person as well as the condition.

2.3 Our approach

In order to develop this Strategic Plan, we held a number of engagement events across all care groups, involving staff, providers, partners, service users and carers. As we got people together to discuss our plans for the next 3 years we asked them what they thought we should focus on in Renfrewshire to enable us to meet the national outcomes. We also discussed issues that cut across more than one or all care groups and identified key interfaces.

The Strategic Planning process has run alongside the early engagement for the service reviews of older people, learning disabilities, addictions and charging and we have ensured, where possible, that emerging issues are incorporated into this plan.

In addition, we asked people to consider 4 main areas on which we want to ensure that our efforts over the next 3 years are focused, namely:

- Prevention
- Self-management
- Treatment
- Recovery/Care/Reablement

Traditionally, health and social care services were primarily concerned with treating people, however the other areas have become more important as we continue to experience rising demand for services while at the same time aiming to improve health and reduce inequalities.

Prevention

For every care group, and for the population as a whole, there are things that can help prevent ill-health, both physical and mental, help to keep people at home for longer and delay the need for medical intervention. These can include providing people with information about services and resources in their local area, promoting active and healthy lifestyles and providing information and training on specific topics such as falls prevention. Community-led activity and partnership working with third sector and community groups is vital to this, and in Renfrewshire we have a thriving partnership of organisations already providing support. We do, however, want to ensure that we develop and enhance this to build the capacity of local people and groups to maintain their own health and wellbeing. Self care for prevention is a significant theme in our work and we know local people recognise their own role in ensuring their own health and well being is maintained.

Self-management

There has been a real shift in recent years to empower and support people to manage their long-term health conditions, including mental health conditions. The HSCP does this in a range of ways including supporting community-led activity with our community and third-sector partners, promoting tools such as My Diabetes My Way and encouraging people to access local assets and resources to maintain their wellbeing.

Treatment

Providing appropriate treatment at the right time and in the right place is at the heart of what the HSCP does, and we work closely with partners in primary and secondary care to ensure that everyone has access to the treatment they need in the most suitable setting. The Moving Forward Together programme will help us to develop and deliver a tiered model of services where people receive treatment as near home as possible, travelling to specialist centres only when expertise in specific areas is required.

Recovery/Care/Reablement

Each of the care groups has a focus on either recovery from a condition if that is possible, ongoing care if this is required or reablement where achievable. Recovery in the context of mental health and addictions is a growing and important element of our work, as well as recovery from cancer and other long-term conditions. We provide care in a range of settings for our older people and people with disabilities and aim to do that in as homely and local a setting as possible. Reablement continues to be a priority for those who have the potential to regain skills and functions to enable them to live independently for as long as possible.

2.4 Localities

Our services are delivered in 2 geographical localities (Paisley and West Renfrewshire) and each has a Locality Manager co-ordinating a range of multi-disciplinary teams and services. Since publishing our last strategic plan, the 29 GP practices within Renfrewshire have been formed into 6 clusters - two in Paisley and four in West Renfrewshire. There is more detail about these in the section on Primary Care.

The HSCP is also a key partner in the new Community Planning arrangements being developed by Renfrewshire Council which will see 7 Local Area Partnerships taking responsibility for community level governance and setting priorities and aspirations for their area.

In addition, we have been working with the Health and Social Care Alliance over the last few years to populate ALISS (A Local Information System for Scotland), and with local community groups in Renfrewshire, to make it easier for people to find local groups and activities which can support their health and wellbeing. There are currently more than 300 entries for Renfrewshire and this will continue to increase over the period of this plan.

2.5 Two key policy documents have been produced in the last year, and both underpin our strategic priorities.

Moving Forward Together (MFT) was a programme of work agreed by NHS Greater Glasgow and Clyde and the six Integration Joint Boards, which developed a vision for the future of health and social care services, based on the best available evidence and looking over the next 5-10 years and beyond. The MFT vision is shown on the diagram below:

Our vision, the blueprint for Transformation

This vision is supported by the NHS Greater Glasgow and Clyde Public Health Strategy, 2018-2028, Turning the tide through prevention. This strategy aims to accelerate the improvement in healthy life expectancy and reduce the gap between Greater Glasgow and Clyde and the rest of Scotland. It emphasises the approach to progressing public health as well as the actions, and focuses on becoming a public health organisation.

2.6 The momentum generated by Paisley's UK City of Culture bid and the legacy work which partners have supported has strengthened a sense of optimism for change in our communities.

There is growing evidence that access to the crafts, culture, heritage and creativity can contribute to health and wellbeing. Over the period of this plan, we will support this connection to improve health and wellbeing.

2.7 Our strategic priorities reflect the values, priorities and ambitions of our partner organisations, NHS Greater Glasgow and Clyde and Renfrewshire Council, and the priorities of our Community Planning Partnership.

We continue to develop strong partnerships with the third and independent sectors across Renfrewshire in order to gain an understanding of not only the issues and challenges they face, but also the strengths and attributes they can bring both strategically and operationally to the delivery of health and social care. This ensures that both sectors are aware of and engaged in the health and social care agenda locally and nationally.

Renfrewshire Community Planning Partnership 4 Priorities	Renfrewshire Council 5 Strategic Outcomes
1 Our Renfrewshire is thriving: maximising economic growth, which is inclusive and sustainable. 2 Our Renfrewshire is well: supporting the wellness and resilience of our citizens and communities. 3 Our Renfrewshire is fair: addressing the inequalities which limit life chances. 4 Our Renfrewshire is Safe: protecting vulnerable people, and working together to manage the risk of harm.	1. Reshaping our place, our economy and our future. 2. Building strong, safe and resilient communities. 3. Tackling inequality, ensuring opportunities for all. 4. Creating a sustainable Renfrewshire for all to enjoy. 5. Working together to improve outcomes.

NHS Greater Glasgow and Clyde 4 Ambitions
1. Better Care 2. Better Health 3. Better Value 4. Better Workplace

3. A Healthy Renfrewshire

3.1 Reporting on Lead Partnership Responsibility

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.

Primary Care Support

Primary Care Support (PCS) is also 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.

Over the next three years, every practice within NHS Greater Glasgow and Clyde 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 generalists.

Primary Care Improvement Plans

All Health and Social Care Partnerships have developed Primary Care Improvement Plans (PCIPs) which take account of local priorities, population needs and existing services. This work will continue throughout 2019/20, supported by the Primary Care Support (PCS) Team who provide advice and oversight on funding arrangements, and ensure effective governance arrangements are in place.

3.2 Population Health and Wellbeing

Improving the health and wellbeing of Renfrewshire's population is one of our key strategic priorities. Ill health places a burden on individuals, the community and our health and social care services. We know that poor health is socially patterned with our most deprived neighbourhoods experiencing more ill health. We will target our resources to promote health and wellbeing through prevention, early intervention and self care with a focus on reducing inequalities.

The drive to improve the public's health has recently gained momentum with the Scottish Government's published six priorities for public health and the Greater Glasgow and Clyde Public Health Strategy: Turning the tide through prevention.

Table 1: Public Health Priorities for Scotland

National Public Health Priorities
A Scotland where we live in vibrant, healthy and safe places in communities.
A Scotland where we flourish in our early years.
A Scotland where we have good mental health.
A Scotland where we reduce the use of and harm from alcohol, tobacco and other drugs.
A Scotland where we have a sustainable, inclusive economy with equality of outcomes for all.
A Scotland where we eat well, have a healthy weight and are physically active.

Table 2: NHSGGC Public Health Priorities

NHSGGC Public Health Strategy Programmes for Action
To understand the needs of the population.
To tackle the fundamental cause of poor health and of health inequalities and mitigate their effects.
To apply a life-course approach recognising the importance of early years and healthy ageing.
To intervene on the immediate causes of poor health and health inequalities.
To improve the quality of services.
To protect the public's health.

3.3 Life Circumstances

Health and wellbeing outcomes are influenced by a number of factors and in particular life circumstances. The fundamental cause of health inequality is the unequal distribution of power, money and resources. Significant inequalities exist across Renfrewshire communities. When comparing areas such as Ferguslie Park (a deprived area) and Houston (a more affluent area) the difference in male life expectancy is 7.8 years (SCOTPHO, 2017). We know the inequality in life expectancy is influenced by the pattern of deprivation especially socio-economic deprivation.

3.4 Poverty

Individuals, families and groups in the population can be said to be in poverty when they lack resources to obtain the type of diet, participate in the activities and have the living conditions and amenities which are customary, or at least widely encouraged and approved, in the societies in which they belong.

The link with poverty and ill health is well documented. Poverty is recognised as the single biggest driver of poor mental health (Mental Health Strategy 2017 – 2027). It is essential we focus efforts on this underlying cause of health inequality. We know over 7,500 children in Renfrewshire live in poverty, preventing them achieving their full potential. It is projected that the percentage of children living in poverty will rise by 2020. This is largely due to tax and benefit changes and insecure employment. We will support local collective action to meet the requirements of the Child Poverty Act 2017. We will continue to promote referral pathways for health and social work staff to direct patients and clients into financial and employability services. We will support the Renfrewshire Tackling Poverty Programme through a range of specific programmes focused on mental and physical health of children in low income families. As a Community Planning partner we will support Paisley: Our Journey Continues Cultural Plan, particularly the vision to 'lift communities out of poverty'.

3.5 Loneliness and Social Isolation

A new national strategy 'A Connected Scotland' www.gov.scot/publications/connected-scotland-strategy-tackling-social-isolation-loneliness-building-stronger-social-connections/ has been developed to tackle loneliness and isolation to ensure those at risk of becoming lonely or isolated have access to the right support networks.

Social isolation and loneliness can affect anyone at all ages and stages of life. There is increasing recognition of social isolation and loneliness as major public health issues that can have a significant impact on a person's physical and mental health.

Results from the recently carried out Renfrewshire Adult Health and Wellbeing Survey showed that one in fourteen (7%) said that they felt isolated from family and friends. Those living in the most deprived areas were more likely to feel isolated (15% most deprived areas; 5% other areas). Respondents were also asked how often they had felt lonely in the past two weeks. Two percent said that had felt lonely all the time, 4% said often, 11% said some of the time, 31% said rarely and 52% said never.

Between October 2017 and March 2018 ACUMEN and RAMH also carried out research on social connectedness within Renfrewshire. The aim of the study was to gain an understanding of people's experiences of loneliness and social isolation, and to understand how best to address these issues. The highest loneliness scores came from those who identified mental health problems as being a barrier to social connectedness. The research identified the importance of providing information on local services, including formal and informal peer support to build people's confidence to access services. Of specific importance was the view that the provision of a service, or large informal group, open-to-all, would provide an inclusive, supportive environment. The research identified a need within Renfrewshire for supportive and welcoming environments where people can come and meet others, socialise and make friends, without feeling self-conscious or stigmatised.

3.6 Adverse Childhood Experiences (ACEs)

Adverse Childhood Experiences are stressful events that occur during childhood. These events can be grouped into three main categories; abuse, neglect and household adversity (figure 1).

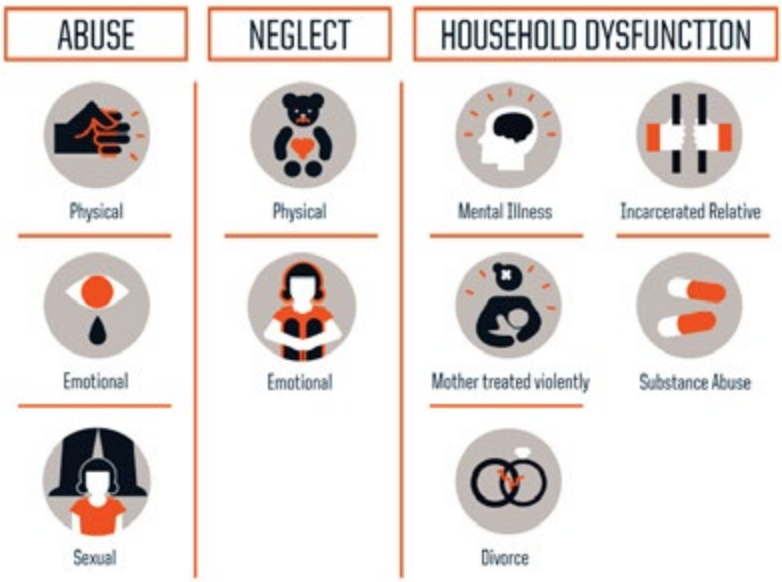

Figure 1: The Truth about ACEs

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There is evidence to show that adverse experiences in childhood can have a negative effect on health outcomes. The impact on the health of those exposed to ACEs are in the following areas:

- Injury and death during childhood;
- Premature mortality and suicide;
- Disease and illness;
- Mental health:

The impact on health harming behaviours and illnesses is stark as is the impact on the social determinants of health such as education, employment and income. Those with four or more ACEs are:

- Almost 4 times more likely to smoke
- Almost 4 times more likely to drink heavily
- Almost 9 times more likely to experience incarceration; and
- 3 times more likely to be morbidly obese.

Those with higher ACEs scores were also at greater risk of:

- Poor educational and employment outcomes
- Low mental wellbeing and life satisfaction
- Recent violent involvement
- Recent inpatient hospital care
- Chronic health problems
- Having caused/been unintentionally pregnant aged <18 years
- Having been born to a mother aged <20 years.

We will ensure that our workforce have a greater awareness and understanding of ACEs and its consequences. Our ambition for Renfrewshire is to work with our Community Planning partners to be a trauma informed area, developing a local approach to reduce the impact of adverse childhood experiences or outcomes.

3.7 Gender Based Violence (GBV)

The HSCP is a committed member of the local Renfrewshire Gender Based Violence (GBV) Strategy Group and in the production of the strategy; Equally Safe in Renfrewshire, Renfrewshire's No to Gender Based Violence Strategy 2018-2021. Gender Based Violence has an immediate and long lasting impact on the women and children in Renfrewshire who experience it. In 2015/16 there were 2,151 reported incidents of domestic abuse in Renfrewshire and 253 sexual crimes.

The rate of domestic abuse incidents reported to the Police in Renfrewshire is higher than the national average (123 per 10,000 of the population compared to 108 per 10,000, 2015/16) and between October 2015 and May 2018 our local Multi-agency Risk Assessment Conference (MARAC) heard 264 high risk cases of domestic abuse and ensured appropriate safety plans were instigated. We are committed to improving the knowledge, skills and behaviour of our staff in relation to GBV and ensuring that they are appropriately trained to identify GBV and respond appropriately to disclosures. We will continue to work with our local partners to achieve the vision that Renfrewshire is a place where Gender Based Violence (GBV) is not tolerated and where victims, perpetrators and communities are supported to address its causes and consequences.

3.8 Equalities

We have produced a set of equality outcomes and mainstreaming report to meet the requirements of the Equality Act 2010 (Specific Duties) (Scotland) Amendment Regulations 2012.

Our services must take into account diverse groups of service users irrespective of race, age, sex, sexual orientation, disability, religion, marriage and civil partnership status, sex reassignment, pregnancies/maternity and socio-economic status. We will undertake Equality Impact Assessments as a matter of course to ensure new and revised policies, strategies and services consider the impact on equality groups. We will undertake the LGBT Youth Scotland Charter of Rights Foundation Award to increase LGBT inclusion in our services. We will continue to provide information and training for our staff in order to best support our patients and clients.

3.9 Homelessness Prevention and Support

We continue to work with our partners to support those at risk of becoming homeless through regular monitoring and review of Referral Pathways into Health and Social Care Services, and by ensuring no-one is discharged from hospital without having accommodation in place.

We will continue to support the referral of pre-school age children affected by homelessness to the relevant Children and Family Service. School age children who have unmet health needs are highlighted to the School Nursing Service.

Our staff attend training alongside our partners to ensure they are qualified to support the most vulnerable and socially-excluded, including those suffering mental or physical ill-health, addiction issues, or previous trauma, any of which is affecting their ability to sustain their accommodation.

3.10 Lifestyle Behaviours

There are a number of lifestyle behaviours that impact on health. We will support people to take greater control of their health and wellbeing.

3.11 Smoking

There has been positive progress in the reduction of smokers in our population over the last six years by 9% from 24% in 2011 to 15% in 2017/18. Our Local Delivery Plan target is measured by a three month quit from 40% most deprived areas in 2018/19, quarter 1. We have exceeded the target of 57 by achieving 62 quits. However, in our most deprived areas the most recent figures indicate 28% are smokers (NHS Renfrewshire Health and Wellbeing Survey 2017/18). Smoking related illness affects both the individual's health and socio-economic outcomes placing additional demands on our health services.

Smoking cessation support will continue to be offered in Renfrewshire, both through pharmacies and NHS Greater Glasgow and Clyde's Quit Your Way Service. As an HSCP we have pledged our support by signing Scotland's Charter for a Tobacco Free Generation by 2034. This includes protecting people from second hand smoke, and reducing the number of young people who start smoking.

3.12 Diet and Obesity

Obesity is the second biggest preventable cause of cancer after smoking. It is also a significant risk factor in Type 2 Diabetes and increases the risk of cardiovascular disease and high blood pressure. Results from the Scottish Health Survey 2016 reported 65% of adults are overweight and 29% are obese. These figures are mirrored in Renfrewshire. We will continue to support weight management programmes currently offered for children and families. The Eat Better Feel Better cooking programme will be offered for the general public in addition to tailored programmes for Type 2 Diabetes. We will join with our Community Planning partners in Renfrewshire to support Scotland's Diet and Healthy Weight Delivery Plan.

In line with Improving Maternal and Infant Nutrition: A Framework for Action we will continue to promote healthy diet in the early years and promote breast feeding. Increasing our breastfeeding rates in Renfrewshire remains a priority for the partnership. The benefits of breastfeeding, for both mother and infant, are well documented; and include attachment, reducing risk of infection, and childhood obesity. The breastfeeding rate in Renfrewshire is 20.7%. However there is an inequality in the breastfeeding rate in our 15% most deprived areas with a rate of 14.5% (Sept 2017). Our efforts will be focused to address this inequality by promoting public acceptability, targeting attrition rates and achieving UNICEF Gold sustainability.

3.13 Physical Activity

In Renfrewshire 47% of adults meet the target of 150 minutes or more physical activity per week (NHS Renfrewshire Health and Well Being Survey 2017/18). Physical inactivity results in significant cost to society and the NHS. Growing evidence supports the health, economic, and social benefits which taking part in physical activity can bring, particularly by improving psychological wellbeing and maintaining healthy weight. We will join with our Community Planning partners in Renfrewshire to support Scotland's Physical Activity Delivery Plan.

3.14 Alcohol and Drugs

For the majority of adults alcohol can be enjoyed as part of their social lives and can bring employment and income to the local economy. However, increased availability and affordability has brought significant health harms to individuals, families and local communities as well as lost productivity and costs to services. When considering health harms there is evidence that some progress is being made in Renfrewshire. Data relating to alcohol related hospital stays is used as an indicator which shows the impact alcohol has on individuals. The last three years have seen small decreases in the number of alcohol related hospital stays which is comparable with the rest of Scotland.

Equally damaging is the impact of drug misuse. It is a contributory factor in violence and crime and affects lives at every level. Those affected have suffered difficult life circumstances and are the most marginalised due to the stigma associated with drug addiction. The estimated number of problem drug users in Renfrewshire is significant and remains higher than the Scottish average.

Addressing wider social inequalities, for example, employment, as well as tackling poverty, can play an important role in the prevention of drug and alcohol misuse and associated harms. As well as raising awareness of low risk drinking guidelines in Renfrewshire we will continue to increase knowledge of the impact of employability and poverty on individuals affected by alcohol and/or drug misuse.

Community Planning Partners will establish a commission to assess the nature, causes and impact of drugs and alcohol misuse in Renfrewshire.

3.15 Positive Mental Health

In Scotland, at least one person in four will experience a mental health issue at some point in their lives and one in six has a mental health issue at any one time. Individuals with poor mental health experience a range of inequalities. They are less likely to rate their general health as good or very good with only 46% of those with a mental health issue rating their health as good compared with 74% of those with no mental health issue. They also more likely to smoke, 31% compared to 20% for those who do not have poor mental health (Scottish Health Survey 2016). In a recent survey one in fourteen people felt isolated from family or friends. The effect of loneliness and isolation on mortality is comparable to the impact of well-known risk factors such as obesity, and has a similar influence as cigarette smoking (Holt-Lunstad et al, 2010[1]). We will continue to enable people to become better connected with each other through community led activity and by using community assets available in Renfrewshire to support positive mental health and wellbeing.

3.16 Priorities for 2019–22

The main priorities for the next three years are:

- Promote positive mental health and wellbeing across the life course from birth to older age.
- Improve outcomes for children in the early years.
- Contribute to reduction in child poverty and inequality by supporting activities which promote income maximisation.
- Work with our Community Planning partners to support local action on Scotland's delivery plans for physical activity, diet and healthy weight.

1. Holt-Lunstad et al (2010) Social Relationships and Mortality Risk

4. Renfrewshire Our Profile

4.1 Population

According to the latest official statistics from the National Records of Scotland (NRS), the population of Renfrewshire is 176,830. The breakdown of this figure into age groups and sex is shown in the table below. There are more women than men in every age group except for those aged 0-15 and 16-29. Overall, Renfrewshire's age breakdown matches the rest of Scotland with the exception being the 45-59 age group, where the percentage population is slightly higher in Renfrewshire and the 16-29 age group where the percentage population is slightly lower than the rest of Scotland.

Renfrewshire	Total	Males	Females
0-15	30,039	15,268	14,771
16-29	30,167	15,319	14,848
30-44	32,234	15,679	16,555
45-59	40,627	19,329	21,298
60-74	29,076	13,762	15,314
75+	14,687	5,903	8,784
Total	176,830	85,260	91,570

Source NRS mid-year population estimates 2017

Projections of Future Population

The size and make-up of the population going forward will be a key consideration when planning and delivering health and social care services. The 2016-based NRS population projections table below shows the estimated change in the population to 2041.

Population Projections to 2041

Age Group	2016		2026		2036		2041	
	Number	%	Number	%	Number	%	Number	%
0-15	29,954	17%	30,222	17%	29,838	16%	29,516	16%
16-29	30,237	17%	27,307	15%	27,331	15%	27,199	15%
30-44	31,892	18%	35,736	20%	33,435	18%	31,922	18%
45-59	40,649	23%	34,107	19%	34,221	19%	36,412	20%
60-74	28,656	16%	33,349	19%	34,047	19%	30,894	17%
75+	14,542	8%	17,901	10%	22,544	12%	25,660	14%
Total	175,930	100%	179,622	100%	181,416	100%	181,603	100%

Source: NRS population projections, 2016-based

4.2 Life Expectancy

The following table shows female life expectancy at birth is greater than male life expectancy in Renfrewshire and in Scotland. Both male and female life expectancy at birth is lower in Renfrewshire than the Scottish average.

While life expectancy at birth has improved for both males and females in Renfrewshire since 2001, there has been a greater improvement for males.

	Renfrewshire		Scotland	
Life Expectancy	Male	Female	Male	Female
2001-03	71.9	78.1	73.5	78.8
2015-17	76.2	80.2	77.0	81.1
% change 2001 – 03 to 2015-17	6.0%	2.7%	4.8%	2.9%

Source: National Records of Scotland

4.3 There are a number of demographic and activity changes that will affect our current and future understanding of need across Renfrewshire.

Ageing Population

The population projections show the percentage of the population in older age groups is due to rise, with an expected increase of 76% for those aged 75+. By 2041, 14% of our population will be over 75 compared to 8% in 2016.

Long Term Conditions

We will see an increase in people living with long term conditions. These are health conditions that last a year or longer, impact on a person's life and may require ongoing care and support.

Increase in Dementia Rates

We expect to see a 47% increase in dementia prevalence by 2035. Current prevalence is 2,994 people at 2017, with a projected prevalence of 4,400 by 2035.

Reliance on Unpaid Carers

Carers in Renfrewshire provide unpaid health and social care to others, usually relatives and close friends. The 2011 Census showed that 17,759 people identified themselves as carers, 10% of the population of Renfrewshire at that time. Just over a quarter of those carers (4,619) provided 50 hours or more of unpaid care per week.

Social Work/Social Care

Contacts with adult social work services have increased by 31% in the last five years, from 22,338 to 29,259. Care at Home services have also seen significant growth in demand and this is expected to continue over the next 5+ years.

In an average week, 15,200 hours of care are delivered to 1,828 clients, most of whom are over 75 years of age.

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). The average age of residents in Renfrewshire care homes has increased from 82 to 88 over the last five years. This means the typical care home resident is older, frailer, likely to have dementia and have a range of long term conditions. The current vacancy rate is over 10% so work is being taken forward to assess the appropriateness of this model of care.

Self-Directed Support

Self-directed support (SDS) gives people control over their 'individual' budget. It lets them choose how it is spent to meet their assessed social care needs. As more people are allocated and manage their own budgets, we must respond both to what services are available and delivered, and also the impact on services where the consequences of SDS reduces the funding available to them and/or the level of demand.

These demographic changes will direct HSCP planning and activity and are likely to include:

- More specialist dementia services and more dementia aware services
- Services working with older, frailer people with multiple long term conditions
- Supporting people at home and in the community with appropriate service delivery
- Developing community resources across Renfrewshire to support our efforts to keep people at home
- Maximising the use of our estate and using fit for purpose buildings
- Delivering best value and making best use of all resources
- Responding to changes in demand as people have increased control of their own budget
- Meeting demand as it arises out of hours and at weekends
- More accessible housing for small/single households, appropriately clustered for support.

5. Measuring Our Progress

5.1 Renfrewshire HSCP has a well developed Performance Framework reporting on over 60 indicators to our IJB every 6 months with additional performance reports at every IJB.

A summary Performance Dashboard and a full Performance Scorecard, structured around the nine National Health and Wellbeing Outcomes, is reported twice a year. We also present performance updates from service areas; exception reporting; updates on survey results as they become available; and benchmark our performance on the national indicators against other Health and Social Care Partnerships across Scotland.

The Strategic Planning Group (SPG) has a key role in reviewing the Strategic Plan and in monitoring progress.

We are also required to produce an Annual Performance Report which measures our performance against the National Core Integration indicators; focuses on the experience and quality of services for people using services, carers and their families; provides an assessment of our performance against the Strategic Plan and Financial Statement; and evidences how Partnership decisions have contributed towards improved outcomes.

Previous Performance Reports and our 2016/17 and 2017/18 Annual Reports can be found on the Renfrewshire HSCP website.

5.2 We can demonstrate significant progress against the commitments of our last three year plan:

Improving Health and Wellbeing

Prevention, Anticipatory Care and Early Intervention

We said:

We will maintain high childhood immunisation rates

Our MMR immunisation rate for 2 year olds is 97.2%, above the target of 95% and the Scottish and NHS Greater Glasgow and Clyde rates.

We will improve anticipatory care planning

We have agreed a process to support Anticipatory Care Planning and are working with GPs and others to increase coverage.

We will support people to take greater control of their own health

We have trialled a service to provide easier access to rescue medications through pharmacy for people with COPD. We have supported people with diabetes to better manage their conditions by accessing advice locally and offering specialist cooking classes.

Community Led Activity

We said:

We will support the tackling poverty programme

We have led three initiatives through the Tackling Poverty Programme. The Peer Education Programme and school counselling in all Renfrewshire secondary schools will improve resilience and mental health for young people. Healthier Wealthier Children is the financial advice service improving access for families with new babies.

We will enable people to become better connected

We have also developed a local directory of services, Well in Renfrewshire (WiRe) to help people access local groups.

Addressing Inequalities

We said:

We will target our intervention to reduce inequalities

We have worked closely with the pharmacy in Ferguslie to target smoking cessation, money advice and diabetes support services in an area where uptake of these supports is generally low and where there are significant health inequalities. This has shown that targeted support through accessing a local pharmacy increases accessibility for a population who are less likely to use traditional models.

Adult and Child Protection

We said:

We will develop our child protection services to keep Renfrewshire's children safe

We have undertaken a multi agency case file audit including an audit of GP records. We have put a system in place to regularly review the recording within child's electronic record of children on Renfrewshire Child Protection Register and now share this register with GP practices quarterly.

We will protect and support adults at risk of harm

We have undertaken a large-scale, multi-agency self-evaluation, inclusive of a case file audit and consultations with relevant stakeholders. Local best practice and areas for development were identified, which has helped shape our future priorities.

Providing the Right Service, at the Right Time, in the Right Place

Pathways through and between services

We said:

We will test new approaches to reduce hospital admissions

We have undertaken a major review of our Care at Home services to ensure they are better able to support people who are at higher risk of hospital admission. We have further developed out technology enabled care services (TECS) to ensure we can respond to people with chronic conditions by supporting them at home. We work closely with care home providers to support them to avoid hospital admissions where possible.

We will improve the transition process for children moving into adult learning and disability servces

For children moving into adult services, we have in place a transitions protocol which is being reviewed in collaboration with education and social work children's services colleagues.

Appropriate Accommodation Options to support Independent Living

We said:

We will improve services for those at risk of homelessness

We continue to review and improve referral pathways into Health and Social Care Services for those at risk of homelessness. For those with multiple and complex needs, are socially excluded and have experienced repeat homelessness, the Council's Housing First Initiative provides tenancies, in conjunction with wrap-around support packages delivered by Turning Point Scotland's Support Workers who assist tenants to access health and social care services relevant to their needs.

Managing Long Term Conditions

We said:

We will take the opportunities offered by technology

My Diabetes My Way (MDMW) is a useful website for patients and improves their understanding of their own disease, by allowing patients to follow their diabetes, see their blood results and follow their blood pressure readings. We encourage all practices and services to promote this www.mydiabetesmyway.scot.nhs.uk. Over the last year there has been a steady rise in people signing up to MDMW in Renfrewshire from 1,340 individuals signed up (Apr to June 17) to 1,713 (Apr to June 18).

We will focus on self management

In addition our HSCP website offers links to advice on how to look after your own and family's health www.renfrewshire.hscp.scot/article/5044/Self-Care.

Working in Partnership to Treat the Person as well as the Condition

Personalisation and Choice

We said:

We will learn from patient experience

We have worked with a local volunteer to gain valuable insight into patient service user and carers' experience. A number of services invited the volunteer into their services to have conversations with people we care for and their carers about their experience, treatment, involvement and care.

Support for Carers

We said:

We will support young carers

Young carers are supported to complete a 'Young Carer Statement' which identifies a young carer's individual needs and personal outcomes and forms a plan to help them achieve their goals. The aim of the Statement is to support young carers to have a life alongside their caring role.

We will support the health and wellbeing of carers

Our local Carers' Centre provides a range of services including information and advice; a break from caring; training; one to one support; group support and advocacy. We have developed a new pathway with the Carers' Centre to encourage more carers to complete Adult Carer Support Plans.

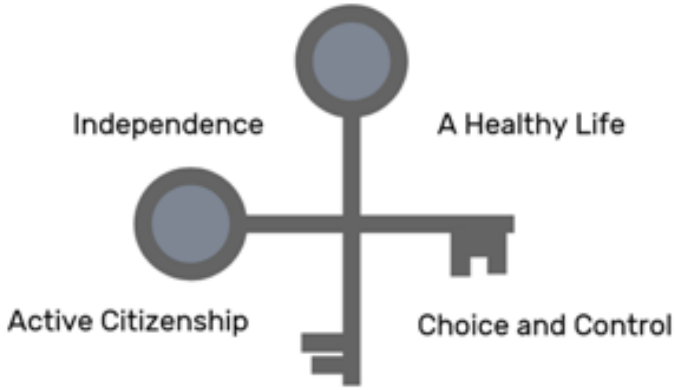
Section 2 - The People We Care For

6. Learning Disabilities

Our HSCP provides services to over 500 adults with a learning disability. Thirty-eight percent of this group of people are aged 35 to 55, and a growing number (12.7%) are aged over 65. We have just completed a review of Learning Disability Day and Respite services, supported by an independent organisation, Paradigm. The output from this review will be built into our priorities for 2019-22.

6.1 What Outcomes do we want for People with a Learning Disability?

The national LD Strategy, Keys to Life, identified four strategic outcomes. In Renfrewshire, we work with people to ensure our services and activities promote these outcomes and the principles embedded within the Keys to Life.



6.2 So, what should our services look like to support this?

Renfrewshire HSCP staff and supported people described ideal services to us. They spoke about wanting to be active in local communities and to be included and there was strong support for developing and building specialist services for people with complex disabilities.

Flexible | Accessible | Inclusive | Affordable

At a consultation event in Johnstone we asked those attending about:

	What's Important	Concerns
Where they live	Being near family/ amenities, stability, feeling safe, neighbours, good staff	Traffic, reliance on staff and family, noise
How they access health services	Having time to talk to doctor, having issues clearly explained, nice friendly staff	Long waits, doctors talking too fast, complicated letters
Accessing community clubs and resources	Sports and physical activity, social networking, wide range of activities	Attending specialist services, rather than accessing wider range available in community
Transport in Renfrewshire	Attitude of people working on public transport. Reliability (buses and taxis)	Booking a ramp on the train in advance. Machines for travel cards not working. Few buses in rural areas.

Engagement and consultation is very important to those who use or are involved in these services. In the last year, extensive engagement has been led by Paradigm (to inform the service review) and through the National Involvement Network.

6.3 Current Services

Integrated LD Team

This consists of specialist nurses, social workers, physiotherapists, speech and language therapy, occupational therapy, psychologists and psychiatrists. The team dealt with over 700 referrals last year.

Day Opportunities

- Mirin Day Services – up to 75 places daily, co-located in the Lagoon Leisure Centre, for people with moderate to severe learning disabilities.
- Milldale Day Services – up to 75 places daily, co-located in the ON-X Centre, for people with moderate to severe learning disabilities.
- Anchor Centre – up to 48 places daily for people with a complex learning disability and often with health needs. Flexicare, providing support to over 200 adults and children with autism and learning disabilities.
- Spinners Gate - Gateway service offering intensive support for 17 individuals daily with complex autism and communication challenges. Community Network service supporting up to 30 adults with moderate learning disabilities. This service will be extended in Paisley and into the Johnstone area.

Respite

Weavers Linn - 10 place building based respite unit.

6.4 Celebrating Success

Services have progressed and improved over the last three years. Following our commitment to the National Involvement Network and the appointment of a Participation and Engagement Officer, we can show how we are listening to and hearing supported people. We have:

- focused on improving physical health by supporting the screening programmes (bowel and breast) and by supporting improved foot care and oral health;
- Identified communication as a priority and have worked with speech and language therapists to profile communication needs and trained staff to support this.
- Improved post diagnostic support for people with dementia and have progressed our autism spectrum disorder work.

In response to a request from carers, we have re-established a learning disability planning group.

Work is ongoing to develop more robust transition planning for young people and their families who will need support from adult services. Nursing staff in the Community Learning Disability team continue to develop and prioritise acute care support plans for adults whose needs are complex and need care from primary and acute services.

The Community Learning Disability Team is working with partners across the Greater Glasgow and Clyde area to progress work following on from the NHS Board-wide review of Learning disability in patient services. In particular, approaches to minimising risk of admissions, planning and commissioning of robust community supports, and the prevention of delayed discharges.

6.5 The Challenges

The Learning Disability Service has faced some difficult challenges in the last year, and we continue to address these issues. These include:

Self Directed Support: whilst this responds to individual need, it can make forward planning difficult, as clients redirect funding from traditional services. In the last year, one provider has had to serve notice to quit as funding levels can no longer sustain the service.

Staff Recruitment: process issues and the availability of staff make recruitment an ongoing challenge.

Building Trust with Carers as Partners: at an individual level, relationships between carers and HSCP staff are constructive and helpful. At a strategic level, we need to develop that relationship and foster a partnership to give carers a meaningful voice in service planning.

Transport: There are ongoing problems with availability of appropriate transport to take people with learning disabilities to community activities and day services.

Unlocking Out of Area Placements: there are some clients placed in out of area placements because no suitable service is available in Renfrewshire. We aim to keep Renfrewshire people in Renfrewshire or near to their local community wherever we can.

Up-Skilling Staff: In particular, mental health and dementia are increasing areas where we need to develop staff and to support clients.

Out of Hours Support: people want to be supported to use services at weekends and in the evenings. SDS can facilitate this model and we need to further develop our services to be more flexible.

Single Referral Process: the process of assessment and review is the same for clients with hugely varying levels of need, making the system slow and unresponsive in cases where levels of need are lower.

6.6 Priorities for 2019-22

The main priorities for the next three years are:

- Implement the findings of the day services and respite review, to develop a wide range of day opportunities, reflecting the diversity of need in our learning disabled population
- Develop the supported people/service user involvement network as a powerful voice and provide evidence of how services develop and change as a result of the views of service users
- Build a positive partnership between service users, their families and carers, and staff to influence the wider services and resources in Renfrewshire to better include people with a learning disability.

7. Physical Disabilities and Sensory Impairment

The most recent census data notes that there are 12,593 people in Renfrewshire with a physical disability – 7.2% of the population compared to 6.7% across Scotland. Older people are more likely to have a physical disability. Only 1.1% of 16-24 year olds have a physical disability, but this rises to 34.6% of those over 85 having a disability. In addition, 6.9% of Renfrewshire's population are deaf or have partial hearing loss, and 2.4% are blind or have partial sight loss. In 2016/17, the HSCP carried out 941 small adaptations to properties and provided 7,688 pieces of equipment for people with a physical disability or sensory impairment.

7.1 What Outcomes do we want for those with a Physical Disability or Sensory Impairment?

National Outcome 2 is that "people, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently or in a homely setting in their community". This is a priority outcome for our population with physical disabilities or sensory impairment.

7.2 So, What's Important to people who have a Physical Disability or Sensory Impairment?

Discussions with service users, and with staff who support them, highlighted areas which are important to them.

Flexibility | Information | Choice | Affordability

7.3 Current Services

The sensory impairment team offers specialist information, advice and support to deaf or hearing impaired people, blind or visually impaired people, carers and professionals. The Disability Resource Centre in Love Street, Paisley, offers day activities to over 100 adults and acts as a hub for a wide range of activities and groups, including Renfrewshire Access Panel and Citizens' Advice Bureau. It works closely with Third Sector partners, and is highly valued by service users.

Housing services are key to supporting people with a physical disability and sensory impairment, particularly Care and Repair services and Aids and Adaptations.

The Community Physical Disability Team within RES provide a rehabilitation service to adults aged 16-65 years, including those with brain injuries. Our Occupational Therapy Team also provide support to people living independently in the community, and Telecare support provides additional safety to aid independence.

7.4 Implications and Challenges for HSCP Services

Health Services: We will continue to raise staff awareness about reducing barriers to access to services. A positive example of this is the production of the DVD for staff dealing with people with a visual impairment. Access to screening services is important and requires different approaches. The transition from children's into adult services can be difficult for young people and their families.

Day Services: We will continue to offer a range of services from buildings based services at the Disability Resource Centre (DRC), to services and groups reaching into the centre, to accessing services in local communities.

Employment: Access to work and volunteering is challenging for people with a physical disability or sensory impairment. We will continue to promote opportunities for the HSCP and partners, as major employers in the area, to support this work.

Financial Issues: Our engagement events highlighted a number of financial issues which impact on those living with a physical disability:

i. SDS budgets are not sufficient to support people on a one-to-one basis for significant periods of time.

ii. People are concerned about losing benefits when working, especially if their health is unpredictable.

iii. People are worried about changes to the benefits system and the local charging policy in case they are less well off.

iv. Respite at home is expensive, but preferred by many service users.

Information: Our engagement event highlighted a wide range of services which many people were unaware of. The DRC provides a good focus for activities but there are many other activities happening in local communities which are accessible to all but not widely known about.

Social Isolation: The risk of social isolation is high where people have a communication difficulty or where they cannot easily access local services. In particular, young people with a sensory impairment in mainstream schools may experience isolation.

7.5 Priorities for 2019-22

The main priorities for the next three years are:

1. Information and technology

- Share up to date information about services which are available across Renfrewshire.
- Explore the potential to exploit technology and Apps to support people with a sensory impairment or physical disability.

2. Access health and care services

- Support people with a physical disability or sensory impairment to avoid hospital admission.
- Support people with a physical disability or sensory impairment to enjoy better physical and mental health and to access screening opportunities.

3. Infrastructure and environment

- Support people to access appropriate financial advice.
- Lobby for more accessible transport to support people to be able to access community resources.

Artwork from the Learning Disability Resource Centre

8. Older People

We know that there are just over 42,500 people in Renfrewshire aged 60 years and over. 50% of this group are aged 75 years and over and these figures are expected to increase.

Projections show that the percentage of the population in older age groups is due to rise, with an expected increase of over 70% for those aged 75+ from 8% in 2014 to 13% in 2039. (Source: RHSCP Renfrewshire's Profile to inform Strategic Commissioning April 2018)

Population Projections to 2041

Age Group	2016		2026		2036		2041	
	Number	%	Number	%	Number	%	Number	%
0-15	29,954	17%	30,222	17%	29,838	16%	29,516	16%
16-29	30,237	17%	27,307	15%	27,331	15%	27,199	15%
30-44	31,892	18%	35,736	20%	33,435	18%	31,922	18%
45-59	40,649	23%	34,107	19%	34,221	19%	36,412	20%
60-74	28,656	16%	33,349	19%	34,047	19%	30,894	17%
75+	14,542	8%	17,901	10%	22,544	12%	25,660	14%
Total	**175,930**	**100%**	**179,622**	**100%**	**181,416**	**100%**	**181,603**	**100%**

Source: NRS population projections, 2016-based

People in Renfrewshire are living longer and experiencing multiple long-term conditions which will have significant implications for health and social care. 43% of all emergency admissions to hospital in 2016/17 were for people aged 65 and over.

The transition from hospital to home setting is becoming more complex, in particular for those who are frail, elderly and who live alone.

Population projections for those aged 65 years and over accounted for 34.6% of single occupancy households in Renfrewshire, some of who may be living in social isolation and experiencing loneliness.

Dementia

We expect to see a 47% increase in dementia prevalence by 2035. Current prevalence is 2,994 people at 2017, with a projected prevalence of 4,400 by 2035.

Scotland's Dementia Strategy 2017-2020 set out an action plan based around 21 high level outcomes that will shape local dementia services. The Renfrewshire Dementia Strategy Group is currently undertaking a consultation to engage with staff, public and service users to inform the development of a local Renfrewshire Dementia Strategy.

In line with the Moving Forward Together strategy, we intend to look at new approaches to community based dementia care as alternatives to hospital care.

8.1 What outcomes do we want for older people?

When we asked what was important for older people, issues such as health and wellbeing, loneliness and isolation, staying mobile, being supported to live at home, connections to community, quality of life and being safe from harm were priority areas.

We have summarised this into two overall outcomes to complement and help fulfil the nine National Outcomes:

- Older people are supported to live in their own home, or in a homely setting, with links to their community, for as long as possible
- Older people are supported and encouraged to look after and improve their own health and wellbeing and live in good health for as long as possible.

Through earlier identification of frailty, people are supported to improve function and reduce falls, in turn preventing avoidable hospital admission.

8.2 What is the range of services currently available to older people?

There are a number of ways in which services are provided to older people in Renfrewshire, and we want to ensure we keep the things that are good and change those no longer fit for purpose. We provide and/or commission assessment and care management; adult protection; rehabilitation and reablement; mental health services; care at home; district nursing; nursing care; supported living; day services and residential care homes. Within Renfrewshire there are five day-centres operated by the Partnership, one commissioned day centre and three residential care homes, some of which are often or always under-used or under-occupied. With the introduction of Self-directed Support, people are choosing to arrange their care in different ways and we need to respond to this change to make better use of our resources.

8.3 Older People's Service Review

An Older People's Services Review was commissioned by the HSCP. This was supported by an external advisor and will report in 2019.

The Older People's Services Review engaged with service users, carers, professional leads, staff, providers, third sector organisations, housing and other key stakeholders. An Older People's Working Group was formed, the members of which acted as representatives of their communities or organisations and participated in a series of workshops.

Within the scope of the review were:

- Care Homes
- Older People's Day Centres
- Older People's HSCP inpatient provision
- Wards 37 and 39 at the RAH and commissioned beds at Darnley Court
- Extra Care Housing and Community Services
- Learning Disabilities within an ageing population

8.4 Priorities for 2019-22

The main priorities for the next three years are to implement the findings of the Older People's Review, including:

- Explore how to make best use of bed-based services
- Continue to develop and support community services which provide a range of diverse activities
- Work with Third Sector partners and other stakeholders to support the prevention agenda and support people to live independently and in their community or in a homely setting.
- Develop a local plan for people with dementia, building on the national strategy.

9. Mental Health

9.1 Renfrewshire Health and Social Care Partnership supports the Scottish Government's 'Mental Health Strategy 2017-2027' and the guiding ambition that 'we must prevent and treat mental health problems with the same commitment, passion and drive as we do with physical health problems.

This means working to improve:

- Prevention and early intervention
- Access to treatment, and joined up accessible services
- The physical wellbeing of people with mental health problems
- Rights, information use, and planning.

In response, the Chief Officers of the six Health and Social Care Partnerships within Greater Glasgow and Clyde, and in partnership with NHS Greater Glasgow and Clyde commissioned and developed 'The Five-year Strategy for Adult Mental Health Services in Greater Glasgow & Clyde: 2018-23'. The strategy concentrates on the following 7 strands of work:

- Unscheduled care, including crisis responses, home treatment, and acute mental health inpatient care.
- Recovery-oriented care including inpatient provision and a range of community-based services, including local authority and third sector provision.
- Well-being-orientated care including working with children's services to promote strong relational development in childhood, protecting children from harm and enabling children to have the best start.
- Productivity initiatives in community services to enhance capacity while maintaining quality of care.
- Medium-long term planning for prevention of mental health problems.
- Bed modelling – Short Stay mental health beds: underpinning the first three strands is the need to estimate the number and type of hospital beds that the system needs to provide in order to deliver effective care.
- Shifting the Balance of Care – Rehabilitation and Long Stay Beds: moving away from hospital wards to community alternatives for people requiring longer term, 24/7 care, with residual mental health rehabilitation hospital beds working to a consistent, recovery-focused model.

We recognise that good mental health and resilience are at the heart of our vision and we will ensure that mental health and physical health are given equal status and priority. As part of NHS Greater Glasgow and Clyde we will continue to work with our community planning partners to ensure that mental health and wellbeing is a priority across the whole of Renfrewshire.

9.2 Key facts and drivers for change

An individual's mental health can be shaped by various social, economic, and physical environments operating at different stages of life. Risk factors for many common mental disorders are associated with social inequalities, whereby the greater the inequality the higher the inequality in risk.

It is estimated that 1 in 4 adults in the UK will experience a mental health disorder in the course of an average year and that 1 in 6 will experience one at any given time. A person's mental health is not static – it may change over time in response to different life stages and challenges. Using the 1 in 4 people estimation means that over 35,500 adults in Renfrewshire experience a mental health problem in an average year. In the 2011 Census, 5.2% of Renfrewshire's population (9,084 people) reported suffering a mental health problem. This suggests that almost three-quarters of people who may be experiencing mental health challenges either do not consider this a long-term condition or are reluctant to publicly acknowledge it.

The rate of hospitalisation for psychiatric conditions is 281.9 (272.5) per 100,000 residents, which is above the Scottish figure of 261.9 per 100,000. Within Renfrewshire, there is a great deal of variation, with psychiatric hospitalisations per 100,000 people ranging from 59.8 in Houston South to 397.8 in Paisley East.

The rate of deaths from suicide, which is strongly linked to mental health problems, is similar to the Scottish average – 13.2 per 100,000 people, compared with 13.3 nationally. In some parts of Renfrewshire, it is considerably higher – 15.6 in Gallowhill and Hillington, and 21.9 in Paisley North West.

There is also a strong link between mental health problems such as depression and overconsumption of alcohol. In 2016, there were 1,634 alcohol-related hospital stays in Renfrewshire, which is a rate of 944.3 people per 10,000 of population. This is significantly higher than the national rate of 680.8 people.

The prevalence of mental health conditions is much higher amongst people with learning disabilities than amongst the rest of the population. Diagnosable psychiatric disorders are typically present in 36% of children and young people with a learning disability, compared with a whole population rate of 8%.

The management of welfare guardianships continues to be an area of high demand. As of 31 March 2018, the Chief Social Work Officer (CSWO) had responsibility for 117 Welfare guardianships, which included 20 new orders granted during period 2017/18. In addition, Renfrewshire Council applied for an Intervention Order in 20 cases during 2017/18. These are in addition to the Welfare Guardianships and can include an application for the appointment of a financial guardian where the authority seeks the appointment of an independent solicitor to act in this role. There are currently over 450 such guardianships across Renfrewshire.

The key drivers for change are contained within the diagram below.

9.3 Strategic Direction

Action15 is one of the 42 commitments in the national Mental Health Strategy 2017 – 2027. Scottish Government Ministers gave a commitment to provide funding to support the employment of 800 additional mental health workers across Scotland to improve access to mental health services for those in need. The goal was to 'Increase the workforce to give access to dedicated mental health professionals in all Accident and Emergency departments, all GP practices, every police station custody suite, and in our prisons.'

At a Greater Glasgow and Clyde level the share of national workforce target, were it to be distributed equally, is 179 additional mental health workers to be achieved in 4 years. (Renfrewshire share of this is 27.2 by 2021/22). The Health Board and HSCPs will work across boundaries and take a collaborative approach due to the way that mental health services are delivered to optimise use of resources in support of delivery of the GGC-wide Mental Health Service.

A number of key developments in relation to the above are underway for year 1, of which some are implemented on a Boardwide basis and others are local to Renfrewshire. Some of these are listed below.

Boardwide:

- Investment in trauma informed and mental health training and a range of prevention initiatives including suicide prevention, Safe Talk
- Roll out of the Cognitive Behavioural Therapy (CBT) service across GG&C
- Unscheduled Care; deliver an efficient out of hours response to planned and unplanned mental health support and assessment
- Deliver an efficient and responsive mental health support to people within the police custody service
- Review of Rehabilitation Beds. This will promote shifting the balance of care and reduce reliance on inpatient services

- Psychological Intervention in Prisons to improve transitions from prison to community and improve support for long term prisoners
- The development of a bipolar hub with the third sector to support service users with longer term care
- Implementation of an evidence-based framework of care for people with Borderline Personality Disorder (BPD) ensuring access to a coordinated programme of clinical care
- Development of a recovery model of care for mental health service users focusing on mental health support and third sector engagement. Peer Support Worker Test of change.

Renfrewshire

- Management of Borderline Personality Disorder Patients on transition from Inpatients into the Community providing additional support.
- Establish a Recovery Hub for Patients with Mental Health and Addiction Issues.
- Establish a test of change linking physical and mental health

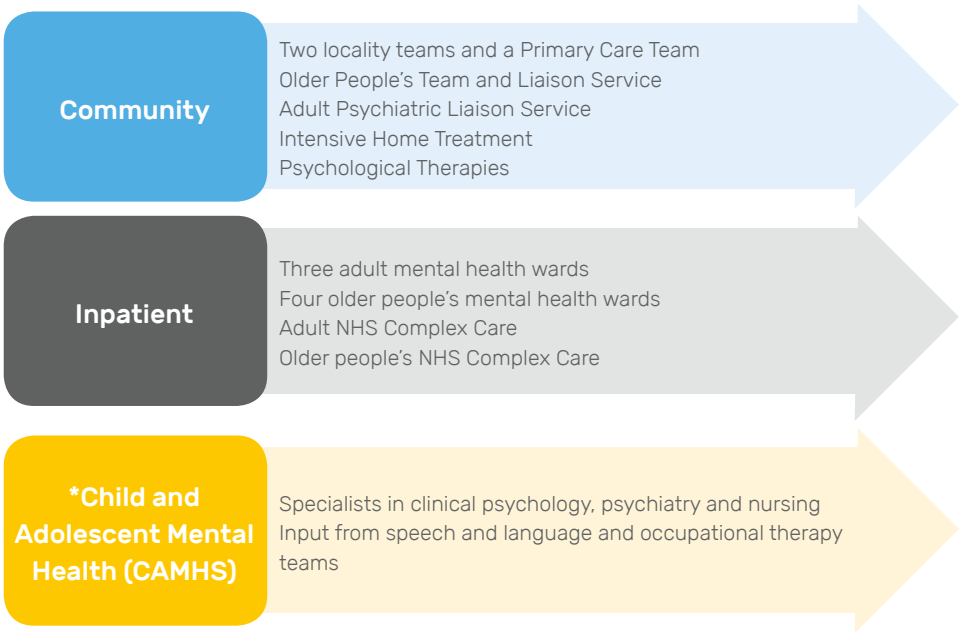
In addition, we have co-created additional local priorities with staff, service users and partners as follows:

- Tackling poverty and isolation: We will further embed our social prescribing model and link with our partners in education, employability, income maximisation and community based services.
- Provision of outreach services: Building on the success of the intensive outreach service we will work with our third sector partners to promote and develop our existing outreach provision.
- Physical Health: we will provide physical health advice and support to our service users in order to prevent further exacerbating poor mental health.
- Developing a Suicide Prevention Strategy and Action Plan
- Tackling the stigma associated with mental illness
- As employers we will improve the mental health of our workplace and enable individuals with mental health conditions to thrive.

9.4 Current Services

A range of mental health services are available in Renfrewshire and are provided by public, third and community sector organisations. Renfrewshire HSCP's current service provision includes a community service; this service provides access to a multidisciplinary secondary care service for people with mental health problems. In addition, an inpatient service is available for those over the age of 16 with a mental health diagnosis.

The Child and Adolescent Mental Health Service assesses and treats moderate to severe mental health disorders in children and young people up to 18 years of age. The service also offers support and guidance to parents, carers and service partners.



*This service is detailed separately under the 'Children and Young People' section of this plan.

9.5 The Challenges

Adult Mental Health Services continue to be subject to transformational change with a pronounced shift in the balance of care significantly reducing the level of inpatient beds and reinvesting progressively in a spectrum of evidence-based quality community and specialist services.

We must also ensure our existing estates are fit for purpose, future proofed and encompass; a welcoming atmosphere, clear sense of place and are appropriately equipped to meet the needs of individuals and their family and friends.

9.6 Priorities for 2019-22

The main priorities for the next three years are:

- Implement Action 15 commitments to increase the mental health workforce and continue to support all of our staff to have good mental health
- Tackle poverty and isolation
- Provide outreach services, including recovery
- Improve opportunities for better physical health
- Develop suicide prevention strategy
- Tackle the stigma associated with mental health

10. Alcohol and Drugs

10.1 Partnership working is key in reducing the impact alcohol and drugs can have on individuals, families and the wider community.

Both alcohol and drugs are associated with a wide range of acute and chronic health issues and evidence would suggest that interventions which take into account the economic, environmental and social factors will be more effective in reducing related harm. Data relating to alcohol and drugs shows that Renfrewshire is consistently higher than the Scottish average in relation to alcohol and drug related hospital stays and alcohol and drug related deaths.

In Renfrewshire there are over 400 individuals accessing drug and alcohol services provided by the HSCP every week. Services provided by our third sector partners also offer a pathway for individuals to achieve and sustain their recovery.

A review commissioned by the HSCP showed that overall drug and alcohol services in Renfrewshire are having a positive impact on service users but recognises that more work needs to be done. The recommendations detailed within the review will form the basis of our priority areas for action for 2019-22.

10.2 What Outcomes do we want for People affected by Alcohol and Drugs

There are two key policy frameworks produced by the Scottish Government with relevance to identifying and responding to alcohol and drugs. This provided a framework to ensure that local delivery of alcohol and drugs services are recovery and outcome based with a clear focus on prevention and early intervention.

There is a wide recognition that individuals can recover with the right treatment and support and continued collaboration with partners is key in achieving our vision *'that Renfrewshire is free from harm caused by alcohol and drug misuse and individuals will have access to quality care and support to achieve and sustain recovery from alcohol and drug use and become contributing members of society.'* Our priority areas for action will inform our intentions for the next three years and creates a path towards achieving our vision. We will continue to apply a 'whole population' approach to prevent or reduce the harm caused by alcohol and drugs with targeted interventions where required. Additionally, individuals will continue to have positive experiences of accessing high quality treatment and support services which are recovery and outcome focused.

1. Prevention and Early Intervention

We want to ensure that less harm is caused by alcohol and drugs by building resilience across communities; that fewer individuals will develop problematic use and those affected will be supported to access high quality services. The HSCP will continue work to prevent and reduce harm associated with drugs and alcohol. Preventing drug or alcohol misuse is more cost-effective than treating issues already established.

Investing in prevention initiatives can assist in reducing personal, family and wider community harms ultimately reducing the associated costs. According to the Scottish Government it is estimated that drug misuse costs society **£3.5 billion a year** whilst the impact of alcohol misuse is estimated to cost **£3.6 billion a year** – combined, this is **around £1,800** for every adult in Scotland. Harm reduction incorporates a range of strategies from safer use, to managed use to abstinence to meet the needs of individuals.

2. Treatment and Recovery

A fully integrated service will provide recovery and person-centred care which will focus on an individual's needs and aspirations applying a whole families approach. We will continue to deliver services which are in line with the current evidence base, as part of a 'person centred recovery focused approach.' The recent review carried out on our drug and alcohol services has provided us with a framework to work towards to ensure we will continue to work within a Recovery Orientated System of Care.

3. Supporting Children and Young People Affected by Parental Alcohol and Drug Use

By working in partnership, we will continue to build resilience, ensure early identification and the provision of appropriate support to children and young people affected by parental alcohol and drug use. Children and young people who live with parents who have drug and alcohol problems are among the most vulnerable in society. Building on the foundations set by national frameworks such as Getting It Right for Every Child (GIRFEC) and Getting Our Priorities Right (GOPR) will assist us to ensure our children, young people and families continue to be protected and well supported.

10.3 What should our services look like to support this?

Renfrewshire Alcohol and Drug Partnership (ADP) is a collaboration between the HSCP, Renfrewshire Council, Police Scotland, Scottish Fire and Rescue Service, Scottish Prison Service and the Third Sector and is responsible for driving forward the national strategic frameworks.

Seeking the views of service users, carers and staff is also important and this helped to inform the outcome of the recent review of alcohol and drug services. They told us that current services were providing improved access to treatment services; there was a renewed focus on services which were recovery and outcome focused and there was more engagement with service users and their families to reduce drug related deaths with the provision of Naloxone. There was agreement, however, that there is a need to enhance the current recovery-orientated model of care so that it identifies a positive pathway and clear end point to allow flexibility to respond swiftly to future critical demands. The review also highlighted the need for a truly integrated alcohol and drug service with an established single point of access team for all alcohol and drug referrals. Assertive outreach to actively engage with hard to reach individuals should also be strengthened and the provision of community based services to further improve access.

One of our key areas of success is the Sunshine Recovery Cafe. The Cafe was established to promote recovery in Renfrewshire and to improve the life chances of individuals affected by alcohol and drugs. The Café provides peer led support to assist individuals becoming abstinent and sustaining abstinence from alcohol and drugs, and provides support to access training and employment opportunities. Between 50-60 individuals attend on a weekly basis and benefit from a broad network of activities such as volunteering in the Café and accessing a variety of holistic therapies. The Café is run by a constituted committee of volunteers who are also in recovery. The HSCP aims to build on the success of the Cafe by considering the development of a Recovery Hub in Renfrewshire which would enable individuals to move forward from traditional treatment settings to explore and manage their own recovery. This model has been successfully adopted elsewhere with significant benefits for individuals and services.

10.4 Challenges and Opportunities

An ageing cohort of drug and alcohol users presenting at services with more complex issues, the stigma associated for individuals accessing drug and alcohol services and the changes in the welfare system are just some of the challenges we have faced in the last year. Moving forward we realise that achieving our outcomes will be a challenge. The proposed new model of service delivery aligned to the new national frameworks for alcohol and drugs will provide the opportunity to achieve the best possible outcomes for individuals, families and the wider community.

10.5 Priorities for 2019-22

The main priorities for the next three years are:

Prevention and Early Intervention

- A local framework will be developed that provides a structure to ensure our children, young people and local communities have the assets required to prevent or minimise the harm caused by alcohol and drugs
- Enhance our role within the alcohol licensing agenda by increasing the knowledge and understanding of alcohol and use this information to influence the decision making process
- Support a Commission with key partners with the principal aim being to assess the nature, causes and impact of drug and alcohol misuse in Renfrewshire.

Treatment and Recovery

- Introduction of a fully integrated, recovery focused Alcohol and Drug Service in Renfrewshire with specialist sub teams.
- Further enhance our recovery orientated systems of care with the development of a Recovery Hub.

11. Children and Young People

According to the latest official statistics from the National Records of Scotland, there are 29,831 children and young people aged 0-15 in Renfrewshire, which equates to 17% of the total population. This figure is similar to the rate for Scotland and according to future population projections to 2039, is expected to remain fairly stable.

11.1 Challenges and Opportunities

Opportunities include increased contact with families/carers due to the new Universal Health Visiting Pathway and raising awareness of Adverse Childhood Experiences. There is a collaborative advantage too in terms of joint working with Health, Education and Social Work, and the benefits of shared learning and training. Our eHealth Strategy also offers opportunities to develop services and identify areas for early intervention, prevention and self-management and we use service feedback at every opportunity to ensure continuous service improvement.

Challenges moving forward include: fully implementing the Universal Health Visiting Pathway, supporting the mental health needs of children and young people, and partnership working amidst a culture of differing IT systems, financial uncertainty and the changing needs of the population.

11.2 What Outcomes do we want for Children and Young People?

We want all children to be healthy and safe from harm

Getting It Right For Every Child (GIRFEC)

GIRFEC is the national approach in Scotland to improving outcomes and support the wellbeing of our children and young people. We offer the right help at the right time from the right people to support our children and young people achieve their full potential in line with the eight wellbeing indicators known as SHANARRI: Safe, Healthy, Achieving, Nurtured, Active, Respected, Responsible, Included. This will be underpinned by a trauma sensitive approach across the Partnership to identify and mitigate the impact of Adverse Childhood Experiences (ACEs) on our children and young people.

Universal Health Visiting Pathway

All pre-school children are offered access to the Health Visiting Service, who make sure the needs of the child are appropriately assessed and responded to in line with GIRFEC. We will continue to implement the national Universal Health Visiting Pathway, which sets out the requirement of a minimum of 11 home visits to be carried out by Health Visitors, for all children prior to commencing school. This will support us to build relationships with the family and carers, responding to their needs in a supportive and person-centred way. We also continue to strive to increase the uptake of childhood immunisations through Pre-school community clinics across Renfrewshire. This is underpinned by prevention, early identification and intervention throughout the early years of life with an emphasis on reducing inequalities.

Access to Services

We will continue to improve opportunities and develop pathways so children, young people and families can access the right care at the right time and in the right place. We also want to improve care co-ordination with both primary care and acute services, particularly for children with complex health needs.

eHealth Strategy

We want to empower children and their families by giving them the support and information they need to self-manage conditions.

We want to safeguard the emotional health and wellbeing of children, young people and their families/carers.

Child Protection

Renfrewshire HSCP is a committed member of the multi-agency Renfrewshire Child Protection Committee. We will work together with local partners to promote children's welfare in Renfrewshire and our aim is to make sure all children are kept safe and to improve outcomes for the most vulnerable children.

Family Nurse Partnership

The Family Nurse Partnership (FNP) is an NHS Board-wide service who support first time mums aged 19 years and under and their families. The programme begins in early pregnancy and runs until the first child's second birthday. All eligible young women in Renfrewshire can access this bespoke programme.

Corporate/Parenting/Looked After Children

We want to ensure all care experienced children are identified and that we assess and meet their health and wellbeing needs. We have the same aspirations for care experienced children and young people as any parent. We will work closely with the Renfrewshire Community Planning Partnership to achieve this aim. A child may become Looked After for a number of reasons including neglect or abuse. Many of these children will have experienced some form of trauma in their lives that impacts on their development and we want to improve their outcomes and provide the support they need to have successful adult lives and reach their full potential.

Mental Health

We will work together with families and local partners to promote children's mental health in Renfrewshire. Our aim is to make sure children and young people who require support and guidance have access to an appropriate range of services, in a timely manner and at the appropriate level required at that time. We will continue to develop and improve pathways and opportunities across services and signpost children, young people and families to an appropriate service.

Parenting Support

We will support our parents and carers by offering targeted parenting programmes which will contribute to achieving better outcomes for our children and young people.

We will promote partnership working to provide efficient and effective services.

Renfrewshire HSCP is a fully committed partner of the Renfrewshire Children's Services Partnership. We are working together to reduce inequalities and deliver improved health and wellbeing outcomes for children, young people and their families. We will consider children's rights and participation in service planning.

Transition

Work will continue with partner agencies to improve transition pathways from child to adult services, particularly with Mental Health services. We want to make sure support is in place for each child transitioning from child to adult services.

Training

Where possible we will undertake joint agency training to improve collaboration, build links and share specialist skills, knowledge and learning.

Location

Where we deliver services will be considered, as we aim to deliver services in a child friendly environment and co-location of service provides even better opportunity to deliver joined up services for children who require to see more than one professional.

11.3 What should our services look like to support this?

Health and Social Care services for children and young people in Renfrewshire are not integrated. However, we work closely in partnership and have agreed joint priorities through our Children's Services Partnership.

Universal Children's services covers School Health, Health Visiting and the hosted Family Nurse Partnership (FNP), while Specialist Children's Services incorporates Child and Adolescent Mental Health Services (CAMHS), paediatric speech and language therapy, physiotherapy and occupational therapy, Looked After Children, the Specialist Community Paediatric Team and the Community Paediatric Nursing Service.

Refugees

Through the Syrian Refugees Strategy Group we will continue to support families that have arrived from Syria. Since 2015 the HSCP has supported 34 families (134 persons).

Carers

The Carers' (Scotland) Act 2016 came into force on 1 April 2018 and aims to provide more support to unpaid carers and improve their health and wellbeing. Children can also be young carers and are entitled to a Young Carers' Statement (YCS), to help identify their needs and proposed personal outcomes. The aim is to support young carers to have a life outside their caring role. A dedicated Young Carers' Resource Worker will work across Children's Services and within Renfrewshire Carers' Centre to support this delivery. For more information visit http://www.renfrewshirecarers.co.uk/ or http://www.renfrewshire.gov.uk/article/3354/Young-Carers

11.4 Priorities for 2019-2022

The main priorities for the next three years are:

- Working in partnership with children and their families to maximise the efficient use of our resources, focusing on early intervention/prevention, and empowering families to self-manage with support and guidance. This includes completing the implementation of the Universal Pathway
- Improved Autism Spectrum Disorder (ASD) post-diagnostic contact and nurse-led medication monitoring for ADHD
- Focus on improving the transition from child to adult services
- Improving oral health and maintaining high rates of childhood immunisations
- The development of pathways for Looked after children at home under 5 years, autism and sleep.

12. Palliative and End of Life Care

In Scotland around 54,000 people die each year and over 200,000 people are significantly affected by the death of a loved one. Driven by population growth, the number of people dying each year will continue to rise and by 2037 the number will have gone up by 12% to 61,600. It is thought that up to 8 out of 10 people who die have needs that could be met through the provision of palliative care (The Strategic Framework for Action on Palliative and End of Life Care 2016-2021, Scottish Government, Dec 2015).

12.1 What Outcomes do we want for People who require Palliative and End of Life Care?

In line with the Strategic Framework for Action on Palliative and End of Life Care, our aim is that by 2021 everyone in Renfrewshire who needs palliative care will have access to it and benefit from it, regardless of age, gender, diagnosis, social group or location. This Framework identifies ten commitments that the Scottish Government wish to achieve in working with stakeholders and drives a new culture of openness about death, dying and bereavement http://www.gov.scot/Resource/0049/00491388.pdf

Along with our partners, we will take a holistic approach to palliative care and aim for Renfrewshire to be a compassionate community where Palliative Care is 'everybody's business'. We want Renfrewshire to be a place where people are supported to live well until their death and families are supported during their bereavement.

12.2 What should our services look like to support this?

In Renfrewshire this work is progressed by the Palliative Care Joint Planning, Performance and Implementation Group which has representatives from most services and third sector partner organisations. The group is in the early stages of developing a Palliative Care Strategy.

Successful collaborative working is crucial to ensure we reach the people we should be reaching. We want to identify palliative care needs at an early stage and provide care coordination that is responsive to change, ensuring the right care is given at the right time, in the right place. By building capacity and resilience we want to continuously improve outcomes for patients and their families.

Access to specialist palliative care services and resources in the community, including the use of hospices, McMillan services and hospital palliative care teams, supports good general palliative care delivery in any setting to individuals, who have life limiting and often complex multiple conditions, based on needs and not diagnosis.

The HSCP works closely with staff in both hospices in Renfrewshire, Accord and St. Vincent's, to ensure the community is aware of the services and support that can be provided.

We acknowledge and appreciate that carers provide lots of support for family members and friends. In delivering palliative and end of life care we will make sure informal carers, family members and volunteers have access to support, education and guidance that can enhance their contribution. In line with the national health and wellbeing outcome 6, we want to ensure people who provide unpaid care are supported to look after their own health and wellbeing.

12.3 Current Situation

Approximately 1% of GP Practice population is expected to die each year. In 2017, there were 2,043 deaths in Renfrewshire. This is a 1.3% decrease from 2,070 deaths in 2016.

End of life care is an important measure to indicate whether adequate plans and structures are in place to allow patients to spend the last six months of life at home or in the community and not in an acute hospital setting, in accordance with each individual's wishes. Similar to the Scottish average, just fewer than 9 out of 10 people in Renfrewshire spent the last six months of their life at home or in the community; this has been the case every year since 2010/11.

12.4 Palliative Care is Everybody's Business

In achieving our aim that palliative care is 'everybody's business', priorities for our services over the period of this plan include:

- The identification and care management of people with palliative care needs in Renfrewshire and the development of a Palliative Care Strategy
- Working in partnership with Macmillan Cancer Support to improve the cancer journey by providing a holisitic needs assessment, signposting service users to community resources and social supports, and linking to Community Connectors
- Refinement of the palliative care redesign/pathway model and increased use of Anticipatory Care Planning.

We will continue to work with partners and services to provide people with end of life care in their place of choice; support care homes with anticipatory care planning so they have a clear understanding of residents' wishes, and provide person-centred services using a co-production approach to find shared solutions.

In developing a Palliative Care Strategy in Renfrewshire, we will ensure staff delivering care are supported with learning and education to understand how best to make a difference to a person's wellbeing (and their families) in the last days, weeks, and months of life.

We want patients and their families to have timely and sensitive conversations with appropriately skilled professionals to plan their care and support and we will make best use of Anticipatory Care Plans to capture the individual's needs, preferences and choice.

We will encourage and support conversations around death and dying, making best use of local and national resources and expertise www.goodlifedeathgrief.org.uk

We will also take account of the Realising Realistic Medicine and Renfrewshire's Carers' Strategy 2019-22 alongside the HSCP's Palliative and End of Life Care Plan.

12.5 Performance

We will monitor progress against our priorities in line with the review of the Strategic Plan. In doing this we want to evidence a well trained workforce; an increase in the numbers of people experiencing end of life care in their place of choice; and gain feedback from patients, carers and family members on the services they received.

12.6 Priorities for 2019-22

The main priorities for the next three years are:

- Develop a Palliative Care Strategy for Renfrewshire
- Improve the Cancer journey by identifying and care managing people
- Increase the use of Anticipatory Care Plans (ACPs).

Section 3 – Working with our Partners

13. Primary Care

Renfrewshire HSCP hosts primary care support on behalf of NHS Greater Glasgow and Clyde for all HSCPs. The Primary Care Support Team is based at Gartnavel General Hospital and has co-ordinated the work across the Board area to implement the new GP contract.

Renfrewshire has a range of primary care services that respond each day to the needs of local people. There are 29 GP practices, 43 community pharmacies, 20 community optometrists and 30 general dental practitioners. Within the 29 Renfrewshire GP practices there are 113 GP partners and 13 salaried GPs (June 2018) serving a registered list population of 189,956 (January 2018). In 2017, the average list size for Renfrewshire practices was 6,235. This is approximately 274 patients more than the Scottish average of 5,961.

13.1 GP Clusters

GP clusters were introduced in Scotland with the 2016/17 GMS agreement between the Scottish GP Committee and the Scottish Government. GP clusters bring together individual practices to collaborate on quality improvement projects for the benefit of patients. The 29 GP practices within Renfrewshire have been formed into a 6 cluster approach, under 2 localities – Paisley and West Renfrewshire. Two clusters sit within Paisley and four within West Renfrewshire. These are professional groupings of general practices that meet regularly to drive quality improvements within Primary Care, represented by their Practice Quality Lead (PQL). Each GP cluster also has a GP designated as the Cluster Quality Lead (CQL), who has a coordinating role within the cluster.

Work will continue to develop the collaborative learning role of GP clusters, to help identify and improve the quality of services. Healthcare Improvement Scotland and National Services Scotland, through Local Intelligence Support Teams (LIST) will support clusters to gather intelligence to establish what these priorities are, and how to collect and evaluate data to determine what action is needed.

13.2 New GP Contract

Our ambition for General Practice over the next three years is to support GPs in Renfrewshire to focus on their core role as Expert Medical Generalist – managing undifferentiated presentations, providing complex care in the community and whole system clinical leadership. In order to achieve this it is essential that the unsustainable pressures on GP workload (and associated challenges in recruitment and retention) are addressed, and that a significant proportion of GP time is released.

Over the next three years, every practice within Renfrewshire will be supported by expanding teams of HSCP and NHS Board employed health and social care professionals. This will create a skilled multidisciplinary team surrounding Primary Care that will enable GPs to delegate responsibilities whilst ensuring that members of the public are able to access the right person, in the right place at the right time.

13.3 Macmillan: Improving the Cancer Journey in Renfrewshire

In partnership with Macmillan Cancer Support we will continue to develop and deliver the Macmillan Renfrewshire Improving the Cancer Journey (ICJ) project. The main aim of the project is to develop and deliver for everyone in Renfrewshire with a cancer diagnosis, clear, seamless and accessible pathways of care based upon a robust holistic assessment of need. In Renfrewshire, approximately 1,100 people per year who receive a new cancer diagnosis together with their carers and families will be offered this service. In addition, the service will also be available to existing cancer patients.

13.4 Primary Care Improvement Plan

Renfrewshire's Primary Care Improvement Plan (PCIP) was approved by the GP Sub-Committee on 31 July 2018 and by the IJB on 14 Sept 2018. The Primary Care Improvement Fund allocation in 2018/19 for Renfrewshire is £1,553,435. This will be used to fund the six priority areas outlined in the MOU.

13.4 Priorities for 2019/22

The 2018 GP Contract and associated Memorandum of Understanding (MOU) outline the key priority areas of focus in order to achieve our aims of reducing GP workload and increasing recruitment and retention by making Renfrewshire an exciting and positive place for current and future GPs to practice.

These priority areas include:

- **Vaccinations services:** From 2021 all vaccination services will be run by the health board, including; pre-school immunisation, school-based immunisation, travel vaccinations, influenza immunisations, at-risk immunisations. This will be a staged approach for types of vaccination. Locally Pre-school Immunisation clinics run daily. Clinics involve support from support workers, dental health workers and nursery nurses. Offering health promotion information and the opportunity for babies to be weighed.
- **Pharmacotherapy services:** Provision of a comprehensive pharmacy service including acute and repeat prescribing and medication management activities
- **Community treatment and care services:** Phlebotomy will be delivered as a priority in the first stage of the HSCP Primary Care Improvement Plan providing the foundation for future Treatment & Care Centres providing chronic disease monitoring and wider treatment room services (e.g. wound dressing, ear syringing)
- **Urgent care services:** These services will provide support for urgent unscheduled care within primary care, such as providing advance practitioner resource such as an advanced nurse practitioner or paramedic for GP clusters and practices as first response for home visits, responding to urgent call outs for patients and working with practices to provide appropriate care to patients. Locally an initial 2.5wte Advanced Nurse Practitioner (ANP) resource has been recruited to.

- **Additional professional clinical and nonclinical services including acute musculoskeletal physiotherapy services, community mental health services:** Advanced physiotherapists and community mental health professionals will join practices/clusters to act as first point of contact for patients with relevant needs. Advanced Practitioner Physiotherapists (APP) will provide musculoskeletal advice support and triaging for patients who present with MSK issues. Locally an initial 1.5wte APP resource has been recruited to.
- **Community link worker services** – Link workers are now based in all GP practices in Renfrewshire, and the service will expand further during 2019/20. They are employed by RAMH and supported by two other Third Sector organisations which provide specialist housing support and physical activity/community support.

13.5 During 2019/20, we will work with HSCP colleagues across NHS Greater Glasgow and Clyde to develop a new model of care for out of hours and urgent care in the community, where patients will be seen by the most appropriate professional to meet their individual needs. The Urgent Care Resource Hub (UCRH) model is currently being developed and will be shared with potential service users over the next few months.

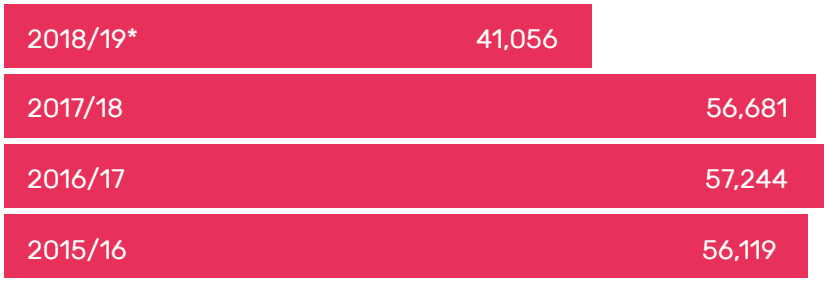
14. Unscheduled Care

14.1 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 RAH, with 8% going to the Queen Elizabeth University Hospital (QEUH).

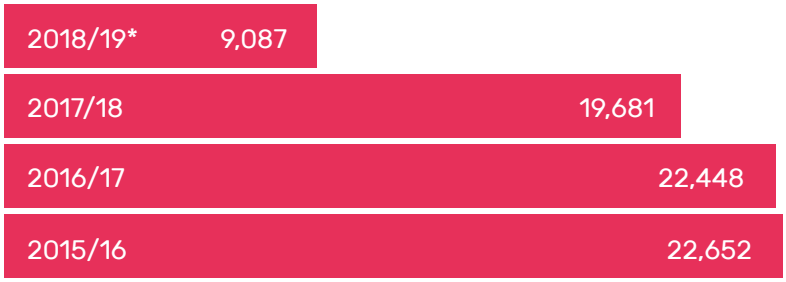
14.2 We have focused our attention in the last year on the six Ministerial Strategy Group (MSG) targets:

i. A&E Attendances



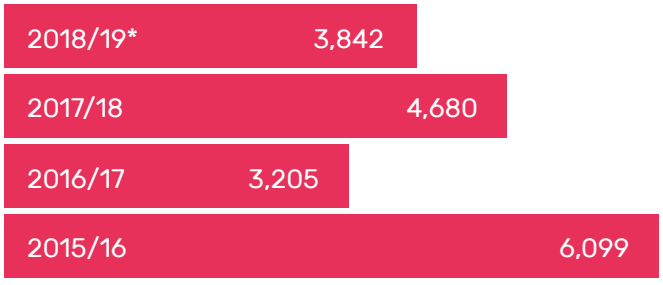
* April–November 2018, Target for 2019/20: 56,119

ii. Emergency Admissions – Number of Emergency Admissions



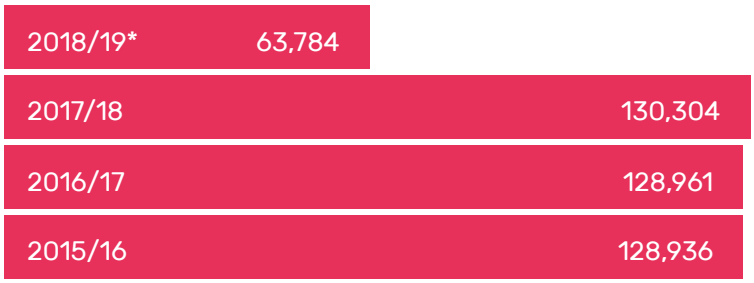
* April–September 2018, Target for 2019/20: 19,302

iii. Delayed Discharges – Delayed Discharge Bed Days



* April–November 2018, Target for 2019/20: 4,501

iv. Unscheduled Hospital Bed Days – Number of Unscheduled Hospital Bed Days; Acute Specialties



* April–September 2018, Target for 2019/20: 126,477

v. End of Life Care

Our target for 2019/20 is to maintain the 2015/16 rate of 87.4% of people spending the last 6 months of their life in the community.

vi. The Balance of Spend across Institutional and Community Services.

Our target for 2019/20 is to continue to support 95.3% of over 75 year olds to live at home.

14.3 To reduce our reliance on unscheduled care we have prioritised the following activities:

- Increasing the use of consistent Anticipatory Care Plans (ACPs);
- Rolling out the 'red bag' initiative in all nursing homes. The red bag contains important information about a care home resident's health in one place so they can receive quick and effective treatment by ambulance and hospital staff, with the aim of reducing residents' length of stay in hospital;
- Agreeing service improvements in specialty areas where usage of unscheduled bed days is high and sharing these across the system;
- Supporting care homes to reduce avoidable admissions to hospital by targeting work with homes that have higher admission rates, and through this understand what is driving this. In addition, encouraging the use of ACPs and providing support to homes through our Care Home Liaison Nurses;
- Focusing attention on frequent users at Emergency Departments (EDs) with GPs to try a preventative approach with these patients; and
- Use of a common frailty tool to be used across the NHS Board area to identify people at risk of hospital admission and support them and their families to manage their conditions.
- A social media and communications plan to educate our population to use the most appropriate health and care services.

15. Carers

The Carers' Act 2016 which commenced in April 2018 introduced a new definition of carer. A carer is:

"an individual who provides or intends to provide care for another individual (the "cared-for person") (but) not in the case of a cared-for person under 18 years old, to the extent that the care is or would be provided by virtue of the person's age, or in any case, to the extent that the care is or would be provided:

(i) under or by virtue of a contract, or

(ii) as voluntary work."

This new definition provides a better understanding for carers themselves of who carers are, including those who may not have thought themselves to be carers.

The 2011 Census reported that 10% of people in Renfrewshire regularly provide unpaid care, with 3% providing more than 50 hours of unpaid care each week[2].

Carers make a crucial contribution to the lives of local people, and the number of carers will likely continue to increase with the growing number of older people and those living longer with complex health conditions.

Without the support of carers, it is likely that many people would require higher levels of support and care from health and social care services and may not be able to live as independently as possible in their own homes. It is widely accepted at a national level that such an increase would be very difficult for public services to manage with the current level of resources.

15.1 What Outcomes do we want for Carers?

The National Health and Wellbeing Outcomes set out what health and social care partners are attempting to achieve. For carers the relevant outcome is:

"People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and wellbeing."[3]

15.2 Carers' Act

The Carers' Act introduced a number of duties and provisions for local authorities to implement, most of which fall within the remit of the HSCP. The duties include:

- Replacing carer assessments with Adult Carers' Support Plans (or a Young Carers' Statement for children who are carers)
- Requiring carers to be involved in the hospital discharge process for the person they care for
- The waiving of charges for carers in situations where replacement care (respite) is required
- The requirement to develop eligibility criteria for carers.

2. www.scotlandscensus.gov.uk/ods-web/area.html

3. www.gov.scot/Topics/Health/Policy/Health-Social-Care-Integration/National-Health-WellbeingOutcomes

An Implementation Group made up of carers, the Carers' Centre, the HSCP, Children's Services and other relevant organisations worked on implementing the Act in time for the April 2018 commencement date. The main focus for the implementation work has been:

- developing eligibility criteria and the new Adult Carers Support Plan
- communicating to staff and carers what is in the Act
- implementing the Act in a way that does not have an adverse impact on the support carers receive
- ensuring our staff have the knowledge and skills they need to put into practice what is in the Act.

15.3 Current Services

The HSCP works in partnership with its statutory and voluntary sector partners, and in particular Renfrewshire Carers' Centre, to support carers in Renfrewshire. There are a range of services that carers can access including:

- Information and advice
- A break from caring
- Training
- One to one support
- Group support
- Advocacy

Carers are entitled to have their needs recorded in an Adult Carer Support Plan (ACSP); the ACSP replaces the Carers' Assessment. Following feedback from carers, the HSCP and the Carers' Centre developed a new pathway to encourage more carers to complete an ACSP. Carers who would like an ACSP can now go direct to the Carers' Centre, instead of having to go through the HSCP, as was the case with Carers' Assessments. The new pathway also gives the Carers' Centre a lead role in supporting carers to complete ACSPs.

15.4 Celebrating Success

Supporting Carers - In 2017/18, 1,435 carers received support from the HSCP and its partners, this included 616 new carers.

Involving Carers - Carers were involved in the development of the Adult Carer Support Plan, and the Eligibility Criteria for Carers.

Staff training and awareness - A programme of staff training and awareness raising sessions were developed to ensure staff are aware of the new development such as the ACSP and eligibility criteria. These sessions are aimed at all Renfrewshire Council and HSCP staff and are being delivered in partnership with the Carers' Centre.

Information and advice – A new information and advice service for carers, staff and the general public has been developed and is based at the Carers' Centre. The service, which commenced in October 2018, will ensure that carers are aware of the Act as well as providing more general information to carers, staff and the public.

15.5 The Challenges

Waiving of Charges – following the introduction of the waiving of charges regulations, carers will not be charged for the support they receive relevant to their caring role. The Scottish Government produced initial guidance setting out how this should be implemented which did not fully address how the waiving of charges should be treated. The Scottish Government is expected to produce finalised guidance in December, which will then allow this aspect of the Act to be fully implemented.

Funding – the Government is providing funding for the implementation of the Carers' Act, however there are a number of elements relating to the implementation of the Act which are not fully quantified at this stage, including waiving of charges, the impact on demand, and how carers being involved in the discharge process will affect delayed discharges from hospital.

Raising Expectations – the HSCP welcomes the Carers' Act and its broad aim of supporting carers. However there is a concern that the HSCP will not be able to meet the expectations raised by the Act. The HSCP's Eligibility Criteria for Carers will ensure that carers with critical and substantial levels of need receive the appropriate support, and through the Carers' Centre, those with moderate or low levels of need will be able to receive advice and support.

15.6 Priorities 2019-22

- Identification – continue to ensure carers are identified early, have the information they need and are signposted to relevant services.
- Adult Carers' Support Plans – continue to ensure that all carers who request an ACSP have one.
- Implementing the Carers' Act – continue to meet the requirements in the Act, including the development of a new Carers' Strategy in 2019.

Section 4 – Our Resources

16. Finance and Resources

16.1 Financial Position

Renfrewshire IJB deliver and commission a range of health and adult social care services. These services are funded through budgets delegated from both Renfrewshire Council and NHS Greater Glasgow and Clyde. We have managed to achieve financial balance each year but have found this increasingly difficult and challenging.

16.2 Future Challenges

Looking at the period in which this Strategic Plan will be delivered (2019-2022), it is anticipated that the public sector in Scotland will continue to face a very challenging short and medium term financial outlook. There is significant uncertainty over the scale of this likely reduction in available funding.

As in previous years, savings will be required to be identified to enable the IJB to meet demand and cost pressures, whilst remaining within the funding made available from partners. It is therefore important that resources are targeted at the delivery of the priorities in the Strategic Plan.

In November 2018, Audit Scotland's report 'Health and Social Care Integration - Update on Progress' highlighted the challenging financial environment within which IJBs are operating:

"Financial pressures across health and care services make it difficult for IAs (Integration Authorities) to achieve meaningful change. IAs were designed to control some services provided by acute hospitals and their related budgets. This key part of the legislation has not been enacted in most areas."

The Public Bodies (Joint Working) (Scotland) Act, 2014 (the Act), the legislation which led to health and social care integration, intended that IJBs would direct some services provided directly within acute hospitals (known as 'set aside'), to move care closer to people's homes and provide more joined-up care. However, in practice, in most areas, the services have not been delegated, impacting the IJB's ability to deliver the Scottish Government's expectations in relation to the commissioning of set aside services.

16.3 Financial Pressures

There are a number of significant pressures which the IJB will require to manage during the period of this Plan:

- Continued impact of costs associated with the Living Wage, as the current Scottish Government funding does not fully cover the cost incurred to deliver on our local commitment to this
- Contractual price increases for: NCHC (National Care Home Contract); Care at Home external providers and Adult Supported Living Providers
- Pay award increases/uplifts
- Impact of real demand growth: an ageing population; increased number of people with dementia and an increase in the number of people with complex needs; Adult Protection and Mental Health Officer caseloads; children transitioning into Adult Placements and demand for Care at Home

- Investment in Digital technology is required. The Scottish Government's Digital Health and Care Strategy, published in April 2018, identifies digital technology as key to transforming social care services so that care can be more person centred. No national funding has yet been made available to support local delivery of this strategy.
- Furthermore, the IJB must fund two key ICT developments being progressed over the next three years:
  - A new case management system for social care has been approved by Renfrewshire Council at a cost of £750k over the next four years; and
  - Telecare Equipment upgrade from analogue to digital is a national initiative to be delivered by 2025. The costs to do so will be significant with no indication of funding to support this essential investment as yet.
- Increasing costs of medicines; and
- The Scottish Government are currently consulting on proposed changes to the NHS Superannuation and Pension Schemes. The proposed change would create an additional pressure, a 6% increase to NHS employee payroll costs, which may require to be fully or partially funded locally.
- A change in legislation from 1 April 2019 means Free Personal Care will be extended to all those aged under 65 who require it. While the HSCP will receive funding from the Scottish Government to mitigate this, the unintended consequences remain unclear.

16.4 Renfrewshire's Financial Planning Strategy

Given these demand and cost pressures, the IJB has a medium term financial strategy, 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.

The IJB's medium term financial strategy is updated on an annual basis to reflect the most up to date financial projections for the years ahead. The Chief Finance Officer, working with colleagues in both partner organisations, projects the estimated pressures for the three years ahead – based on low, medium and high scenarios. These financial planning scenarios focus on a range of pressures and the likelihood of their emergence in the year(s) ahead.

- As our financial planning for 2019/20 and beyond progresses, financial sustainability will clearly be a focus for the IJB. With limited resources, difficult choices may have to be made in terms of priorities and service delivery. Early and continual dialogue with our partners will ensure our Financial Plan is at the forefront of discussions with our partner organisations.

- In the context of the above, our financial planning continues to be framed by the medium-term strategy set out in the Scottish Government's Medium Term Financial Strategy. Our financial strategy's guiding principles, outlined below, are pivotal/critical to delivering our Financial Plan and these principles continue to underpin all HSCP activity, helping to ensure the IJB is equipped to respond to the current, challenging financial environment and also the likelihood of reduced budget allocations in coming years

Prevention and Early Intervention - our ability to support early intervention and prevention activities is directly linked to our immediate demands and availability of resources. We recognise the value of early intervention services to promote positive outcomes, and to tackle long term inequalities across Renfrewshire. Financially, where appropriate, we will continue to support tests of change to demonstrate how we can support a shift from treating the problem to prevention. The nature of this is such that any potential benefits are often only realised in the longer term, 5-10 years or beyond.

Examples include:

- Investment in services to support people to live independently, including the Community alarm and responder service; Care at Home, RES Service and Occupational Therapy equipment and adaptations services which enable people to undertake daily living activities more independently and support informal carers to continue their caring role;
- Partnership initiatives to promote smoking cessation, active lifestyles, alcohol brief interventions and breast feeding; and
- Commissioning a number of third sector providers to deliver early intervention services.

Strategic Planning and Commissioning – in line with our Market Facilitation Plan, we will continue to work with key stakeholders, such as the third sector and community partners, to proactively transform our health and social care services: to critically appraise and challenge current models of service delivery; to exploit opportunities for more integrated working; optimise community capacity; and ensure resources are focused on areas of greatest need.

Financial Planning Process - to support the delivery of our Financial Plan, we have established a robust and inclusive financial planning process to ensure:

- our parent organisations, professional leads, staff and other key stakeholders are actively engaged with their views taken into account;
- all Service Reviews, and associated savings proposals, are impact assessed to ensure they are safe and viable, and conducted within the context of our Strategic and Market Facilitation Plans.

Current and future pressures – we will continuously seek to manage and monitor financial pressures. The Chief Finance Officer will keep the IJB and parent organisations sighted on these pressures, their impact on the in-year financial position, and any associated assumptions for future budget projections.

Change and Improvement Programme - this Programme will continue to provide a structured approach to manage change activity across the HSCP; to provide assurance to the IJB that this work is being progressed in a timely, inclusive and effective manner to support the delivery of our strategic, financial and statutory objectives.

NHSGGC and Partner IJBs system-wide - we recognise the importance of system-wide working to support shifting the balance of care; allowing best use of our limited resources and offering greater consistency in professional care standards. Renfrewshire is already involved in a number of initiatives including:

- Renfrewshire's Primary Care Improvement Plan
- NHSGGC's Unscheduled Care Programme
- NHSGGC's Mental Health Strategy
- Parent Organisation Transformation Programmes - NHSGGC's 'Moving Forward Together' and Renfrewshire Council's 'Better Council' Programme.

Workforce Planning - our Workforce Plan identifies the key actions the HSCP is taking to improve current recruitment, retention and attendance challenges in our workforce.

Reserves Policy - in line with recommendations from the Audit Scotland report on integration published on 15 November 2018, which provided clear recommendations on what was required to deliver integration well, we will continue to work with the IJB to ensure our reserves' policy is both transparent and prudent. This will ensure reserves are identified for a purpose and held against planned expenditure, with timescales identified for their use, or held as a general reserve as a contingency to cushion the impact of unexpected events or emergencies.

17. Quality, Care and Professional Governance

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

The HSCP produces an annual Quality, Care and Professional Governance report to the IJB and the NHS Board.

In addition, the Chief Social Work Officer provides an annual update report to the Council. The requirement for every local authority in Scotland to appoint a professionally qualified Chief Social Work Officer (CSWO) is set out within Section 3 of the Social Work (Scotland) Act 1968.

17.2 In our commitment to ensure safe, high quality care and services, we will continue to work to ensure:

- Services are compliant with national standards and guidance
- Establish unified quality care and professional governance arrangements
- Manage and promote arrangements to ensure safe and effective practice and promote a culture of learning and support within the organisation
- Obtain feedback from patients/service users and carers and use this to inform continuous improvement
- Use complaints as an opportunity to identify learning and improvement.

18. Workforce

18.1 Context

Workforce planning in Renfrewshire HSCP supports Scotland's Health and Wellbeing National Outcomes, in particular, 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." and Outcome 9 "Resources are used effectively and efficiently in the provision of health and social care services".

The purpose of our workforce planning is to ensure the workforce is integrated, sustainable and capable of delivering services, specifically those priorities laid out in this Strategic Plan.

It is important to understand the scale of the workforce resource and challenge in Renfrewshire. Services are delivered by 2,380 NHSGGC and Renfrewshire Council employees working together in integrated services and managed by the HSCP.

Table 1

	Workforce at April 2018						
	Renfrewshire Council		**NHS**		**Renfrewshire HSCP**		
Age Bands	Head Count	WTE	Head Count	WTE	Head Count	WTE	As % of available work-force
16-20	3	2.68	3	3	6	5.68	0.29
21-30	126	103.64	115	102.82	241	206.46	10.55
31-40	188	152.27	245	199.62	433	351.89	17.99
41-50	309	248.36	357	292.69	666	541.05	27.66
51-60	462	374.68	408	341.47	870	716.15	36.61
61-65	94	71.76	58	48.36	152	120.12	6.14
66+	6	10.7	6	4.07	12	14.77	0.75
Total	**1198**	**964.1**	**1192**	**992.03**	**2380**	**1956.12**	

18.2 Challenges

We have an aging workforce which means that loss of knowledge, skill and experience is an ongoing issue. Additionally there are few roles that are open to, or attractive to, those in the lower age ranges particularly the 16 to 20 bracket. This is largely due to the professional and/or demanding nature of jobs within health and social care.

Recruitment and retention continue to be a priority with difficulties in recruiting to particular staff groups. Distinct challenges are faced in areas where individuals are required to hold post graduate or specialist professional qualifications. For example: General Practitioners in Primary Care services; Mental Health Officers in Adult Social Work Services; and District Nurses in Community Nursing Services. Significant recruitment and retention challenges are also faced in service areas such as our Care Homes and the Care at Home Service, where staff are able to attract the same rates of pay to undertake jobs in other sectors (e.g. retail) which may be less physically and emotionally demanding; have more supervision and less responsibility; and offer opportunities for progression without undertaking academic or professional qualification.

There continues to be increasing demand for services within challenging budgets, leading to a need to do more with less and differently, and requiring our staff to be resilient and adaptable.

Ultimately the ageing workforce and challenges described may impact on absence levels due to their effects on the motivation and physical and mental health of staff, thereby putting additional pressures on service delivery. Supporting our staff to stay at work or to remain at work is a key priority for us over the next three years. We are working with Staff Side representatives to do this, seeking innovative ways to improve attendance. We have offered training and support to all managers to ensure they are confident to implement policies consistently. In addition we have offered mental health awareness training to help managers support staff with poor mental health.

This means that whilst challenging, prioritising time and resources for staff engagement, learning, and development along with developing creative ways of working and approaches to recruitment, is essential.

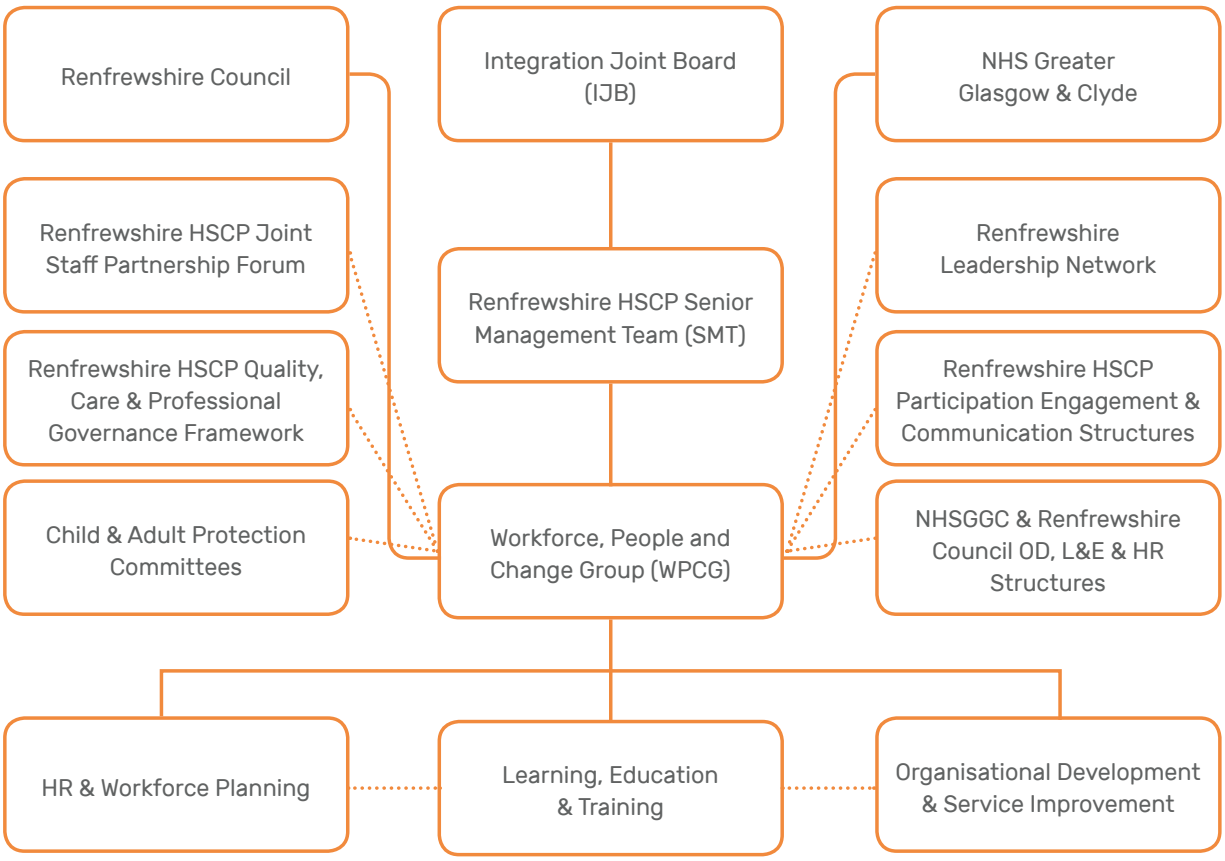
18.3 Approach

The workforce planning approach continues to follow the principles and objectives laid out in the *2016/2019 Organisational Development and Service Improvement Strategy and the 2017/2019 Workforce Plan* as agreed by the IJB (March 2016 and June 2017). Therefore the focus of the 2019/2022 Workforce Plan is on the development and maintenance of Healthy Organisational Culture; continued clarity of approach to Organisational Development and Service Improvement activity; and the delivery of workforce planning that supports tomorrow's workforce to deliver tomorrow's services.

All workforce activity will take into account the guidance and requirements of the National Health and Social Care Workforce Plan as these are fully developed, and of the NHSGGC and Renfrewshire Council Workforce Plans. Governance of Workforce planning activity is via the Workforce People and Change structure in *Figure 1*.

Figure 1

Renfrewshire Health and Social Care Partnership
Workforce, People and Change Structure



The approach is to tailor activity to support the priorities identified across services and HSCP wide.

In particular where:

- review has identified a need to reshape services
- improvements in the way we do things can lead to quality improvement efficiency and effectiveness
- Additional workforce knowledge, skill and qualification/registration is required to meet the needs of the population.

Examples of such activities include:

- Full programme of service improvement and change activity
- Continually evolving Induction and Statutory/Mandatory Training
- Full implementation of TURAS and Business World for individual PDP and appraisal purposes
- Focus on achievement of SSSC registration for our Home Care/Care at Home workforce
- Access to ongoing professional training for disciplines where this is required
- Delivery of effective staff engagement activity e.g. iMatter
- Standardised approach to team development
- Continued focus on communication with staff
- Further developing our leadership cohort through development and network activity
- Continued work with Further and Higher Education establishments to ensure SLAs in place to create candidates for hard to recruit posts i.e., MHO, DN, GPs, Physiotherapy, Psychology
- Developing our brand and marketing to ensure we are competitive and attractive to candidates who might otherwise be attracted to work in sectors such as retail
- Development of our Leadership and Succession Planning Strategy

18.4 Priorities for 2019-22

- Identification and implementation of core workforce dataset for reporting and measurement purposes in line with national guidance
- Activity to support recruitment and retention i.e. staff engagement; personal development planning and succession planning
- Configure the workforce to meet the challenges of a changing population and workforce demographic and increased and changing service demand through service review, improvement and change
- Deliver training, learning and development that ensures the workforce has the appropriate knowledge skills and qualifications to meet legislative, professional, and care delivery requirements.

19. Technology

19.1 Digital

Currently, most people's lives will already be highly dependent on technology whether this is applicable to services they use from us or something they use in their everyday life. Technology has advanced hugely in the last decade and is in a continuous cycle of upgrade and advancement.

Scotland's Digital Health and Care Strategy was released in April 2018. It aims to show how we will use technology to reshape and improve services, support person-centered care and improve outcomes. Within the Strategy it states that *'Digital technology has the potential to change the face of health and social care delivery.'* It also recognises that while digital technology can improve service delivery the real-life experiences of people are not so positive just now and we recognise this. We believe the only way to improve outcomes for our citizens is by putting digital firmly at the core of transformational change in our services.

Under the Public Bodies (Joint Working) (Scotland) Act 2014, the provision of ICT to lever the HSCP's digital capacity is provided through our two parent organisations, Renfrewshire Council and NHS GGC. In practice, this means the systems our social care and health staff use are not fully integrated which can limit effective partnership working. However, the HSCP continues to work closely with both the Council and NHS GGC to break down some of these technical barriers, increase interoperability and exploit digital opportunities which can improve service delivery; with the parent organisations reflecting the requirement to provide technologies to support this.

Some recent developments include:

Our new Clinical Portal allows a secure single view to information held in different clinical and care systems, providing a more seamless experience for users, and;

Agile and mobile technologies continue to improve the way our staff access real time information, supporting our strategic priority to provide 'the right service, at the right time, in the right place'. A recent example being, health staff can now access their work systems from Council premises, and remote working care staff are trained and able to use mobile devices to access work systems outwith Council premises.

19.2 Vision

Scotland's Digital Health and Care Strategy's Vision (April 2018)

The strategic aim for Health and Social Care is that Scotland offers high quality services, with a focus on prevention, early intervention, supported self-management, day surgery as the norm, and – when hospital stays are required – for people to be discharged as swiftly as it is safe to do so.

This strategy focuses on how digital can support this aim whereby, as a citizen of Scotland:

'I have access to the digital information, tools and services I need to help maintain and improve my health and wellbeing. I expect my health and social care information to be captured electronically, integrated and shared securely to assist service staff and carers that need to see it, and that digital technology and data will be used appropriately and innovatively:

- *to help plan and improve health and care services*
- *enable research and economic development*
- *and ultimately improve outcomes for everyone.'*

19.2 Strategic Priorities

i. We will work with Renfrewshire Council and NHS Greater Glasgow and Clyde to develop a local Joint Digital Strategy for Health and Social Care, and a supporting Delivery Plan, which will align with, and complement, our parent organisations' digital strategies. This Strategy will explain clearly what digital is and how it can support the delivery of health and social care services. It will consider information gathered from stakeholder consultations, in particular with service users, their carers and families, and our staff.

   Our Strategy will determine local priorities and requirements to underpin and influence the key areas (also referred to as 'domains') within Scottish Government's Digital Health and Care Strategy, taking account of our digital maturity, available finance, capacity and capability.

Scotland's Digital Health and Care Strategy's 6 Domains

- National direction – establishing a joint decision-making Board from national and local government and the NHS, supported and advised by industry, academia and the third sector to make national decisions for investment, priorities and policy, and achieve greater consistency, clarity and accountability.
- Information governance, assurance and cyber security – ensuring appropriate safeguards are in place for the management of data and ensuring consistency in decision-making about sharing data and understanding about data protection requirements.
- Service transformation – a clear, national approach to service redesign and the scaled up adoption of successful models such as home and mobile health and care monitoring.

- Workforce capability – recognition that leadership and workforce development in digital skills and capability underpin successful uptake and use of digital technology, with the establishment of a joint approach between NHS Education for Scotland, the Local Government Digital Office (working with COSLA and Integration Joint Boards) and the Scottish Social Services Council.
- National digital platform – commitment to the interoperability of systems by developing a national Health and Social Care services digital platform through which real-time data and information from health and care records is available to those who need it, when they need it, wherever they are, in a secure and safe way.
- Transition process – a recognition of the need to improve and upgrade existing systems to contribute to future developments, with a joint approach required between NHS National Services Scotland and the Local Government Digital Office to ensure that existing systems continue to work effectively.

ii. Implementation of a number of business-critical digital developments:

- Social Care Case Management System - the contract for the current system, used by the HSCP and Renfrewshire Council's Children's Services, will expire in March 2021. Given the significant work required to introduce a replacement system, a new contract has been awarded and an implementation programme will commence in 2019. The replacement system will provide an opportunity to review and improve the way we deliver services and provide a more responsive service.
- Introducing a Scheduling and Monitoring System for Care at Home Services – this new system will provide more accurate management information and improve how we schedule our care workers' visits, enabling us to better manage our resources and offer a more responsive service. This included delivery of an Essential Digital Skills Survey and bespoke Digital Skills Training for Care at Home staff.
- Upgrade of Telecare from Analogue to Digital Technologies - all Telecare equipment (used to support our most vulnerable service users in their home) must be upgraded from analogue to digital technologies by 2025. This new technology will improve connectivity and quality of calls; provide a more resilient solution; and remove reliance on service users' own telephone lines.
- Replacement of Primary Care GP Systems – NHS Greater Glasgow and Clyde will replace the range of existing systems used by our GPs with modern Cloud-hosted systems. These will enable easier online patient interaction and facilitate multi-disciplinary working with HSCPs.

19.3 Priorities for 2019-22

- Develop a local joint Digital Strategy for Health and Social Care
- Implement the following digital developments:
  - Social care case management system
  - Scheduling and monitoring system for Care at Home services
  - Upgrade Telecare from analogue to digital technology.

20. Buildings

20.1 Key themes emerging from our service reviews and from wider consultation with stakeholders include the need to develop a wide range of services (particularly Day Services) which are not necessarily buildings based.

Where we do require to work from a building, it is important it is fit for purpose.

Our property is a valuable resource.

It provides the means from which we deliver some of our services and manage our business. Using our property well to support service delivery can bring about efficiencies and enhance public experience of our services.

It is, therefore, important we have a vision for our properties that sustains future growth, development of joined up services and that this supports the HSCP's objectives.

NHS Greater Glasgow and Clyde and Renfrewshire Council collectively own or lease the properties across Renfrewshire where HSCP functions are carried out.

It is within the context of Outcome 9 of the National Health and Wellbeing Outcomes which the IJB is required to work towards.

"Resources are used effectively and efficiently in the provision of health and social care services" that an IJB Property Strategy was developed.

A significant amount of work has already been undertaken to modernise our health property portfolio, including a new Renfrew Health and Social Work Centre in 2010 and upgrading several Health Centres.

In addition, Renfrewshire Council has created two new Day Centres within the Lagoon and On-X, a new town hall in Johnstone and has undertaken building improvements in several other centres.

20.2 The key strategic issues currently for Renfrewshire are:

Paisley

Although many services are provided in Paisley, it does not have a health centre. Healthcare provision within Paisley is provided in a number of town centre GP practices, most of which require upgrading and expansion to comply with the new GP contract.

After an assessment of our property needs, the priority is for the development of a new, purpose built facility in Paisley which could co-locate a range of primary and secondary care services together with health and social care staff and services.

Bishopton Health Centre

Renfrewshire Council approved a large housing development in Bishopton with up to 3,500 new houses. Officers from NHS GGC have been in dialogue with Renfrewshire Council and the developers BAE, about the delivery of health care provision in the area.

The existing health centre has been refurbished. However with the expected rate of growth of new housing, it will not have capacity to cope with the increased demand.

21. A Day in the Life

Robert Price, Social Work Team Manager based with the West Renfrewshire Locality, Johnstone Town Hall

Tell us about a typical working day and what it involves…

I am a team manager within the West Renfrewshire Locality. I manage a team of social workers, Adult Support co-ordinators and Occupational Therapists within Adult Services. My role is wide ranging and varied, often pushing me to be creative in a crisis while working within established procedures and complex legal frameworks.

Our service supports adults over the age of 18 with a variety of complex needs. We work closely with other teams within the Partnership such as Community Nursing, Reablement, Community Mental Health teams and Addictions services. We work closely with Police Scotland, the Scottish Fire and Rescue Service, Acute Inpatient Services and third sector agencies.

One of my favourite tasks is managing our frontline duty service, responding to referrals from colleagues, partner agencies and members of the public. These referrals can range from calls for advice, to concerns under the Adult Support and Protection (Scotland) Act 2007. This is a challenging role that allows us the opportunity to engage with partners across Renfrewshire.

What partnerships matter most to you?

The partnerships I have within my team matter the most to me. I have supportive colleagues who help share the load and provide a sounding board when I need to work through complex decisions. As a service, we also value our relationships with Police Scotland, the Scottish Fire and Rescue Service, Acute Inpatient Services and third sector agencies. These agencies provide us with information and support in times of crisis.

What else are you involved in?

Over the last few months I have been taking part in a collaborative leadership programme with managers from across the Partnership and Local Authority, the Scottish Fire and Rescue Service, Police Scotland, the Scottish Ambulance Service and the third sector. This course has given me the opportunity to build new relationships as well as explore different approaches to situations I commonly encounter in my role.

In addition to my role as a team manager I am also a Mental Health Officer, a role I am very passionate about. I enjoy the opportunities it gives me to explore legislation and the variety which is inherent in this role.

Paula McIntosh, Community Psychiatric Charge Nurse for the Assertive Outreach Service and Finalist in the 70th Anniversary Platinum Chairman's Awards 2018

Tell us about a typical working day and what it involves…

The Assertive Outreach Service was set up for people who had become disengaged from Community Mental Health Services. Traditionally these are the most unwell, vulnerable and socially isolated members of the community. We are a small team, consisting of myself and one part-time nurse along with two amazing support workers, and we hold caseloads of between 20 to 30 patients.

A typical day for me consists of a team meeting first thing in the morning. We operate a live service, responding to events that crop up over the course of the day. I prepare a daily planner illustrating each staff member's workload for the day. We discuss any issues surrounding workloads and required interventions before heading out to take care of our patients.

We work within a medical model initially, reviewing medications and ensuring all physical healthcare checks are complete. We follow this up by encouraging dental and optical appointments are met as well as monitoring for physical side effects of medications. We monitor nutritional state and liaise with dieticians if necessary. Once a therapeutic relationship has been established and medications are adjusted as required, we can then begin to implement a Recovery Model of Care, offering a holistic approach.

We escort patients to medical reviews with their consultant psychiatrist. I like our staff to be involved in the review process to ensure the care plan is patient centred and the patient has understood fully what was discussed at the meeting.

I attend Adult Support and Protection case conferences where my patients may have been abused or exploited in some way. These may require me to submit a formal report and be part of the solution. I also attend CPA (Community Psychiatric Assessment) reviews and visit acute inpatient settings to help facilitate the discharge of patients who may have become acutely unwell and have had to spend a short while in hospital.

I have been involved in training third sector care providers in how to manage complex mental health illnesses, such as schizophrenia. Not all care providers have the specialist mental health training, and they can sometimes be quite frightened. Our staff work alongside the carers to ensure good working relations are established for the benefit of the patient.

Poverty is the biggest driver of Poor Mental Health in Scotland. I contribute to tackling the poverty experienced by my patients through supporting the application and appeals process for Personal Independence Payment (PIP). I have attended formal appeals and supported their application. I have also on occasion attended Children's Panel hearings where the children of the parents I look after are subject to a Social Work Supervision Order.

When all the physical and mental health checks are complete, we then focus on the social aspects. We arrange bus passes for our patients, as well as cinema passes. We attend community groups with them and try to promote better social inclusion. We source food banks for patients and try to ensure income is maximised.

I am very lucky to be surrounded by excellent team mates who help make this service work. The patients without doubt have benefited from the service we deliver.

We had our service audited after 18 months. The results were collected from staff, patients and carers or family members. It was carried out by an independent organisation and we were so proud of the results. We really do think imaginatively when it comes to problem-solving for our patients.

What do you find most rewarding?

Every time I manage to re-engage a person I am so delighted. I love the start of a new journey. I love the contract between the person and myself in terms of what we hope for and how we plan to get there. I love discharging patients from our service after having given them their life back. I love helping people to be the best they can be or the best they want to be. I enjoy helping people re-engage with society and watch them explore things we take for granted like museums, galleries, cinemas, shopping malls; even the electronic self-service order machine in McDonalds. Our patients have lived such isolated, reclusive existences that the opportunities we provide are incredible. Technology has moved on so quickly they often feel overwhelmed by it and many find it easier to avoid. In our first year we supported a man to leave the country for the first time in 32 years; a step by step process from passport to check-in. Every intervention that demonstrates improvement in my patients' lives is rewarding to me. I am also blessed with colleagues who hold the same passion and that is so greatly appreciated.

I am so proud of what I do and how I do it and I am so proud of who I work for. To be recognised for what I do is just amazing!

Brighter futures

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