EAST RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

East Renfrewshire Council

NHS Greater Glasgow and Clyde

Working Together for East Renfrewshire

East Renfrewshire Health and Social Care Partnership (HSCP) Annual Performance Report 2021-22

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1. Introduction

1.1 Purpose of Report

The Public Bodies (Joint Working) (Scotland) Act 2014 requires Integration Joint Boards to publish an Annual Performance Report, setting out an assessment of performance in planning and carrying out those functions for which they are responsible.

This is the sixth report for the East Renfrewshire Integration Joint Board. It sets out how we delivered on our vision and commitments over 2021-22. As required, we review our performance against agreed local and national performance indicators and against the commitments set out in our 2021-22 Interim Strategic Plan. This one-year 'bridging' plan was developed in recognition of the need for the partnership to continue its focus on our response and recovery from the Covid-19 pandemic. The plan has been succeeded by a full three-year plan for the period 2022-25.

This report looks at our performance during another exceptional 12 month period as the impacts from the pandemic have continued and changed in nature. During the period we have seen a combination of increased demand and more complex presentations across all services. As such our performance outcomes for the period are different from those previously predicted. In our discussion of performance we seek to include as much information as possible on the additional activities undertaken, although we recognise the challenge in doing justice to the incredible efforts of individuals and teams during 2021-22.

The main elements of the report set out:

- the established strategic approach of the East Renfrewshire Health and Social Care Partnership (HSCP);
- how we have been working to deliver our strategic priorities over the past 12 months and additional activity to meet the challenges of the pandemic;
- our financial performance; and,
- detailed performance information illustrating data trends against key performance indicators.

1.2 Our Covid-19 response

East Renfrewshire HSCP has been at the forefront of the local response to the Covid-19 pandemic. Over the course of the Covid-19 crisis we have seen incredible resilience, commitment and creativity from staff at the HSCP, our partner providers and community groups in East Renfrewshire. Our teams have established and adapted to new ways of working and have continued to maintain and deliver safe and effective services to our residents. During the pandemic period there has been innovation and collaborative working across the health and care system building on and strengthening local partnerships. This positive response is informing current and future approaches and we will continue to build on innovation and best practice moving forward.

Our response to the pandemic has necessarily been tailored within service user groups to meet the specific needs of communities and respond to specific challenges posed within these services.

The HSCP provides care, support and protection for people of all ages, to enhance their wellbeing and improve outcomes for them as children, young people, families and adults. Over the course of 2021-22, our teams in collaboration with our partners and communities have continued to deliver this work in the most unprecedented and challenging times throughout

the Covid-19 pandemic. This has involved responding to higher demands for support, supporting individuals with higher levels of emotional distress, complex needs and limited informal support networks. Our teams have responded compassionately, creatively and with an unwavering commitment to improve outcomes for the individuals and families we support.

Our strong local partnerships continue to respond with great innovation and we have seen greater collaborative working with and in support of our local communities.

Despite progressing our recovery during the year, the emergence of the Omicron variant during the winter months had a significant impact on progress. The HSCP and our partner organisations experienced increased staff absence with resulting pressures within the health and social care system. This year we have also seen significant recruitment and retention challenges in the sector impacting on our performance. As the pandemic has continued we are seeing an increasingly fatigued workforce and we are placing a significant focus on supporting staff health and wellbeing.

Our Covid-19 response activity has happened in addition to our planned operational priorities. Much of the performance data for 2021-22 reflects the direct impact of the pandemic on operational activity and changed behaviours among the population during the pandemic period.

The performance data shows that despite the continuing pressures of the pandemic there has been strong performance across service areas. We have continued to support our most vulnerable residents and have performed well against many of our outcome-focused performance indicators. Throughout the period we have seen excellent collaboration across the HSCP and with our independent, third and community sector partners. And we are seeing positive signs of recovery across many of our performance indicators as discussed below.

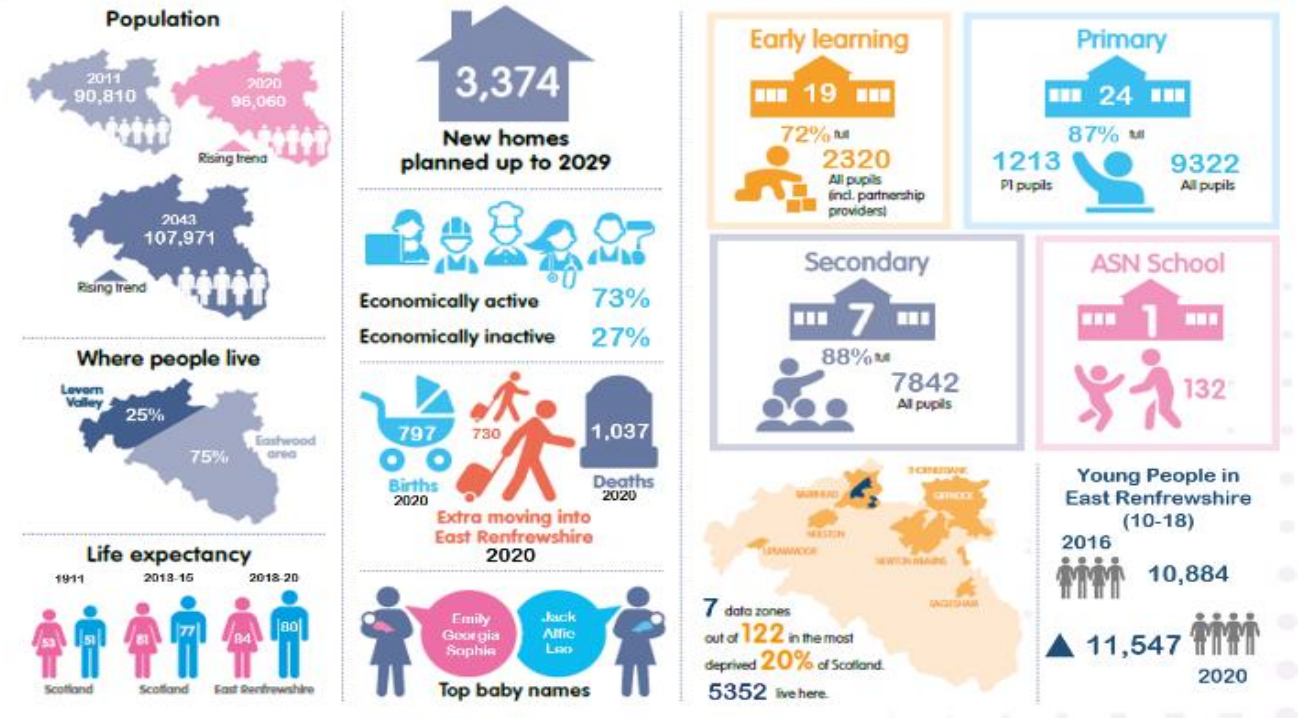
1.3 Local context

East Renfrewshire covers an area of 174 square kilometres and borders the city of Glasgow, East Ayrshire, North Ayrshire, Renfrewshire and South Lanarkshire.

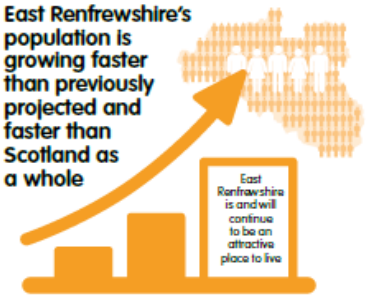
Our population continues to grow and reached 96,060 in 2020. 74% of the population live in the Eastwood area (Busby, Clarkston and Williamwood, Eaglesham and Waterfoot, Giffnock, Netherlee and Stamperland, Newton Mearns and Thornliebank) and 26% live in the Barrhead area (Barrhead, Neilston and Uplawmoor).

East Renfrewshire has an ageing population with a 44% increase in the number of residents aged 85 years and over during the last decade. The 85+ population is projected to increase by 18% between 2019 and 2024. People over 80 are the greatest users of hospital and community health and social care services.

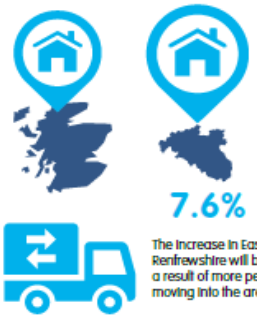
EAST RENFREWSHIRE FAST FACTS



EAST RENFREWSHIRE'S POPULATION – WHAT TO EXPECT



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



The increase in East Renfrewshire will be as a result of more people moving into the area

The two age groups that will grow the most

Children and young people aged 0-15 years

Older people aged 85+

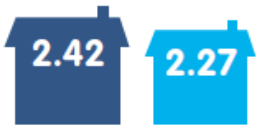
More houses are being built for three reasons

Demand will increase for services

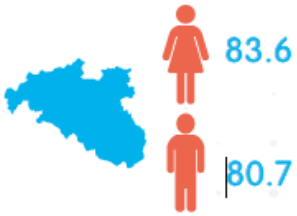
For older people, as well as general public services (such as health and care, leisure and environmental services)

More places will be needed in early years, primary and secondary education establishments

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



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



East Renfrewshire Health and Social Care Partnership (HSCP) was established in 2015 under the direction of East Renfrewshire's Integration Joint Board (IJB) and it has built on the Community Health and Care Partnership (CHCP), which NHS Greater Glasgow and Clyde and East Renfrewshire Council established in 2006.

Our Partnership has always managed a wider range of services than is required by the relevant legislation. Along with adult community health and care services, we provide health and social care services for children and families and criminal justice social work.

During the last 16 years our integrated health and social care management and staff teams have developed strong relationships with many different partner organisations. Our scale and continuity of approach have enabled these relationships to flourish. We have a history of co-production with our third sector partners and we are willing to test new and innovative approaches.

East Renfrewshire HSCP is one of six partnerships operating within the NHS Greater Glasgow and Clyde Health Board area. We work very closely with our fellow partnerships to share good practice and to develop more consistent approaches to working with our colleagues in acute hospital services.

1.4 Our Strategic Approach

1.4.1 Our Strategic Vision and Priorities

In East Renfrewshire we have been leading the way in integrating health and care services. From the outset of the CHCP we have focused firmly on outcomes for the people of East Renfrewshire, improving health and wellbeing and reducing inequalities. Under the direction of East Renfrewshire's IJB, our new HSCP builds on this secure foundation. Throughout our integration journey during the last 16 years, we have developed strong relationships with many different partner organisations. Our longevity as an integrated partnership provides a strong foundation to continue to improve health and social care services.

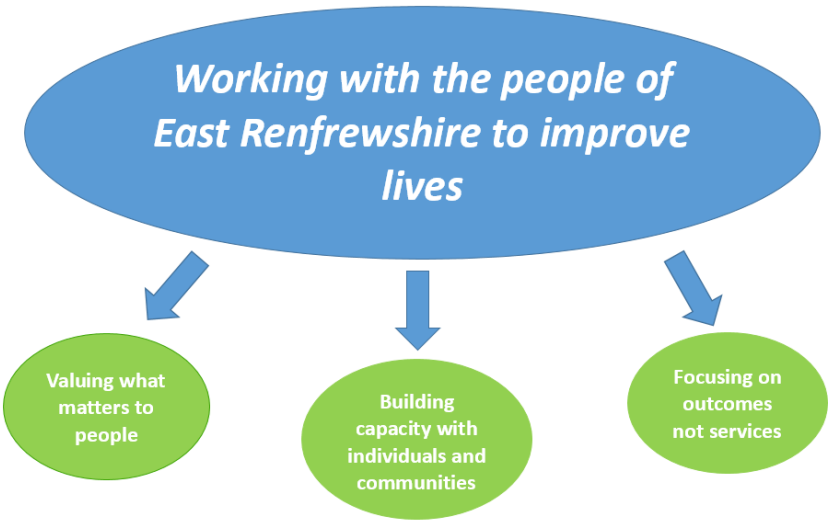
Our Vision

Our vision statement, *"Working together with the people of East Renfrewshire to improve lives"*, was developed in partnership with our workforce and wider partners, carers and members of the community. This vision sets our overarching direction through our Strategic Plan. At the heart of this are the values and behaviours of our staff and the pivotal role individuals, families, carers, communities and wider partners play in supporting the citizens of East Renfrewshire.

We developed integration touchstones to progress this vision. These touchstones, which are set out below, are used to guide everything we do as a partnership.

- *Valuing what matters to people*
- *Building capacity with individuals and communities*
- *Focusing on outcomes, not services*

The touchstones keep us focused when we are developing and improving the quality of our service delivery.



Our Strategic Plan

Our first Strategic Plan covered the period 2015-18 and took its priorities from the National Health and Wellbeing Outcomes. It set our high level planning intentions for each priority and was underpinned by an Annual Implementation Plan reviewed and monitored at HSCP level.

Our second Strategic Plan covering 2018-21 recognised that the partnership must extend beyond traditional health and care services to a wide partnership with local people and carers, volunteers and community organisations, providers and community planning partners. The plan placed a greater emphasis on addressing the wider factors that impact on people's health and wellbeing, including activity, housing, and work; supporting people to be well, independent and connected to their communities.

Recognising the impact of the Covid-19 pandemic on capacity, it was that for the next round of strategic planning, the HSCP would depart from the normal approach of developing a three-year plan and establish a one-year 'bridging' plan for 2021-22 reflecting priorities during our continuing response and recovery from the pandemic. It was also agreed that during 2021-22 we would undertake a more comprehensive strategic needs assessment and full programme of community and stakeholder engagement to support the establishment of a full three-year strategic plan for the period 2022-25. This revised approach recognised the challenges of undertaking planning activity during the pandemic period and was in line with the other HSCPs in Scotland.

The interim Strategic Plan 2021-22 described our partnership and vision recognising the benefits of working together as a broad and inclusive partnership and the opportunities that exist to build on the strengthened partnership working we have seen during the pandemic. The plan provided an updated assessment of our operating context including current needs assessment information, the key impacts from the Covid-19 pandemic that we continued to face during 2021-22 and changes in our approach to delivery resulting from the pandemic. It also recognised the changing strategic planning landscape notably through the priorities set out in the NHS Greater Glasgow and Clyde Remobilisation Plan 3 (2021-22), Moving Forward Together and the findings and recommendations from the recent Independent Review of Adult Social Care.

In light of our review of performance to date and recognising the context we are now working in, we have revised our headline strategic planning priorities. The majority of our priorities remain unchanged for 2021-22 but were to be taken forward recognising the challenges and changing requirements following the pandemic. We extended our planning priority for mental health which had previously focused on mental illness to include mental health wellbeing

across our communities. We changed the emphasis of our priorities relating to health inequalities and primary and community-based healthcare. Finally, we introduced a new strategic priority focusing on the crucial role of the workforce across the partnership. For each priority we set out the contributing outcomes that we will work to, key activities for 2021-22 and performance measures. Our revised strategic priorities under the plan are:

- Working together with **children, young people and their families** to improve mental and emotional wellbeing.
- Working together with people to maintain their **independence at home** and in their local community.
- Working together to support **mental health and wellbeing**.
- Working together to meet people's **healthcare needs** by providing support in the right way, by the right person at the right time.
- Working together with **people who care for someone** ensuring they are able to exercise choice and control in relation to their caring activities.
- Working together with our community planning partners on new **community justice** pathways that support people to stop offending and rebuild lives.
- Working together with individuals and communities to tackle **health inequalities** and improve life chances.
- Working together with **staff across the partnership** to support resilience and wellbeing.

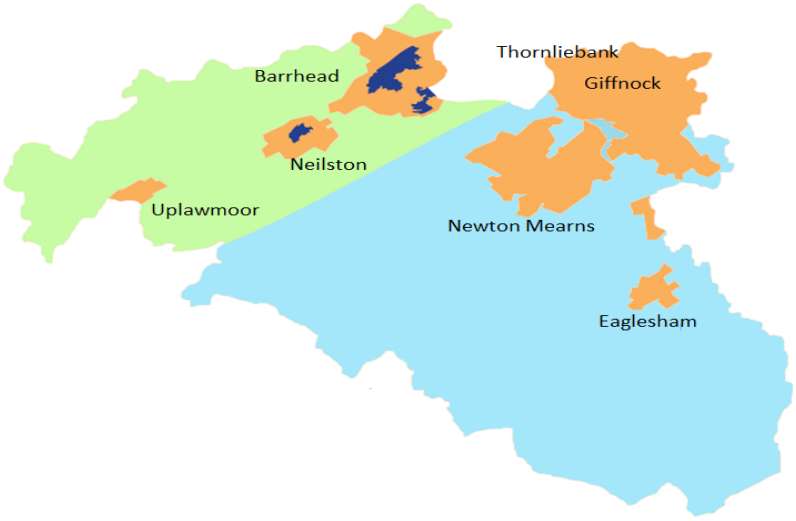
The partnership has now published its full three-year Strategic Plan for 2022-25. The plan was developed in consultation with stakeholders and East Renfrewshire residents, despite the continuing challenges of the pandemic. This included a highly participative engagement process coproduced with wider partners through our Participation and Engagement Network and a comprehensive strategic needs assessment.

The 2022-25 plan carries forward the strategic priorities set out in our interim plan but we have also added a distinct priority focusing on protecting people from harm, reflecting the cross-cutting and multi-agency nature of this activity. The key messages from the plan are being communicated to our residents through innovative, user friendly methods including an interactive online version of the plan. The plan represents a strong strategic footing for the partnership over the next three years as we continue our recovery and renewal following the Covid-19 pandemic.

1.4.2 Locality planning in East Renfrewshire

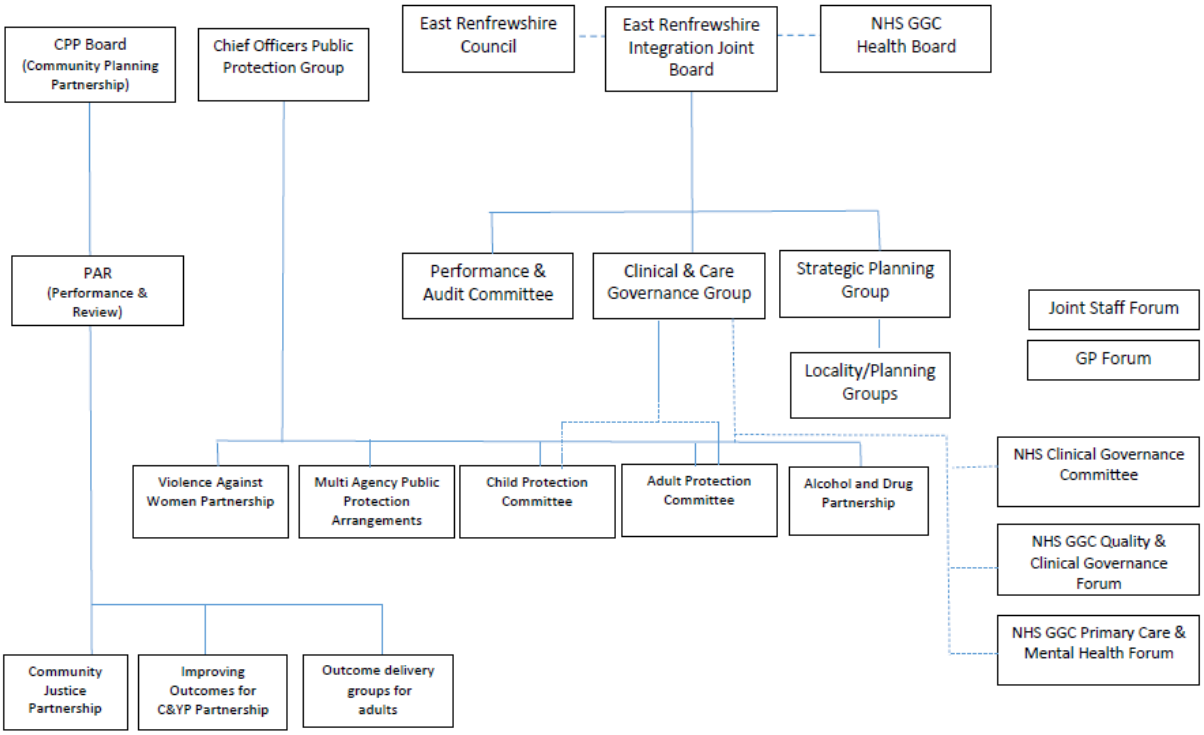
Our previous 2018-21 Strategic Plan reduced our locality planning areas from three to two localities – one for Eastwood and another for Barrhead. This allowed us to coordinate our approach with our local GP clusters while also reflecting the natural communities in East Renfrewshire.

Our locality areas also reflect our hospital flows, with the Eastwood Locality linking to South Glasgow hospitals and the Barrhead Locality to the Royal Alexandra Hospital in Paisley. Our management and service structure is designed around our localities. Our locality planning arrangements continue to develop and will be supported by new planning and market facilitation posts and financial reporting at a locality level.



The IJB continues to build on the long standing delivery of integrated health and care services within East Renfrewshire and the continued and valued partnership working with our community, the third, voluntary and independent sectors, facilitating the successful operation of the HSCP.

The chart below shows the governance, relationships and links with partners which form the IJB business environment.



1.4.3 Our integrated performance management framework

Since the establishment of the Community Health and Care Partnership in 2006, there has been a commitment to integrated performance management.

Our performance management framework is structured around our Strategic Plan, with all performance measures and key activities clearly demonstrating their contribution to each of our seven strategic planning priorities. The framework also demonstrates how these priorities link to the National Health and Wellbeing Outcomes and East Renfrewshire's Community Planning Outcomes.

An Implementation Plan and a supporting performance framework accompany our Strategic Plan. Working with key stakeholders, we developed these through outcome-focused planning. The plan is presented as a series of 'driver diagrams'. These diagrams show how we will achieve our strategic outcomes through 'critical activities' measured by a suite of performance indicators. This is the basis for strategic performance reporting to the Integration Joint Board (IJB) and it also feeds into East Renfrewshire Council's Outcome Delivery Plan and NHS Greater Glasgow and Clyde's Operational Plan. Our Strategic Performance Reports are presented to the IJB Performance and Audit Committee every six months (at mid and end year). We also provide quarterly updates (at Q1 and Q3) when data updates are available.

Every six months we hold an in-depth Performance Review meeting which is jointly chaired by the Chief Executives of NHS Greater Glasgow and Clyde and East Renfrewshire Council. At these meetings both organisations have the opportunity to review our Strategic Performance Report and hear presentations from Heads of Service, which set out performance progress and key activities across service areas.

The HSCP draws on qualitative and quantitative information from a range of sources. Our main sources of performance data include Public Health Scotland, Scottish Public Health Observatory and National Records Scotland. We also use local service user data and service data from NHS Greater Glasgow and Clyde.

We gather service user feedback from a variety of sources. These include patient/service user surveys through for example, our Primary Care Mental Health Team; day centres and community groups; and users of our integrated health and social care centres. We monitor feedback from residents through the recently established Care Opinion system. We also gather local feedback from East Renfrewshire Council's Citizens' Panel, Talking Points data and the National Health and Wellbeing Survey. We support a local Mental Health Carers Group, where carers are able to raise issues about their needs and the support they receive. We continue to develop our approach to engagement through our multi-agency Participation and Engagement Network, strengthening our methods in drawing in residents' views to our evaluation processes.

2. Delivering our key priorities during the pandemic

2.1 Introduction

This section looks at the progress we made over 2020-21 to deliver the key priorities set out in our Strategic Plan and how we are performing in relation to the National Health and Wellbeing Outcomes. We also set out performance for cross-cutting areas that support our strategic priorities including public protection. For each area we present headline performance data showing progress against our key local and national performance indicators. In addition to an analysis of the data we provide qualitative evidence including case studies and experience from local people engaging with our services. Our intention is to illustrate the wide range of activity taking place across the partnership during the pandemic.

A full performance assessment covering the period 2016-17 to 2021-22 is given in Chapter 4 of the report.

2.2 Working together with children, young people and their families to improve mental wellbeing

National Outcomes for Children and Young People contributed to:
Our children have the best start in life and are ready to succeed
Our young people are successful learners, confident individuals, effective contributors and responsible citizens
We have improved the life chances for children, young people and families at risk

2.2.1 Our strategic aims and priorities during 2021-22

Improving the mental and emotional wellbeing of children and young people continues to be one of the highest priorities for East Renfrewshire HSCP. Our multi-agency approach to supporting the needs of children and young people in East Renfrewshire is set out in our Children and Young People's Services Plan 2020-2023.

Our Strategic Plan recognises the impact of the Covid-19 pandemic in exacerbating the circumstances of many children, young people and families, resulting in a significant rise in the number of those experiencing challenges with their mental health and wellbeing. We aim to provide a holistic range of appropriate supports through our multi-stakeholder Healthier Minds Service which works alongside our Family Wellbeing Service and links to GP practices and the Child and Adolescent Mental Health Services (CAMHS) service. Through preventative approaches we aim to reduce the use of mental health inpatient beds, the number of GP consultations for mental wellbeing and alleviate pressures on CAMHS.

We continue to support our care experienced children and young people and are committed to fully implementing the findings of the national Independent Care Review report "The Promise". We will work in our role as Corporate Parents to ensure all care experienced children and young people have settled, secure, nurturing and permanent places to live, within a family setting.

Our aim is to **improve mental wellbeing among children, young people and families in need**, by:

- Protecting our most vulnerable children, young people and families
- Delivering on our corporate parenting responsibilities to our care experienced children and young people by fully implementing The Promise

- Responding to the mental and emotional health and wellbeing needs of children and young people
- Ensuring children and young people with complex needs are supported to overcome barriers to inclusion at home and in their communities

During 2021-22 the impacts from the Covid-19 pandemic continued to present significant challenges and required us to refocused our operational priorities. These are areas that we continue to focus on as we recover from the pandemic.

- The pandemic has exacerbated the circumstances of many children, young people and families, and we have seen a significant rise in the number of those experiencing challenges with their mental health and wellbeing. This is a key priority in our new multi-agency Children and Young Peoples Services Plan 2020-2023.
- Teams are seeing increasing complexity particularly for children with diagnosed neurodevelopmental disorders and a higher prevalence of families in crisis leading to more of these children coming under child protection and an associated increase in numbers coming into care.
    - There was a 30% increase in the number of children placed on the Child Protection Register (39 children in 2021-22 compared with 30 in 2020-21).
    - Children accommodated in residential care settings has increased by a quarter compared with 2020-21. 83% have a neurodevelopmental diagnosis.
    - There has been a 20% increase in referrals to the CAMHS duty system for urgent or crisis referrals.
- Coronavirus (COVID-19) has brought particular challenges for disabled children and their families. This can be seen by the increase in numbers of disabled children in the child protection system and becoming looked after.
    - The proportion of looked after children away from home with additional support needs increased from 17% to 22% over the year

2.2.2 The progress we made in 2021-22

Our children's services have continued to see increasing demand and complexity following the pandemic. In particular we are seeing more children with diagnosed neurodevelopmental disorders and a higher prevalence of families in crisis leading to more of these children coming under child protection and an associated increase in numbers coming into care. CAMHS continues to experience high demand and an increase in urgent referrals. However, referrals to our alternative (Tier 2) services, Healthier Minds and the Family Wellbeing service are increasing while monthly referrals to CAMHS have been reducing. As a result we are beginning to see more positive performance on CAMHS waiting times.

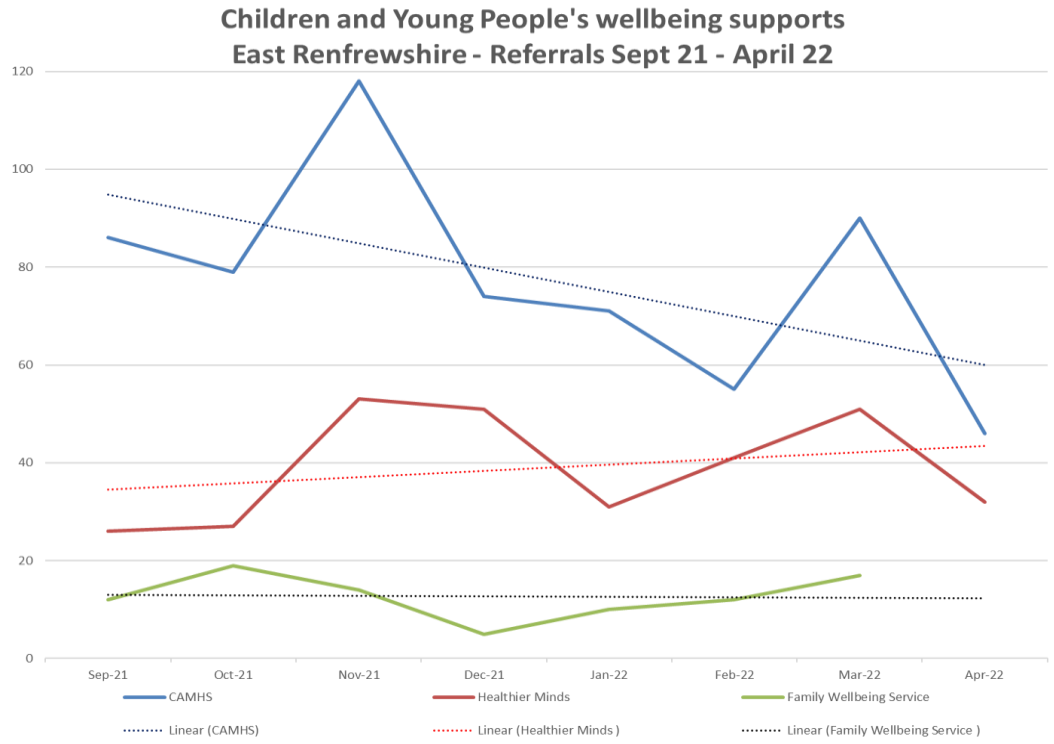
Headline performance data includes:

- % starting CAMHS treatment within 18 weeks – 55% (year average) down from 61% in 20/21. Team reporting 63% at end March 22.
- Care experienced children – good performance on permanence – 2 children with 3 or more placements
- 91% of care experienced children supported in community – a high rate but has been reducing during pandemic
- 94% care experienced children waiting no longer than 6 months for a review
- Child protection - 84% child protection cases with increased safety
- Reduced % of children subject to child protection offered advocacy – 62%

2.2.3 The support we provided in 2020-21

East Renfrewshire HSCP and our partners recognise the extent of mental health concerns among the children's population, and in our multi-agency Children and Young Peoples Services Plan 2020-2023 we have agreed mental and emotional wellbeing as a key priority. The impact of the Covid-19 pandemic has exacerbated the circumstances of many children, young people and families, and we have seen a significant rise in the number of those experiencing challenges with their mental health and wellbeing and this also includes those who have a neurodevelopmental diagnosis.

We have been working to alleviate pressure on CAMHS by establishing appropriate (Tier 2) alternatives that work with young people and families to support recovery and minimise crisis. During 2021-22 we have seen a declining number of referrals to CAMHS services as more referrals have been made to Healthier Minds and the Family Wellbeing service, demonstrating that we are achieving our strategic intent.



In response to growing demand during the pandemic a multi-stakeholder **Healthier Minds Service** approach aligned to school communities was developed to identify and ensure delivery of mental wellbeing support to promote children and families' recovery. Working with schools and young people prior to and following referral helps the team build a fuller picture of the support required and the young people are then assigned to the most appropriate support based on their needs. This is in addition to the existing Family Wellbeing Service which links to GP practices.

Healthier Minds Hub
In recognition of the identified increase in mental health concerns for children and young people, the partnership invested in multi-agency mental health provision. The Healthier

Minds Hub is East Renfrewshire's framework for supporting and nurturing the mental health and wellbeing of children, young people and families. It is also a resource for staff. The component parts of the hub are:

- Family Wellbeing Service
- Healthier Minds Service
- School Wellbeing Service
- Youth Counselling Service.

The hub is enhanced by the Healthier Minds website and resources.

The hub has representatives from CAMHS, Social Work, Youth Counselling, Educational Psychology, and the Family Wellbeing Service which is delivered by Children 1st. Hub members meet weekly to consider referrals. The needs of the child or young person determine the route for provision of the optimal support. The newly-formed, multi-agency recovery team, Healthier Minds service, was developed and aligned to school communities to identify and ensure delivery of mental wellbeing supports that promote children and families' recovery.

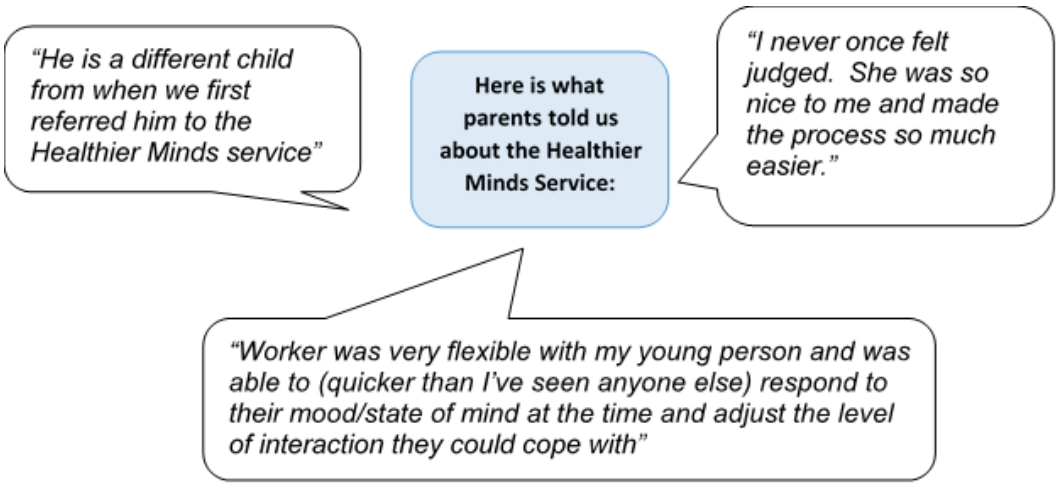
The three key elements of the service are:

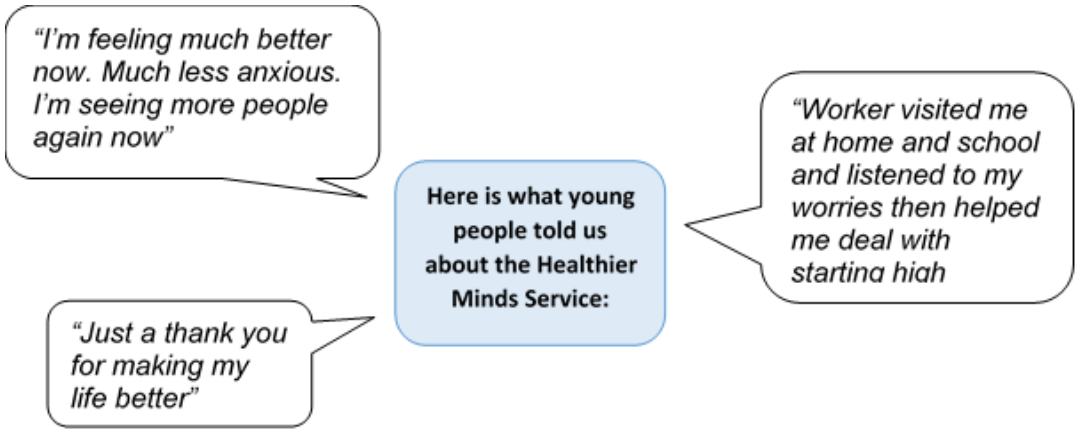
- strategic mapping and support to maximise school community capacity to be trauma responsive
- provision of direct services to children and families to build on strengths and improve social, emotional and mental wellbeing
- strengthening of the existing school counselling model.

One young person described how the trusting relationship with the staff had supported them to overcome many challenges such as not attending school, difficult relationships at home and an eating disorder. The young person detailed how this support impacted positively on their wellbeing.

The Healthier Minds Service gathers data effectively to evaluate and improve its work. Recent self-evaluation shows that more girls accessed the service and Black and minority ethnic groups were underrepresented. Staff considered how to address these issues and introduced a worker with a focus on sport to encourage boys to access services.

602 Referrals were received between 25 November 2020 and 30 April 2022. The majority (247) were referred to the Youth Counselling Service, 179 were referred to Healthier Minds Team, and 104 continued with existing services. The majority of persons referred were female and aged 13-16 years.





East Renfrewshire's **Family Wellbeing Service** supports children and young people who present with a range of significant mental and emotional wellbeing concerns. The services works with the HSCP to deliver holistic support based in GP surgeries to:

- Improve the emotional wellbeing of children and young people aged 8–16;
- Reduce the number of inappropriate referrals to CAMHS and other services;
- Support appropriate and timely recognition of acute distress in children and young people accessing clinical help if required;
- Improve family relationships and help build understanding of what has led to the distress and concerns;
- Engage, restore and reconnect children and young people with school and their wider community.

During 2021-22 there have been significant developments at **East Renfrewshire CAMHS** including the establishment of a dedicated eating disorder clinic. This followed an unprecedented increase in the number of young people presenting with an eating disorder to CAMHS, particularly during the COVID 19 pandemic many of whom have been acutely and severely unwell with this illness. During 2021-22 East Renfrewshire was seeing the highest number of eating disorder presentations across the CAMHS teams in Greater Glasgow and Clyde. A key measure of success for the clinic has been a significant reduction in hospital admissions - 5 in 2021-22; down from 14 in 2020-21.

During the year the partnership underwent a **joint inspection of services for children and young people at risk of harm**. We are proud that the inspection found strengths that significantly impacted on the experiences and outcomes for children and young people at risk of harm and rated our service and rated our quality of service as "Excellent". The inspection found that the partnership has a long track record of innovative, effective practice and very high-quality performance across a wide range of activities. And that the partnership is fully committed to the promotion and protection of children's rights

Joint inspection – Key Messages

The inspection of services for children and young people at risk of harm was carried out by the Care Inspectorate in partnership with Healthcare Improvement Scotland, Her Majesty's Inspectorate of Constabulary in Scotland, and Education Scotland. It's report highlighted the following key messages:

1. Staff recognised and responded quickly to concerns raised about children and young people at risk of harm. Very effective collaborative early interventions were preventing risk from escalating.
2. Children and young people at risk of harm were benefiting from high-quality assessments, plans and support from a wide range of services. These were impacting positively on their safety and wellbeing.

3. The safety and wellbeing of children and young people who were at risk of harm was improving as a result of the caring relationships they had with key members of staff. Children and young people were listened to and respected.
4. Children and young people at risk of harm and their families were actively participating and influencing service planning, delivery and improvement.
5. The partnership was successfully using data and quality assurance information to inform and support decision making, service planning and delivery. This helped to identify emerging risks and inform future priorities.
6. The partnership was providing strong and effective leadership and shared a very strong vision for children and young people. This continued throughout the Covid-19 pandemic ensuring appropriate supports reached the families who were in most need.
7. The partnership has a strong track record of continuous development and improvement of its services. Focused plans were in place to support improvements and build on achievements. They had realistic goals and strong measures in place to monitor progress with clear timescales.

Our **Inclusive Support Service (ISS)** continues to provide three distinct services: holiday provisions, out of school activity clubs and individualised support services. Providing a range of targeted supports for children and young people aged 5-18 years. All of the children and young people who access the service have either complex health or behavioural support needs, with a significant number having limited verbal communication. ISS, in consultation with partners, has refocused its activity over the course of the pandemic. The service supported 247 children and their families ensuring that they received support when many services had ceased. The team also worked with Adult Services supporting young people transitioning from children's services meaning young people received the right support at the right time.

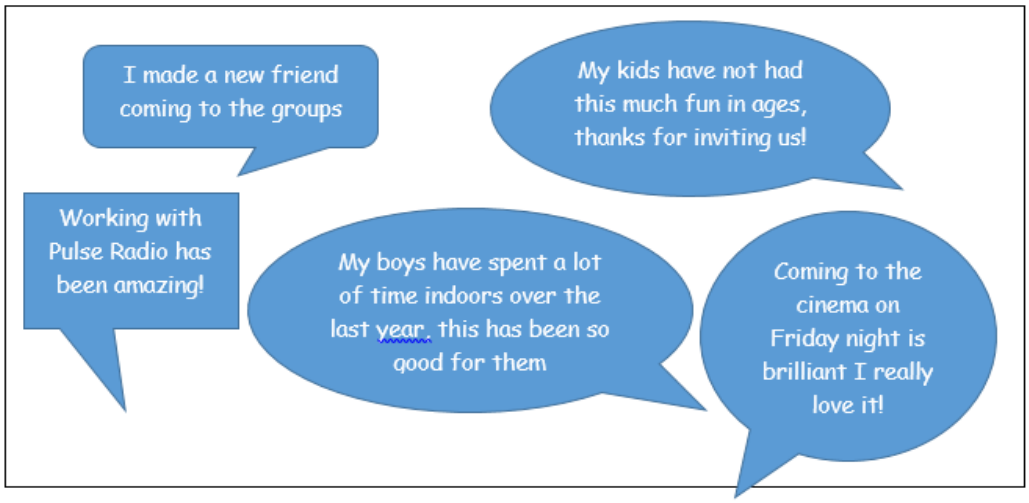
Prior to the pandemic our practice for vulnerable young people was to undertake regular multi-agency reviews of their plan to ensure that they, and their family, were getting the right support at the right time. Children looked after at home had additional Child's Plan meetings compensating for reduced provision of Children's Hearings. This meant that delays in decision making and planning were minimised and immediate action was taken to manage any risk presented.

During the pandemic Children's statutory processes were prioritised to ensure the safety of children. Meetings took place online and we also used a blended approach due to feedback from staff and families. Support was given to families to access laptops, tablets and internet allowing them to participate.

Increased levels of isolation for children and families meant that we wanted to increase our face-to-face contact. In partnership with Culture and Leisure Trust and Youth Services, we delivered an Enrichment Activity Programme. Children were able to try new skills outside of their home, build confidence, encouraging them to socialise and feel part of their community. We provided 321 events reaching 68 children and young people. Evidence indicates that this enabled improving

relationships between children and their families with general feedback positive. The work of the multi-agency team was recognised when they won the Innovation of the Year award in the NHSGGC Excellence Awards.

In summer 2021, we delivered a programme of activities via the Get into Summer Programme. Over 2000 children and young people participated in activities and this included high numbers of vulnerable children and young people. Evaluations told us that the programme increased the time children spent outdoors with their peers engaged in physical activity. Children felt part of their community and parental stress was reduced.



Over 2021-22 we have continued the implementation of the **Signs of Safety** model, led by the Chief Social Work Officer and the Head of Education Services (Equality and Equity). The model supports practice improvement, with a particular focus on developing relational interventions with children, young people, their families and carers in order to reduce risk and improve children's wellbeing. It is the most effective framework to assess and manage risk for children and young people while supporting families. The approach recognises the need to define harm, outline danger and identify safety goals. Children's assessments and plans benefit from the use of the Signs of Safety analytical tools such as the harm matrix, scaling questions, the danger or worry statements and the safety and wellbeing goals. They provided children and their families with opportunities to fully engage in assessment activity and decision-making.

In East Renfrewshire **Youth Intensive Support Service (YISS)** is the lead service for all looked after young people aged 12 – 26 years, recognising that more intensive interventions are required to improve recovery from trauma, neglect and abuse. The service aims to successfully engage the most hard to reach young people in East Renfrewshire and has the following shared aims across social work and health services:

- To reduce the number of young people looked after and accommodated and at risk of hospitalisation and custody.
- To reduce the impact of historical trauma and abuse for young people.
- To ensure that the transition into adulthood achieves better long term outcomes.
- Maximise social capital.
- To keep whenever safe to do so a connection to their local communities.

The **Youth Intensive Support Service (YISS)** makes a positive difference in the lives of young people at risk of harm, and their families. The team's ethos is to support young people and ensure their rights are upheld and promoted. The service provides intensive intervention (including out of hours and weekend support) to enhance recovery from trauma, neglect and abuse. Additionally, the service provides the defined pathway for protective processes for young people at risk of harm.

The service supports children and young people aged 12 – 26 years, who are at risk of being accommodated, custody, placement breakdown and hospitalisation due to poor mental health. Support is also provided to young people who are looked after, in continuing care or in aftercare. The School Nursing Service is aligned to the Youth Intensive Support Service. Both services adopt a relational-based approach to effectively engage the hardest to reach young people by co-ordinating and providing multi-dimensional support plans. The responsiveness of the service to the young person's needs has made mental health support more accessible.

The success of the Youth Intensive Support Service was reflected during the Covid-19 pandemic with an average of 81% of young people having contact at least fortnightly. Young people told us the support they received had made a positive difference to their lives. The approach taken by staff working together helped them to accept support to keep them safe. We consider this relational based collaborative approach, which resulted in positive outcomes for young people and their families, to be an example of good practice.

East Renfrewshire Champions Board aims to improve life chances of looked after young people both within our community planning partnership and in the wider community. A central focus is on inclusion and participation allowing looked after young people a meaningful forum to directly influence and, through time, redesign services that affect them in a co-produced way by influencing their corporate parents. The Champions Board offers looked after young people leadership opportunities and the opportunity to change practice and policy. Our aim is to demystify and challenge misconceptions about looked after children and young people and strengthen awareness of the barriers that they face.

Participation and influence through the Champions Board

The Champions Board offers young people opportunities for leadership and to influence policy and practice development. Young people involved with the Champions Board have expressed that they are encouraged to share their views and expertise, even when their views might challenge the partnership.

In recognition that the views of younger care experienced children were under-represented, the Mini-champs group for those aged 8-12 years was formed. Young people in the Champions Board were responsible for shaping the agenda of the group. They identified themes and influenced change. The influence of the Champions Board and feedback from parents and children, was central in the development of the Healthier Minds service. The Champions Board has also influenced the establishment of care experienced traineeships. Care experienced trainees support the partnership to further improve their approach to participation and consultation. This included ensuring the voice of older young people at risk of harm was heard and influencing development. Other influencers such as young people who were at risk of offending, have been actively engaged in the co-development of harm reduction programmes. This included a programme with police, which took a young person through a mock custody process. Some young people who were involved in carrying knives helped frame and took part in the local No Knives, Better Lives campaign, which heightened young people's and community awareness.

2.3 Working together with people to maintain their independence at home and in their local community

National Health and Wellbeing Outcomes contributed to:
NO2 - People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
NO3 - People who use health and social care services have positive experiences of those services, and have their dignity respected
NO4 – Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services

2.3.1 Our strategic aims and priorities during 2021-22

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

We work to minimise isolation and engage with those in need through approaches such as befriending, peer support and the work of our Kindness Collaborative and Talking Points, linking people to local supports. We will continue to build on this collaborative working going forward to increase the community supports and opportunities available. We will make best use of technology and health monitoring systems to support independence and self-management. We are committed to increasing choice and control and delivering the full potential of Self-directed Support.

Our aim is to **support people to maintain their independence at home and in their local community**, by:

- Ensuring the people we work with have choice and control over their lives and the support they receive;
- Helping more people stay independent and avoid crisis though early intervention work;
- Ensuring people can maintain health and wellbeing through a range of appropriate activities.

The pandemic has impacted our approaches to supporting independence and the delivery of our preventative supports. Teams were required to establish and adjust to alternative ways of working in a short space of time. Across our services we have seen increased demand and higher levels of complexity among the people we support. And as a direct consequence of the pandemic restrictions we have seen increased frailty and social isolation particularly among older people.

The pandemic has changed some of the choices people make and disrupted pathways within the health and social care system. For example, our care at home services have seen additional pressures due to a desire from more people to be supported at home and we have been dealing earlier and more complex hospital discharges. We are aware that many older people, shielding residents and those who live alone have become more isolated and had less opportunities for leisure, exercise and social activities. At the same time, the response to the pandemic has demonstrated the resilience of our community-based supports with teams of volunteers and staff keeping touch with the most vulnerable and isolated, notably through the Community Hub.

2.3.2 The progress we made in 2021-22

Over 2021-22 we have continued to support people to live independently and well at home, despite additional demand pressures on our services due to more people seeking support at home as well as increased levels of frailty and complexity. During the year we have seen continuing pressure on our Care at Home service with increased referrals and reducing capacity among partner providers. Quarterly referral rates have doubled since 19/20 and this level of demand was sustained during 2021-22. We saw a 48% reduction in support packages from partner providers between 20/21 and 21/22. Increased frailty, complexity of need and de-conditioning has been evident with higher referrals to rehabilitation services and twice as many Care at Home service users requiring two or more carers during visits.

Headline performance data includes:

- 60% of people with reduced care need following re-ablement / rehabilitation (up from 31% at end 2020-21; was 67% pre-pandemic)
- 89% reporting 'living where you/as you want to live' – down slightly from 91%
- 62% aged 65+ with intensive needs receiving care at home – up from 58%

2.3.3 How we delivered in 2021-22

The HSCP remains committed to promoting Community Led Support which sees a move from traditional day service provision for older people to enabling access to more local, personalised and flexible services. The pandemic has resulted in many people's wellbeing has been affected by the isolation and changes to routine. Through strong local partnerships our teams have responded with great innovation and greater collaborative working in support of our communities. And with the aid of technology teams have been able to offer people ongoing support throughout the pandemic, and access to support and treatment has been maintained.

An East Renfrewshire community phoneline for local people and organisations looking for support, signposting and community information.

Support

Get in touch with The Community Hub if you or someone you know needs support.

In East Renfrewshire a local **Community Hub** was developed to coordinate the community response to the Covid-19 pandemic. The Community Hub is a partnership between Voluntary Action East Renfrewshire, HSCP Talking Points and East Renfrewshire Council Communities and Strategic teams. It has supported residents to access information and signposted to local community supports as well as establishing new shopping and prescription delivery service. It also responded to the growing need for social contact by those who were reporting feeling isolated, especially those who were shielding. The Community Hub has now formalised the partnership and will continue to co-produce new delivery models in response to community need.

Responding in partnership with our communities – Talking Points and the Community Hub

Talking Points continues to develop its role as a member of the Community Hub and as the main route for residents to get advice and support around their health and social care as well as information surrounding accessing community supports. The services has a membership of over 60 local and national organisations that work together to offer the correct support and information as early as possible. This preventative approach based around a person-centred approach is integral in our delivery of Talking Points. Talking Points is coordinated by Alan Stevenson, a member of the Initial Contact Team within East Renfrewshire Health and Social Care Partnership.

- Talking Points has developed a new online referral form for HSCP and partners that allows us to collate the information in a central database hosted by Voluntary Action.
- Residents can now contact Talking Points via the "Talking Points at the Community Hub" telephone number. This number is staffed five days per week by our Community Hub partners at Voluntary Action.
- Residents can also contact Talking Points by our dedicated email address "talkingpoints@eastrenfrewshire.gov.uk" or by messaging our Facebook Page. We are in the process of developing and online referral process that will allow residents to self-refer.
- Talking Points now has a dedicated ERC Webpage that shares what we do and how to get in touch.
- Talking Points has a screening group that meets weekly and triages all new Talking Point referrals. This has a dedicated group of partners attending and together we can share our knowledge and experience to respond to the specific needs of each referral. The screening group is made up of staff from the following organisations: Recovery across Mental Health (RAMH), The Carers Centre, Enable Local Area Coordinators, Voluntary Action, Money Advice and Rights Team and the Talking Points Coordinator.
- Talking Points have, via Voluntary Action, sent out 30,000 Talking Point/ Community Hub postcards directly to resident's homes via Royal Mail. This was funded by Voluntary Action.
- Since March 2022, when Talking Points began to re-engage with our resident's post COVID, we have received and actioned 442 referrals.
- Between June and the end of August, talking Points held 37 community based " Hubs" where residents could make an appointment or drop in to have a conversation with staff from a variety of organisations. There is always staff from the Initial Contact Team present. These "Hubs "covered all areas of East Renfrewshire and were held in community partner spaces that included Libraries, Trust Housing, Neilston Development Trust, Community Centres and the Market Places.
- Both Market Places in Barrhead and Newton Mearns are advertised as Talking Point venues where residents can visit five days a week and meet with trained staff who will fill out our referral forms and offer one to one support. Both staff and venues are led by community hub partners Voluntary Action.
- Talking Points has, in partnership with Community Hub and Talking Point Partners, set up two new Older Persons that support 58 residents weekly. We are looking at how we can develop capacity to continue to assist our communities to offer and grow community-based supports.

Talking Points will continue to support the residents of East Renfrewshire and assist them in engaging with local supports based upon their needs. We will continue to work with

trusted partners to bring the expertise and knowledge swiftly to allow residents to continue to live at home while staying healthy and safe.

I felt frustrated, anxious, angry and didn't know where to turn to next. Phoned the Community Hub and within 15 minutes the officer from Talking Points had phoned and was on my case. He's a great listener, had a very calming manner and told me not to worry as he would find out the required information… I'd like to thank him for helping me and resolving my problem so quickly

Using resources to address pressure on services

During 2021-22, the Scottish Government provided additional funding to support health and social care providers tackle demand pressures on services following the Covid-19. Phase One of the additional resources was for the recruitment of 16 additional **Health Care Assistants** for the NHS Greater Glasgow and Clyde health board area with local deployment to East Renfrewshire to enhance the capacity of our Care at Home Responder Service, Community Nursing and Community Rehabilitation teams.

We have strengthened our HSCP **adult services 'front door'** to include a much wider Multi-disciplinary Team (MDT) approach, a focus on Technology Enabled Care (TEC) and more streamlined pathways for individuals and families to access our supports. East Renfrewshire HSCP have contributed to the development of a **hospital discharge hub** across Greater Glasgow and Clyde (GGC) hospitals to prevent hospital admissions and support timeous hospital discharges.

Phase Two of the funding programme included an additional £2.1m for East Renfrewshire in 2021-22 to support **Interim Care**, **Care at Home** and **Multi-disciplinary Teams**. In 22/23 we have continued to implement our model for interim care including the development of our intensive support model at Bonnyton care home. This creates a step up/step down service locally, to avoid unnecessary hospital admissions and timely discharge to home/homely settings.

For Care at Home, the additional resource has been used to address the ongoing demand pressures the service has been experiencing, increase frontline staff as well as management and support, and increase capacity for the **Home First model** and **Technology Enabled Care**. We are continuing to enhance the capacity of our multi-disciplinary teams across the HSCP including: developing our multi-disciplinary Front Door model and leadership arrangements; additional capacity for social work and our Care Home and Community Review Team; support for the wider GGC frailty hubs; and increased capacity for frailty practitioners, data and quality analysis and peripatetic business support.

Phase Three funding to strengthen Adult Social Work has allowed us to create additional leadership posts within Communities and Wellbeing. This has provided us an opportunity to create a **dedicated transition team** to support young people with complex needs in the

transition to adulthood, and **Long Term Conditions team** to support the local residents with long term conditions as we recover from the pandemic.

During 2021-22 our focus on developing approaches for **day services** has continued. Days Services staff were key to supporting our Intensive Services particularly throughout the challenges presented by the Omicron variant. This resulted in Day Services being reduced. However, by March 2022 staff were returning to the day service and service began increasing. We are now establishing a fuller blended model of building based and outreach for our day service. During 2021-22 we met regularly with carers to develop our model and identify where support has been most required. A survey for carers focussing on the pandemic experience was also conducted. Face-to-face carers support meetings also recommenced and these have been well received by attendees.

Improving access through our 'Front door'

We recognise the impact of the pandemic on the individuals and families and commissioned an independent review of the HSCP Front Door for adult services in partnership with individuals, families and professionals in order to ensure that the single point of access to adult services was fit for purpose as we move towards recovery.

The independent review noted many strengths of our approach, mainly in terms of our rapid access Occupational Therapy service, our Talking Points and the single point of access model. The report also noted some key recommendations to strengthen our front door which includes:

- Widening out the Multi-disciplinary element of our front door to include access to Rehab Physio, Rehab Nurse (prescriber), Pharmacy, technology enabled care and money advice.
- Operating a daily huddle model to support our right support, right place, right person approach to referrals.
- Strengthening our call handling model to free up our social work assistants to complete less complex assessments.
- Streamline our assessment and resource allocation process to reduce duplication and make more user friendly for individuals and families.

An implementation plan was developed in partnership with the team, people who use our services, unpaid carers and frontline practitioners with a new model to be launched during 2022-23.

For our **Care at Home** team, there has been continued pressure throughout 2021-22 as a result of the volume and complexity of new referrals into the service as well as reduced capacity among partner providers in the independent and third sectors. Covid-related absence amongst frontline staff was a significant challenge for the service during the year. Recruitment into the service has continued despite significant challenges. Fifty-nine new members of staff were appointed following a multi-channel advertising campaign running during the early months of 2022.

At a glance – Supporting people at home in 2021-22

- 164,632 hours* of homecare provided by the HSCP's in-house Care at Home Service
- 401,549 hours* of homecare provided by partner providers
- 1,729 service users receiving homecare support

- 395 Community Care outcomes assessments completed by Adult and older people Social Work
- 111 Care at home staff trained in dementia awareness
- 67 Care at Home staff trained in medication management

*inc homecare elements from SDS packages

The **Telecare Team** also recruited extra staff during the year to assist in delivering its overnight response. Face-to-face reviews resumed, having been conducted by telephone throughout the pandemic. This is allowing responders to more thoroughly check on telecare customers and their home environments and ensure they have telecare equipment appropriate to their level of need, helping keep them safe in their homes. Progress is being made on the analogue-to-digital transition with our new cloud-based call handling system (including responder app) which is scheduled to go-live later in 2022.

Our partnership with local **care home** providers has continued to develop and strengthen in following the pandemic. Testing and vaccination for residents continued during 2021-22. Care homes have been caring for some of our most vulnerable residents over the course of the pandemic. Care home liaison staff have supported homes to manage residents' care, with advice on pressure area care, food, fluids and nutrition and individual nursing issues. Along with NHSGGC colleagues, they have offered infection prevention control advice and supportive visits. Commissioning and contracts staff continued to support homes with daily welfare calls, and arranged virtual meetings and workshops for managers, updating them on changes to guidance and providing a forum for peer support. The HSCP adult support and protection team has worked closely with homes advising and investigating to keep the most vulnerable individuals safe from harm. Bespoke support has been offered to care homes particularly affected by the pandemic and the wellbeing of staff and residents continues to be a high HSCP priority.

Care Home Collaborative Hub

Support to our care homes continues using our existing support and governance mechanisms including the newly established Care Home Collaborative Hub model. The Collaborative is made up of three multidisciplinary teams (Hubs) of health professionals to support care homes: one to cover Glasgow City HSCP; one hosted by Inverclyde HSCP on behalf of the remaining 5 partnerships; and, one central 'specialist' team with shared resources spanning both local Hubs. Additionally, the MDT Hubs are supported via a Corporate Hub in order to strengthen professional oversight and robust governance. The overarching purpose is to enable care home residents to live their best life aligned to what matters to them. The Hubs provide professional and practical support, oversight and leadership offering a range of additional support in key areas including, but not limited to, infection prevention and control, person centeredness, food fluid and nutrition, tissue viability, quality improvement, leadership and education.

2.4 Working together to support mental health and wellbeing

National Health and Wellbeing Outcomes contributed to:
NO1 - People are able to look after and improve their own health and wellbeing and live in good health for longer.
NO3 - People who use health and social care services have positive experiences of those services, and have their dignity respected
NO4 – Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services

2.4.1 Our strategic aims and priorities during 2020-21

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

We are enhancing our approach to minimising drug-related harms and deaths and improving overall wellbeing amongst people with harmful drug or alcohol use and their families.

We will continue to work in partnership with people who use services, carers and staff to influence the Greater Glasgow and Clyde Five Year Strategy for Adult Mental Health Services and contribute to its delivery to ensure the needs of East Renfrewshire residents are met. We will ensure a particular focus on prevention, early intervention and harm reduction; high quality evidence-based care; and compassionate, recovery-oriented care recognising the importance of trauma and adversity and their influence on well-being.

Our aim is to **support better mental health and wellbeing**, by:

- Ensuring individuals can access a range of supports on their journey to recovery from mental health and alcohol and drugs harms
- Ensuring wellbeing is enhanced through a strong partnership approach to prevention and early intervention
- Helping staff and volunteers to have the skills, knowledge and resilience to support individuals and communities

For many people experiencing and recovering from mental health and addiction the lockdown has been particularly challenging. Our teams have been dealing with a significant increase in demand across mental health and addiction services due to increased complexity in the cases we are working with and we expect this to increase going forward.

2.4.2 The progress we made in 2021-22

During 2021-22 our teams have continued to deal with increased demand across mental health and addiction services due to increases in complexity. With the aid of technology teams have been able to offer people ongoing support throughout the pandemic, and access to treatment has been maintained. The HSCP has been supporting mental health and wellbeing concerns across care groups related to stress and distress related to the pandemic but also wider economic problems. There have been increased caseloads across all teams (Community Addictions Team, Adult Mental Health Team, Primary Care Mental Health Team,

Older Adult Team). For older people we are seeing overall wellbeing impacted by issues such as isolation and reduction in mobility.

Headline performance data includes:

- Mental health hospital admissions remain low (at 1.4 admissions per 1,000 population)
- 76% waiting no longer than 18 weeks for access to psychological therapies (av. 2021-22); End March 2022 - 65%
- 95% accessing recovery-focused treatment for drug/alc within 3 weeks – up from 69% in 20/21
- 9% of service users moving from treatment to recovery services in the year – up from 6% in 20/21

2.4.3 How we delivered in 2021-22

Our teams continue to deal with a significant increase in demand across mental health and addiction services due to increases in complexity. We will build on the new approaches and ways of working that have been developed during the pandemic to help meet the demands on us going forward as we support good mental health and wellbeing, help people manage their own mental health, and build their emotional resilience.

During 2021-22 we have seen mental health concerns across the care groups that we work with, related to stress and distress resulting from the pandemic but also due wider economic problems.

Among older people we have seen the continuing impacts of isolation and reduction in mobility affecting overall wellbeing. Across our services we are remaining in contact with individuals over longer periods of time.

Demand pressures – increased caseloads at our mental health teams

- Community Addictions Team – 15% increase (from 363 in April 2021 to 420 in March 2022)
- Adult Mental Health Team caseload increased by 7% during 2020-21 (from 1283 to 1373 and has remained around that level over past year)
- Primary care mental health team – increased 33% this year from 256 in April 2021 to 341 in March 2022 although this reflects a gradual return to pre-Covid levels
- Older adult team caseload increased from 850 to 942 over the year (10% increase)

During the year we have faced challenges on workforce recruitment and retention across internal and external providers, and higher turnover within HSCP teams. We are planning our recovery from the pandemic in terms of establishing what a hybrid-working model looks like for all teams. This work is led by our short life working group reviewing use of accommodation. Primary Care Mental Health Team (PCMHT) staff have devised a rota of staff returning to the office this month, in order to deliver more face-to-face interventions with patients as our recovery continues.

The **Mental Health Officer (MHO) team** continue to support our most vulnerable population. We are in the process of hiring a Development Officer to facilitate the coaching and mentoring of newly qualified MHO staff, which is also increasing capacity within the team. We successfully hired an additional **Post-diagnostic Support (PDS) worker** through our partnership with Alzheimer's Scotland. Recruitment to psychiatry has been a concern during the year due to long term vacancies and pending retirement of a consultant psychiatrist. We

remain focused on ensuring that we have adequate psychiatry capacity across both the Community Mental Health Team (CMHT) and the Older People's Mental Health Team (OPMHT).

During the year we rolled-out the **Medication Assisted Treatment (MAT) standards**. This enables people to access same-day prescribing for opioid use disorder, facilitating low barrier access to assessment and treatment.

Local **care homes** (Norwood house and Eastwood Court) have been benefitting from expanded **Occupational Therapy input**. In Eastwood Court, an under-utilised space was transformed into a dementia-friendly "pub-like" environment creating a new social space for residents, signage was introduced to aid orientation particularly for those with dementia, simple technology was introduced to support activities and dementia-friendly menus were developed. In Norwood House, a sensory room was created, dementia-friendly décor was adopted such as repainting areas with a more calming colour with contrasting handrails, lighting was altered to decrease distress and the risk of falls, dementia-friendly signage and simple technology for activities were also introduced.

During 2021-22 we have continued to invest in alternative models including **peer support** for mental health and addictions. Peer support is where people with similar life experiences offer each other support, especially as they move through difficult or challenging experiences. The service received its first referrals in 2020, initially offering opportunities to meet face-to-face, within the restrictions at that time. Peer support is also being offered via phone or video call, in line with individuals' preferences.

East Renfrewshire Peer Support Service

East Renfrewshire HSCP recognised the potential of peer support to enhance the opportunities for recovery, working alongside formal services, and prioritised investment in a peer support test of change. Perhaps uniquely, it was proposed to test peer support as a joint service across the alcohol and drugs and mental health service settings. A 12-month test of change was proposed, incorporating a robust service design and evaluation approach from the outset, to design and develop the service, implement and evaluate, to identify the optimum model of service delivery for individuals.

Penumbra were identified as the preferred provider of peer support in East Renfrewshire. Penumbra is one of Scotland's largest mental health charities and have significant experience of delivering peer work in locality based recovery teams across Scotland. Penumbra brings to East Renfrewshire a strong understanding of recovery, robust evidence based recovery tools to measure outcomes and an inclusive approach where peer workers and individuals who use services influence the development of services. Identifying goals

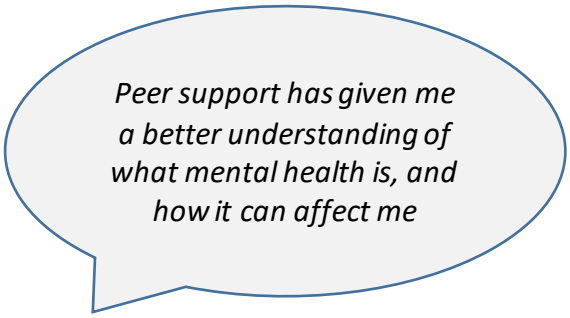
is a core part of Penumbra's approach to peer support and is enabled by their use of the I-ROC (Individual Recovery Outcomes Counter) outcome measurement tool and HOPE (focusing on Home, Opportunity, People and Empowerment) model of wellbeing.

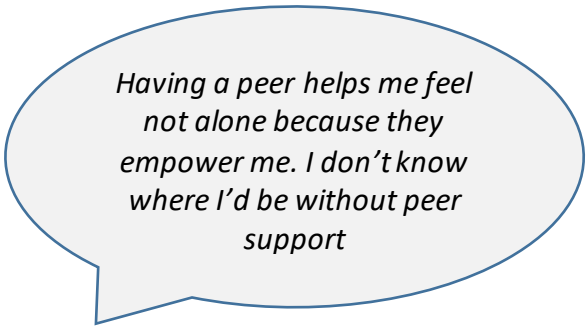
Despite the significant challenges presented by Covid-19, the service design work with stakeholders took place virtually from summer 2020. Ensuring that individuals with lived experience were involved remained a high priority and interviews via telephone took place. The East Renfrewshire peer support service took the first referrals in early September. Peer support was offered to individuals for the first time very quickly thereafter with opportunities to meet face-to-face, within the restrictions at that time. In line with the test of change approach, a robust evaluation model was built in from the outset, working with an independent evaluation facilitator, Matter of Focus, and utilising the OutNav outcome mapping tool.

The peer support service works with individuals already engaged with services in East Renfrewshire, with referrals made by Health and Social Care Partnership adult mental health and alcohol and drugs services, as well as RAMH and RCA Trust. It is an additional, complementary support to help individuals identify their personal goals for recovery.

A recent evaluation of the services made the following findings:

- Strengths of the project include how quickly it reached capacity and the way in which people using the service chose to sustain their engagement. There is strong evidence that the Peer Support Service has been well-received by people accessing support. People using the service valued the nature of the relationship and the holistic approach taken.
- People valued working with someone with lived experience because it helped them develop a sense of clarity and reflection on their own experiences. In this way of working connections can extend beyond the experience of mental ill-health or substance use to other experiences or passions.
- A common thread across the experiences of those using the service was that it supported greater self-awareness and knowledge, and therefore aided their own personal goals. In this evaluation we heard powerful testimonies of people using the service.
- There was evidence that people who engaged with the service used the space for open dialogue to understand what was important to them and to take positive steps forward.





We are committed to working together with community planning partners on activities that support mental wellbeing and resilience across our communities, with Voluntary Action East Renfrewshire taking a leading role. During the year, the rollout of the Scottish Government's **Community Mental Health and Wellbeing Fund** in East Renfrewshire has enabled grassroots community organisations to provide vital supports and activities to local communities with £238,000 already distributed – ranging from community food, cooking and

exercise initiatives, mindfulness courses, social activities to reduce loneliness and isolation, a recovery college and dementia support services. We continue to work closely with Voluntary Action and wider partners to assure the success and sustainability of funded programmes.

We have continued to deliver our **mental health and wellbeing remobilisation programme** with the third sector including staff capacity building around bereavement, mental health and suicide prevention, and wellbeing support to carers.

Remobilisation programme for health and wellbeing

Following on from the success of the 2020-21 remobilisation fund, NHSGGC led another successful bid for remobilisation funding with East Renfrewshire receiving an allocation of £35,657. An additional fund of £3,700 was also allocated to East Renfrewshire later in the year due to underspend in other local authority areas. The total for remobilisation spend was therefore £39,357.

Activities delivered in partnership have included:

Staff & Volunteer Training / Capacity Building – delivered by SAMH
Delivery of 16 training courses including:

- Having the Conversation Workplace
- Looking After Your Wellbeing
- Impact of Poor Mental Health
- Intro to Suicide Prevention
- Food and Mood
- 5 Ways to Wellbeing Workplace
- Using Wellness Action Plan
- Sleep & Mental Health
- Managing Stress in Workplace
- Having the Conversation Hybrid Working
- Mental Health: Supporting Others

SMHFA (Scottish Mental Health First Aid) – delivered by SAMH
20 delegates attended SAMH SMHFA training. Delegates included Health Improvement staff, Social Work, Addiction, third sector partners and two volunteers. SMHFA training took place over two full days.

Bereavement training - delivered by Cruse Scotland
Bereavement and Loss training was identified as a need from staff within our primary care mental health team and third sector partner RAMH Addictions Team. Cruse Scotland delivered Bereavement and Loss training online.

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

National Health and Wellbeing Outcomes contributed to:
NO2 - People, including those with disabilities or long term conditions or who are frail are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community
NO4 – Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services

2.5.1 Our strategic aims and priorities during 2021-22

The vision set out by NHSGGC in its recovery and remobilisation planning is to have in place a whole system of health and social care enabled by the delivery of key primary care and community health and social care services. HSCPs are working in partnership to ensure effective communications, a consistent approach, shared information and the alignment of planning processes.

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

Significant investment in winter 2022 has helped add resilience to our health and care response. We have strengthened the capacity of our Care at Home Responder Service, Community Nursing and Community Rehabilitation teams and have established an intensive support service at our in-house care home for a multidisciplinary 'step-up', 'step-down' approach. This is supporting rehabilitation and reablement and timely discharge to home/homely settings. Additional resources are being used to address the accelerated demand pressures we have seen for Care at Home services, with increased frontline staff as well as management and support, and increased capacity for the Home First model and Technology Enabled Care.

We continue to work together with HSCPs across Glasgow, primary and acute services to support people in the community, and develop alternatives to hospital care. In partnership we support the development and delivery of the joint strategic commissioning plan which outlines improvements for patients to be implemented over the next five years.

Our aim is to **ensure people's healthcare needs are met (in the right way, by the right person at the right time)**, by:

- Early intervention and prevention of admission to hospital to better support people in the community
- Improved hospital discharge and better support for people to transfer from acute care to community supports
- Improved primary / secondary care interface to better manage patient care in the most appropriate setting.

2.5.2 The progress we made in 2021-22

Patterns of accident and emergency use and unplanned hospital admissions were significantly altered by the pandemic; but for some measures have been moving above pre-pandemic levels during the year. Despite increased activity we remain ahead of target for emergency admissions and A&E attendances. During the reporting period we have seen an increase in discharges with delay. This is being driven by the pressure on care at home services which is restricting access. Our Hospital to Home team work to deliver timely and appropriate discharges from hospital. During the pandemic the team have experienced significant issues around supporting 'adults with incapacity' and establishing appropriate guardianship/Power of Attorney arrangements. However, our performance for delays remains among the best in Scotland. We continue to support the hospital discharge efforts by promoting the use of intermediate care beds where a care at home package cannot be immediately accommodated.

Headline performance data includes:

- Discharge without delay – averaged 7 delays for 2021-22 – up from 3 for 20/21
- Adult bed days lost to delayed discharge – 4,546 for 21/22 – up significantly from 2,342 in 20/21
- Adult A&E attendances – 16,877 up from 13,677 in 20/21
- Adult Emergency admissions – 6,772 - up from 6,518 in 20/21

2.5.3 How we delivered in 2021-22

During 2021-22 the HSCP has continued to work with other partnerships and acute services in the Glasgow area to develop new services and pathways that will continue as we move into recovery.

Our **Hospital to Home team** (which facilitates complex hospital discharges) has been supplemented by the creation of a new team focussing on the appropriate and effective use of intermediate care beds. This supports timely hospital discharge where the required homecare package is not immediately available and delivers improved outcomes from assessment activity carried out in this setting (versus hospital). The targeted work by the new team includes requests for intermediate care beds, care home liaison, occupancy tracking, data collation, arranging interventions / reablement and carrying out outcome-focussed reviews and care planning. A specific test of change within this promotes early involvement at hospital admission point. The collaborative working between these teams has ensured that delays in hospital discharges have been minimised and kept within manageable levels.

The team is taking forward improvement activity to support earlier in-reach and effective discharge planning with individuals and their families. Despite this proactive activity the HSCP is still challenged with delays resulting from Adults with Incapacity (AWI) and family choice/indecision and delays due to Power of Attorney (PoA) not being in place.

Our **Community Rehabilitation Teams** continue to experience increased pressures due to the ongoing impacts and consequences of the pandemic on the older population, with an increase in frailty and frailty related falls. The average of 40–50 referrals per week in 2019 / early 2020 has risen to and been sustained at 65-70 referrals per week over the past two years. Due to increased complexity of need and deconditioning, the service is finding that services users are requiring longer and more frequent inputs, adding to demand pressures.

The partnership has seen increased falls/ frailty presentations due to unintended consequences of Covid-19 lockdown restrictions on individuals' health including deconditioning, reduced social supports, implications of the pausing, ceased or phased

remobilisation of NHS and community services and groups. There remains increased pressure on HSCP community assessment and rehabilitation teams to deliver assessment, intervention, and rehabilitation but without some of the wider supports previously available.

Multi-agency approach to prevent falls in the home- case example.

Mrs B. is a 76 year old lady who lives on her own. She has worsening breathing problems due to COPD, and had recently been discharged from hospital with medical oxygen to use if required. She was independent although had lost confidence with some of her activities of daily living such as showering, preparing meals, and mobilising outwith the house due to her fear of falls. She had becoming increasingly reliant on her daughter since being in hospital. Mrs B had a fall in her bathroom when turning at the toilet. She managed to phone her daughter who called the emergency services as she was unable to assist her mother up from the floor, and she had also sustained a minor injury to her lower leg as a result of the fall.

The Scottish Ambulance Service (SAS) responded and, following full clinical assessment, treated the injury on scene and it was agreed that no conveyance to hospital was required. Mrs B agreed to SAS making a referral to East Renfrewshire HSCP to request urgent follow up by the Community Rehabilitation Team in relation to falls multifactorial assessment and any additional supports which could be offered.

A home visit was carried out by the Community Rehabilitation Team the following day to assess Mrs B. It was found that there were a number of factors contributing to her risk of falls. Over the next ten weeks, Rehabilitation Support staff helped Mrs B to improve her function, strength, balance, mobility, independence and confidence by working through the rehabilitation programme devised between Mrs B, the Physiotherapist and the Occupational Therapist. Dietetic advice was also provided to improve Mrs B's nutrition. Equipment was provided which improved her ability to get in and out of bed, off and on to the toilet and with access to her shower, and also a mobility aid to help Mrs B move safely around her home independently, and outdoors with family. A community alarm referral was made, and Telecare was installed comprising of a wrist strap "red button" alarm to press for assistance if, for example, she had a further fall. A referral was made to the Scottish Fire and Rescue Service for a home fire safety visit and advice was given to her daughter about the local Carer's Centre.

Mrs B has made significant improvements. She is independent at this time with all her activities of daily living, and Mrs B and her daughter are aware of how to access advice about additional supports, if they require them, through Talking Points and the Initial Contact Team. She is going to commence the local Vitality exercise classes which run in the leisure centre with the help of her daughter, in order to continue with her strength and balance programme

During 2021-22, all 15 **GP Practices** in East Renfrewshire were operating at Escalation Level 1. The HSCP has continued to support GP Practices with list pressures due to new housing developments to improve sustainability.

The HSCP has supported the development of primary care through the delivery of the Primary Care Improvement Plan (PCIP) which neared full implementation over the year.

East Renfrewshire's Primary Care Improvement Plan (PCIP) 2018-2021

The national priority for PCIPs) was to reduce GP and practice workload with HSCPs delivering services through a range of multi-disciplinary teams (MDTs) including

pharmacists, physiotherapists and advance nurse practitioners and other health professionals. The development of this new Primary Care service redesign should not only reduce GP workload but deliver a safe, person-centred, equitable, outcome focused, effective, sustainable, affordability and value for money service according to the seven key principles of the new General Medical Services (GMS) Contract 2018 by increasing access and reducing inequalities for our patients.

We began implementing the new GMS Contract in 2018 through our East Renfrewshire Primary Care Improvement Plan (PCIP) 2018 – 2021. We recruited a 1.0 wte PCIP Implementation and Development Officer to deliver the plan objectives and since 2018 we have worked steadily to recruit and train staff to deliver services across the six Memorandum of Understanding (MOU) areas.

Progress on MOU priority areas

Vaccination Transformation Programme (VTP)
All vaccinations within the VTP in place by spring 2022 and we moved from a GP based delivery model to an NHSGGC board delivery model, through various vaccination teams reducing GP practice workload. Of the five vaccination work streams, three have been fully shifted and two are in transition.

Pharmacotherapy Services
Early in 2018 we agreed to expand existing pharmacy teams to introduce the pharmacotherapy service for the new GMS Contract in a phased approach across the HSCP. By increasing pharmacists and pharmacy technicians working within GP practices we were able to provide a new medicines management service, referred to as the Pharmacotherapy Service. The development of the new service has allowed GPs to: focus on their role as expert medical generalists; improve clinical outcomes; more appropriately distribute workload; enhance practice sustainability; and support prescribing improvement work. There have also been positive impacts in terms of effective and efficient prescribing and polypharmacy all of which have real outcomes for patients.

Community Treatment and Care Services (CTAC)
The creation and implementation of CTAC services providing support to General Practice for minor injuries, chronic disease monitoring and other services suitable for delivery within the community began in October 2018 by recruiting 3.0 wte Community Health Care Assistants (CHCAs). These were shared across all 15 GP practices offering not only clinic and domiciliary phlebotomy but additional CHCA tasks including: B12s; biometric data collection including BP; and suture removal. We have subsequently increased provision by an additional 0.8 wte CHCA within GP Practices. In year three, following a delay due to the pandemic, we were able to develop the CTAC services further by implementing our new treatment room provision across both localities of Eastwood and Barrhead to all GP practices, offering leg ulcer management, Doppler assessment, wound dressings and suture/staple removal.

Urgent Care (Advanced Practitioners)
The creation and implementation of 3.0 wte Advanced Nurse Practitioners (ANP) to work across 3 GP clusters within Eastwood and Barrhead localities proved challenging due to workforce availability. Recruitment was slow therefore we were unable to establish this service until years 2 and 4. Two practices, Mearns and Carolside Medical Centres in EW2 Cluster, were chosen to participate in the first test of change for 1.0 wte ANP provision from October 2019 to June 2020 and further scale up progressed to the three other GP Practices within the cluster following this. Overall, the test was positive and was able to show that GP time was released across all practices by the ANP. We will reflect on the cluster test as we continue to develop and train a further 2.0 wte newly recruited ANPs to EW1 and Levern Clusters, spreading the Urgent Care provision across all of our GP practices.

Additional Professional Roles

We originally agreed provision of 3.0 wte NHSGGC Advanced Practice Physiotherapists (APP)/ musculoskeletal (MSK) Physiotherapists to work across 6 of our 15 GP practices (40%) based on modelling from Inverclyde New Ways of Working. However, following successful implementation of our first 1.0wte in two GP practices in year 1 we remodelled our planned 3.0 wte to work at cluster level. This helped to expand provision to 9 of our 15 GP practices (60%) in year 3, covering a total of 72% of our population. The service has allowed patients to benefit from quicker access to a physiotherapists and treatment therefore reducing unnecessary referrals to GPs. NHSGGC are scoping models to ensure this approach can be greater equity across practices going forward.

Community Link Workers (CLW)

Prior to the GMS Contract we had piloted a CLW programme in December 2016, an output following our Safe and Supported Programme. The development was a partnership between Recovery Across Mental Health (RAMH) and East Renfrewshire HSCP. It reflected shared awareness of the impact of a significant cohort of patients who sought recurring and regular support from GPs, for what were often issues associated with loneliness, social isolation, and lack of community connectedness and associated 'social' issues. Following the success of this programme in nine of our GP practices with 2.0 wte practitioners, we agreed to increase the total number of CLWs to 4.0 wte in 2018.

We also regularly collect qualitative GP practice feedback across the MOU services including the following comments:

- *"The Advanced Nurse Practitioner has played a very valuable role in the practice which has facilitated a reduction in GP workload".*
- *"Consistently positive feedback from patients about the Community Link Workers".*
- *"They Community Link Workers are an extremely valuable resource".*
- *"The Advanced Practice Physiotherapist has very effectively complemented our clinical skill-mix and feedback from patients continues to be extremely positive".*

The physio was very caring and patient... He went above and beyond to help us.

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

National Health and Wellbeing Outcomes contributed to:
NO6 - People who provide unpaid care are supported to look after their own health and wellbeing, including support to reduce any negative impact of their caring role on their own health and wellbeing

2.6.1 Our strategic aims and priorities during 2021-22

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

Our Carers Strategy sets out how we will work together with partners to improve the lives of East Renfrewshire's carers. Through our local engagement and discussion we know that we need to develop our workforce, pathways and supports for carers. We have committed to working together with East Renfrewshire Carers Centre (ER Carers) to improve access to accurate, timely information. We will continue to encourage collaboration between support providers for advice, information and support for carers ensuring local provision that best meets carers needs. We will provide information and training to raise awareness of the impact of caring responsibilities. We will continue to support the expansion of personalised support planning in collaboration with our unpaid carers and ensure that self-directed support options are offered to all adult carers who have been identified as eligible for support.

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

Our aim is to **ensure people who care for someone are able to exercise choice and control in relation to their caring activities**, by:

- Ensuring staff are able to identify carers and value them as equal partners;
- Helping carers access accurate information about carers' rights, eligibility criteria and supports;
- Ensuring more carers have the opportunity to develop their own carer support plan.

2.6.2 The progress we made in 2020-21

Working with East Renfrewshire Carers Centre, we have continued to ensure that carers have had access to guidance and support throughout 2021-22. Check-in calls to carers were delivered by ER Carers, and carers have been offered support to set up and manage a peer support Facebook Group. The Mental Health Carers group continued to run virtually.

Headline performance data includes:

- 92% of those asked reported that their 'quality of life ' needs were being met – up from 91% in 20/21

2.6.3 How we delivered in 2021-22

The pandemic has impacted significantly on carers, with potentially restricted access to support, resources and activities away from caring. The restrictions during the crisis have impacted on the health and wellbeing of carers and the people being cared for.

Throughout 2021-22 we have maintained our positive partnership working with the **East Renfrewshire Carers' Centre**, continuing to deliver community-based integrated support for carers in East Renfrewshire including access to tailored advice, support, planning and community activities.

A **newsletter** is sent weekly with updates and guidance on Covid-19 and support available to all carers registered with ER Carers by email or post. We subscribed to a Carers digital advice and information resource and care coordination app was available 24/7 on the HSCP and partner's websites. This was promoted in local press and social media.

Check-in calls to Carers continued to be delivered by ER Carers and carers were offered support to manage a **peer support** Facebook Group.

Carer awareness sessions have been being delivered online since January 2021 across HSCP teams and partner organisations to increase awareness of Carers Rights, the impact of Caring and the support available.

The **Mental Health Carers Group** is a vital support for many of our local unpaid carers. The group has continued to run virtually throughout the year.

East Renfrewshire Carer's Strategy – **"I Care, You Care, We Care"** was updated for 2021-22 in collaboration with collaboratively with carers and the Care Collective (East Renfrewshire Carers' Centre and Voluntary Action East Renfrewshire). The Care Collective approach involved research, interviews, face to face engagement events and social media activity involving 2,000 local people. The work of the Care Collective demonstrated how we needed to strengthen our approach to involving carers through the planning process and with identifying the outcomes that matter to them.

East Renfrewshire Carers' Strategy has four strategic carer outcomes that are fully in line with the principles of the Carers (Scotland) Act 2016, the National Health and Wellbeing Outcomes and East Renfrewshire HSCPs Strategic Plan.

- Carers are identified, valued and involved
- Carers have choice, control and a life alongside caring
- Carers are living full lives and able to support their health and wellbeing
- Caring is a positive experience

Local Implementation of the Carers Strategy

Using the Care Collective's approach to involvement:

- A leadership collaborative was established involving carers, partner organisations and HSCP managers to form the Carers Act Implementation Group (CAIG) to ensure a shift to meaningful co-production with carers in the process of planning and commissioning services. A Carers Lead post was appointed in January 2020.
- Adult Carers were involved in developing an Adult Carer Support Plan and a Carer's Emergency Plan.
- We collaborated with third sector organisations to ensure good, accurate and up to date online advice and information.
- We worked closely with our partner ER Carers and a group of around 20 carers who meet regularly and are actively involved in the planning of community support and services for carers and the people they care for.

I can feel vulnerable as a carer. I have had times when services have made it very clear that I am not the client. The biggest challenge is being unable to follow my own activities and have a break for a few hours during the course of the day to recharge my energy.

There has to be a far greater appreciation from Government, Health and other bodies of what unpaid carers do and the sacrifices they have to make to do the caring role

East Renfrewshire's **Short Breaks Statement** was also updated for 2021-22 to ensure all advice and information is accurate and includes the development of creative, Covid-safe online breaks that meet the outcomes of the carer and the cared-for person. In collaboration with carers and other stakeholders we established guiding principles for planning short breaks with carers and these remain key to short break provision. These are:

- Carers will be recognised and valued as equal partners in planning for Short Breaks.
- Planning and assessment will be outcomes focused to ensure that we focus on what both the carer and the cared for person wants to happen.
- By using our eligibility framework we will have an equitable and transparent system for determining eligibility for funding Short Breaks that is consistent and easily understood.
- There will be timely decision making.
- Planning a short break will be a safe, respectful and inclusive process with every carer treated equally.
- When planning a Short Break questions about needs and outcomes will have a clear purpose for carers, not just to inform the support system.
- Prevention will be key. Planning and assessments for support should prevent deterioration in the carer's health or the caring relationship.

Supporting carers during the pandemic – a partnership approach.

Very few of us have been unaffected by Covid-19, but we recognise that carers have been affected more than most. In East Renfrewshire Carers' Centre's annual survey:

- 76% of carers reported that their caring role had increased.
- 76% of carers reported that their own mental health had been impacted.
- 53% reported that their physical health had been impacted
- 46% reported that the pandemic had impacted on their caring relationship.

Against such a difficult picture, it is positive that referrals to the Carers' Centre increased to 567; a number that exceeds pre-pandemic levels.

The HSCP have appointed a Carers Lead Officer post who along with the Centre Manager has delivered 22 carer awareness sessions across the HSCP. This has resulted in the HSCP being responsible for half of all new referrals made to the Centre.

The Carers' Centre has continued to deliver a range of emotional and practical support to carers in line with the restrictions, but we recognises that support for carers and their families has been affected or reduced during the pandemic.

The Carers Lead has worked with carers to try and mitigate some of these challenges and carers have been actively involved in making suggestions and improvements to many of our services and supports including day centres, dementia supports, hospital discharge experience, transition planning and Self-directed Support.

The partnership is committed to keeping carers at the heart of the Carers Collective Strategy Group and building on the information and awareness session that carers delivered to the East Renfrewshire Integration Joint Board in June 2022.

Access to short breaks and time out from caring has been the biggest challenge for carers during the pandemic. The HSCP and Carers Centre are committed to providing carers with short breaks and again, we continue to work with carers to improve the awareness and availability of short breaks and pilot new and different approaches to supporting carers.

The Carers Centre continues to deliver Adult Carer Support Plans and Young Carer Statements on behalf of the HSCP with 128 completed in the last year. We have developed a pathway and increased funding to enable carers to get the support they need timeously and efficiently.

The HSCP is supporting the Carers' Centre to set up a respitality initiative in East Renfrewshire with local businesses showing their support to carers in East Renfrewshire by providing a range of discounts and concessions.

The Carers Centre continues to provide grants to carers through the Time to Live initiative. This was supplemented this year by additional funding to support carers through the winter which saw grants totalling over £80,000 being awarded and directly supporting over 180 carers.

The Centre also participated in the Scotspirit Holiday scheme which used £18,000 of funding awarded by the Scottish Government to provide 47 carers families with breaks away in hotels and bed and breakfast accommodation in locations across Scotland.

We know that there are many challenges ahead, but we are confident that by continuing to develop the partnership between the HSCP, Carers Centre, carers and other stakeholders we can work together to provide the best possible support for carers in East Renfrewshire.

2.7 Working together with our community planning partners on new community justice pathways that support people to stop offending and rebuild lives

National Outcomes for Community Justice contributed to:
Prevent and reduce further offending by reducing its underlying causes
Safely and effectively manage those who have committed offences to help them reintegrate into the community and realise their potential for the benefit of all

2.7.1 Our strategic aims and priorities during 2021-22

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

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

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

We are aware of the impact of lockdown on people experiencing domestic abuse. As part of our community planning work to protect people from harm and abuse, we have established and continue to support a Multi-Agency Risk Assessment Conference (MARAC) in East Renfrewshire for high-risk domestic abuse victims. During the pandemic we have seen higher numbers of referrals to MARAC and greater levels of complexity in the cases being dealt with. We will ensure that all high-risk domestic abuse victims and children have multi agency action plans in place to reduce the risks posed to them by perpetrators. We will work together with East Renfrewshire Women's Aid Service to provide direct support for women and children who have experienced domestic abuse.

Our aim is to **support people to prevent and reduce offending and rebuild their lives**, by:

- Reducing the risk of offending is through high quality person centred interventions;
- Ensuring people have improved access to through-care and comprehensive range of recovery services;
- Ensuring effective interventions are in place to protect people from harm.

2.7.2 The progress we made in 2020-21

The provision of unpaid work was significantly impacted by the pandemic with Community Payback Orders suspended on 23rd March 2020. At end-year we were missing targets for commencement of unpaid work placements within seven days but had reached target for completion of placements within court timescales. At the end of March 2022 there remained a backlog of 6,200 hours of unpaid work for East Renfrewshire although this is low in

comparison with other areas and only represents 1% of Scotland's overall backlog. During the year we increased our capacity to deliver by focusing on outdoor work activities and increasing the number of supervisors available.

Adult Support and Protection (ASP) activity is significantly higher than pre-pandemic levels but decreased during 2021-22 compared with 20/21. We have seen an increase in support required as a result of domestic abuse / violence against women. 125 victims and 205 children were discussed at MARAC (Multi-agency risk assessment conference) - an increase of 4% and 19% respectively compared to 20/21. 1226 women and children supported by Women's Aid - a 52% increase across the service. And the reporting period saw the highest recorded number of women supported in outreach services in the past two years. Despite this additional demand for support we have continued to improve personal outcome measures for women and families affected by domestic abuse throughout the pandemic.

Headline performance data includes:

- 58% Community Payback Orders (CPOs) commencing within 7 days – down from 65% in 20/21
- 81% of unpaid work placement completions within Court timescale – up from 75%
- Positive employability outcomes for people with convictions – 75% up from 66% in 20/21
- 100% of people reported that their order had helped address their offending – up from 92% in 20/21
- Improvement in domestic abuse outcomes women – 87% increase by 3% - target met.
- Improvement in domestic abuse outcomes children – 84% increase by 1% - target met.

2.7.3 How we delivered in 2021-22

The provision of unpaid work was significantly impacted by the pandemic with **Community Payback Orders** suspended on 23rd March 2020. Legislation was introduced in March 2021 to reduce the number of hours originally imposed on Community Payback Orders (CPOs) by 35%. This excluded Community Payback Orders imposed for domestic abuse, sexual offending or stalking. The legislation reduced the backlog of hours by 2,329 hours. The current outstanding backlog of hours for completion totals 6,402. East Renfrewshire has one of the lowest rates of outstanding hours in mainland Scotland and the justice service has significantly increased capacity to ensure people complete their orders. During the period of January to March 2022, the percentage of unpaid work placement completions within court timescale has risen to 93%.

In line with the increased throughput through the courts the justice service has seen a 166% increase in Diversion from Prosecution requests received from the Crown Office and Procurator Fiscal Service (COPFS) during April 2021 to March 2022. Requests for Criminal Justice Social Work Reports have also increased by 149% over this period compared to the same period last year.

To support recovery and renewal the justice service modernised key aspects of the unpaid work service. Two new workshop premises were secured with the space upgraded and equipped for future use. This will allow the service to expand and assist in addressing the outstanding balance of hours. A full-time supervisor and sessional workers were recruited who have skillsets in joinery and carpentry. This enabled socially distanced 1:1 work with service users and supported people to learn a range of new skills. We were able to provide

benefit to the community by delivering the items built by the service users to community projects, nursery schools and care homes.

During the period April 2021 to March 2022, **East Renfrewshire Women's Aid** service reported a significant increase in referrals across their services compared to the same period last year. In total, 1,226 women and children were supported across the three core services, helpline and drop-in enquiries compared to 805 during the same period the previous year. This is an increase of 16% supported in the three core services, 72% increase in duty and helpline contacts and 52% increase across the whole service.

The reporting period saw the highest recorded number of women supported in outreach services in the past two years. Outreach staff have worked closely with partner services including mental health, the Community Addictions Team and Justice Social Work to reach and support very vulnerable women.

East Renfrewshire Women's Aid – Wellbeing Group

A wellbeing group established post-Covid provides a safe space for women who have experienced domestic abuse to explore and enhance their mental health and wellbeing. It is recognised that domestic abuse has significant psychological consequences for women and a profound and enduring impact on mental health.

Women had expressed that generic services may lack the required understanding of the complex and longstanding impacts of domestic abuse on mental health and wellbeing. The wellbeing group was formed in response.

In the summer months the group operates outdoors from the Rouken Glen Centre with links made with Young Enterprise Scotland and introductions made to the various projects taking place there - gardening, bee keeping, vegetable growing.

Group activities include stress management, improving nutrition, gentle exercise, yoga, positive self-talk, mindfulness, and complimentary therapies. The group focus is on improving coping skills and developing new ways of dealing with problems. The group also discusses the impact of domestic abuse on mental health. The group is informal, and women can join whenever they are able to. The group moved indoors or to zoom over the winter months.

The women embraced learning new techniques to enhance their own wellbeing and spoke about the improvements in their mood through the yoga and meditations. They used the space to discuss events in their own lives regarding domestic abuse and general stresses they were trying to overcome. They offered each other support through shared experience. It was noticeable that the women were growing in confidence and camaraderie over the weeks as they made each other welcome and prepared the space for activity. This created a strong core group.

Women's Aid report an increase in complex trauma, mental health issues, alcohol dependency and child contact issues. The service is supporting children with a range of needs and vulnerabilities including anxiety, self-harm, eating issues, autism and behavioural problems.

A range of actions have been taken to respond and mitigate risk and ensure a whole system response to meet the needs of women, children and young people. Additional resource ensured that Women's Aid were able to provide immediate support and safety planning for all women and children. This reduced waiting times for allocation and provided independent

domestic abuse support at the earliest opportunity ensuring all MARAC referrals were responded to promptly, risk was identified at an earlier stage and all necessary safety planning completed.

In collaboration with housing services two additional refuge units were provided to meet increased demand ensuring women and children and young people were protected from risk and harm. In partnership with the HSCP and the Culture and Leisure Trust a new base and additional outreach accommodation were provided, ensuring Women's Aid are able to operate effectively across the local authority.

East Renfrewshire Women's Aid - Peer Support Group

Women's Aid peer support group was set up in 2019 following a meeting with the Chief Social Work Officer and the Chief Executive of East Renfrewshire Council. The women expressed the need to meet and support each other in an informal way but were also keen to contribute to service development and to improve agency responses and outcomes.

The Chief Social Work Officer met with the women on a regular basis to hear their views and concerns. The women's voices have been represented at strategic level and included in the VAWG partnership Improvement Plan

The group have been consulted on a variety of issues and their feedback used to shape policy and procedure not only for Women's Aid South Lanarkshire and East Renfrewshire (WASLER) but at planning level within East Renfrewshire Council. The group have worked with the local authority to inform a new HR approach to staff experiencing domestic abuse and had a significant contribution to the development of the Housing Domestic Abuse Policy with many of their suggestions included. The group have also met with Safe & Together Champions to discuss their training programme and with the Police Inspector to discuss safety issues.

The group continue to meet in the community and provide an "expert" view on domestic abuse policy.

Multi-Agency Risk Assessment Conferences (MARAC) are recognised nationally as best practice for addressing cases of domestic abuse that are categorised as high risk. In East Renfrewshire Multi-Agency Risk Assessment Conferences was first introduced in March 2019. MARAC has witnessed an increase in referrals for high risk victims and children as the COVID restrictions have eased. In the period April 2021 to March 2022, there were 125 victims and 205 children discussed at MARAC. This is an increase of 4% and 19% respectively compared to the previous year. It is expected that domestic abuse referrals will continue to increase longer-term and that there are significant challenges in ensuring our services have sufficient capacity to respond.

Training and Capacity Building

Training on Domestic Abuse, Risk Assessment and MARAC is delivered by the Domestic Abuse Co-ordinator and Gender Based Violence Lead Planner. This is a half day course, multi-agency and currently delivered online with pre reading / course materials sent to all participants in advance. All scheduled courses are promoted on the Public Protection Training Calendar. A decision will be made this year about the return to face-to-face training.

Between April 2021 and March 2022, 149 staff from Children & Families Social Work, Justice Social Work, Health Visiting, CAMHS, Adult Social Work, Adult Mental Health, Addictions, Housing, Education, Care at Home organisers / reviewers, Police, Women's Aid and Human Resources attended the sessions. This is compared to 127 staff trained last year an increase of 17%. The evaluations have been extremely positive. Additionally, ten bespoke sessions were delivered to each fire crew within East Renfrewshire's Fire & Rescue Service.

The Domestic Abuse Coordinator delivered MARAC representatives training to our new MARAC representatives via Microsoft Teams in October 2021

Bespoke domestic abuse training was delivered to the Citizens Advice Bureau in response to the increase in domestic abuse disclosures since the ease of lockdown restrictions.

Bespoke training was also delivered to the Primary Mental Health Team in January to raise awareness of the complexity of domestic abuse and the MARAC pathway for referral.

The MARAC Co-ordinator and Safe & Together Lead Practitioner continue to offer monthly Domestic Abuse Advice Sessions. These monthly drop-ins are available to support all professionals in any aspect of domestic abuse work and scheduled dates are advertised in the Public Protection calendar.

At the end of each training session participants are offered the opportunity to come and observe a MARAC to increase their understanding of the meeting and to hear the variety of situations and action plans that are discussed. Over the last year 37 observers attended the MARAC.

MARAC / DASH and Safe & Together are now essential training for all children and families HSCP staff.

Gender Based Violence Prevention is a significant priority in the Violence Against Women (VAW) Partnership Improvement Plan and Children's Services Plan. We have developed multi-agency Gender Based Violence Guidance for schools, which was launched with training for all child protection coordinators in schools. We work closely in partnership with Rape Crisis Rosey Project, Equally Safe in Schools and the Mentors in Violence Prevention programme.

Key Successes include:

- Rape Crisis Rosey Project prevention worker has engaged with 6 secondary schools, delivering 48 workshops to 1183 young people through partnership working with pastoral care staff;
- Secondary school working to become our first accredited Equally Safe school;
- All secondary schools now trained in the Mentors in Violence Prevention approach.

16 Days of Action on Gender Based Violence

A significant range of national and local communications were progressed to support the 16 days campaign (25 November to 10 December 2021) with a specific programme of key messaging developed by the HSCP and shared with partner's through-out this period. Gender Based Violence and Disability was specifically highlighted with a briefing event led by the MARAC Co-ordinator. This event brought in a wide range of partners who haven't been reached before with services requesting further training for their staff.

2.8 Working together with individuals and communities to tackle health inequalities and improve life chances.

National Health and Wellbeing Outcomes contributed to:
NO1 - People are able to look after and improve their own health and wellbeing and live in good health for longer.
NO3 - People who use health and social care services have positive experiences of those services, and have their dignity respected
NO4 – Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services
NO5 – Health and social care services contribute to reducing health inequalities

2.8.1 Our strategic aims and priorities during 2021-22

We are committed to the local implementation of Greater Glasgow and Clyde's Public Health Strategy: Turning the Tide through Prevention which requires a clear and effective focus on the prevention of ill-health and on the improvement of wellbeing in order to increase the healthy life expectancy of the whole population and reduce health inequalities. This includes a commitment to reduce the burden of disease through health improvement programmes and a measurable shift to prevention and reducing health inequalities through advocacy and community planning.

The significance of health inequalities has been brought into even sharper focus as a result of the Covid-19 pandemic. We will continue to work together with community planning partners to improve health and wellbeing outcomes for our most disadvantaged localities and those who have been disproportionally impacted by the pandemic. We will also work collaboratively with local and regional partners to develop our understanding of health inequalities in East Renfrewshire and changing patterns of need as we recover from the pandemic.

Longer-term, the HSCP will continue to support community planning activity that aims to tackle the root causes of health inequalities as reflected in our Community Plan (Fairer EastRen). This includes activity to address child poverty, household incomes and strengthen community resilience. We will continue to promote digital inclusion with a particular focus on supporting people to live well independently and improve health and wellbeing.

Our aim is to **tackle health inequalities and improve life chances**, by:

- Increasing activities which support prevention and early intervention, improve outcomes and reduce inequalities;
- Reducing health inequalities will be reduced by working with communities and through targeted interventions.

2.8.2 The progress we made in 2021-22

- Our premature mortality rate remains significantly below the national average at 334 per 100,000 (Scotland 457)
- 7.5% of infants in our most deprived areas (SIMD 1) were exclusively breastfed at the 6-8 weeks (19.2% Scotland wide) (2020-21 figure)
- Male life expectancy at birth in our 15% most deprived communities is 74.7 compared to 72.1 for Scotland.
- Female life expectancy at birth in our 15% most deprived communities is 79.8 compared to 77.5 for Scotland.

2.8.3 How we delivered in 2021-22

Although we are seeing a decrease in numbers of people **breastfeeding** (data to 20/21), East Renfrewshire continues to have the highest breastfeeding rates in Scotland. Across East Renfrewshire, the initiation rate of breastfeeding in 2020-21 was 75% (av. 66% for Scotland) which is a reduction of 5% from the previous year. The data shows that there has been a reduction in the percentage of children exclusively breastfed within our most deprived neighbourhoods (SIMD 1) from 15% in 2019-20 to 8% in 2020-21. This reduction is also seen in SIMD 5 neighbourhoods with a reduction from 52% in 2019-20 to 42% in 2020-21.

The Covid-19 pandemic is most likely to have influenced this drop due to several factors. There is evidence that maternity services were unable to provide breastfeeding support in hospital due to the requirement to discharge mothers from hospital quickly at the height of the pandemic. Other factors include lack of wider family support available, NHS services being provided from digital platforms and lack of peer support.

Our staff have continued to work exceptionally hard during the pandemic supporting mothers with breastfeeding in all areas in East Renfrewshire, and have continued to offer face-to-face visits, telephone calls and virtual support. The HSCP is currently looking to develop an infant feeding group within Dunterlie centre to focus on our more vulnerable families. We currently offer extra support visits to parents within our more deprived areas where they are breastfeeding. We have managed to retain our UNICEF Gold award during the pandemic and we are due to revalidate in July 2022.

Our **Health Improvement Team** have continued to promote self-help and information campaigns throughout the year using alternative communication methods. Information about self-help and community support is provided via the 'Your Voice' Bulletin which is sent directly to individuals on our database and online. As we moved beyond lockdown restrictions health and social care information was made available in public settings including our Health and Care Centres, libraries and other local public and community facilities.

As we move beyond the pandemic, we were keen to implement a health improvement campaign and promote health prevention resources alongside our annual health events campaigns, such as suicide prevention week. In 2021-22 we allocated funding to create targeted social media campaigns around mental health and wellbeing with advertising which targets East Renfrewshire residents. Tailored social media campaigns allow us to target individuals by gender, age range etc. The **Health Improvement Communication Plan** has now been approved for 2022-23. Social media and marketing plans will now be established to create targeted social media campaigns that align with our target audience for each campaign. Evaluation of our social media reach can be collated at the end of each campaign to allow or learning, reflection and evaluation.

The **Live Active programme** funded by ERHSCP and NHSGGC continues to be actively promoted in Barrhead to increase referrals and we have strengthened links with East Renfrewshire Culture and Leisure Trust (ERCLT) and other exercise providers to develop smooth referral pathways between services. The programme has been operational throughout the pandemic, adapting services continually to support existing and new service users to be physically active.

We continue to support third sector organisations promoting health and wellbeing including **Barrhead Men's Shed**. The shed involves retired people who want to remain physically, mentally and socially active. It supports older men and women in Barrhead "to be happy, healthy and connected to their communities, with interesting things to do, things they have chosen to do and things which reflect the skills and interests they have". Covid remobilisation funding was provided to purchase health and safety equipment (ventilation) to support the safe return of members to the shed following the pandemic restrictions.

Health and wellbeing for minority ethnic carers

Funding was provided to East Renfrewshire Carers' Centre to support the health and wellbeing of local black and minority ethnic carers through the provision of wellbeing activities. Health & Wellbeing activities included :

- Weekly Badminton
- Monthly peer support
- Monthly Walk and Coffee group (Rouken Glen)
- Eid Celebration event
- Monthly Book Club
- Monthly Gardening Club

In addition, the BAME parent carers group requested meetings with professions from a range of services and we have facilitated meetings with Education Psychology, Learning Disability Team, Education Department, SDS Forum, Speech and Language Team.

The HSCP allocated funding to extend the post of the **Community Health Worker** by an additional day per week. This supported the remobilisation of **Community Health Walks** and **Community exercise classes** such as Strength and Balance and chair based exercise.

Consultation with both primary services and community partners highlighted widespread negative outcomes from the pandemic such as decreased mobility for many adults, increased weight (due to lack of mobility), loss of independence and increased isolation. Locally this impact is reflected in physiotherapy currently seeing a 200% increase in referrals. As Covid restrictions slowly eased, we were keen to re-establish local community walking groups and exercise provision to support communities and individuals impacted with the issues mentioned above. Additional hours to support this post were also used to recruit and train volunteers to become Walk Leaders and lead Chair-based exercise programmes to build local capacity longer term.

2021-22 Service Provision

Community Exercise Classes (delivered by our Community Health Worker)

- 8 Strength & Balance delivered per week across the area (Barrhead and Eastwood Locality)

Community Walks (delivered by Health Walk Volunteers and Community Walk Leader)

- 9 Community Walks are delivered per week across the area. (Barrhead and Eastwood Locality)

2.9 Working together with staff across the partnership to support resilience and wellbeing

National Health and Wellbeing Outcomes contributed to:
NO8 – 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

2.9.1 Our strategic aims and priorities during 2021-22

During the pandemic the people who comprise the health and social care workforce have gone above and beyond to deliver much needed care to individuals under incredibly difficult circumstances. While these challenges are still evolving, we continue to rely on the workforce to support all aspects of health and social care and their wellbeing and resilience has never been more important.

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

Our activity aligns to the NHSGGC Mental Health and Wellbeing Action Plan and national objectives. We will continue to input at a national level to the health and wellbeing conversation and to the development and delivery of the NHSGGC vision to support the mental health and wellbeing of staff. This includes ensuring rest and recuperation, peer support, helping staff fully utilise their leave allowance, and ensuring working arrangements are sustainable in light of continuing constraints and reflect ongoing changes to services and pathways.

Our aim is to **support resilience and wellbeing among staff across the partnership**, by:

- Ensuring staff have access to resources and information that can improve their wellbeing;
- Ensuring staff feel connected to their team or service and we embed a health and wellbeing culture across the partnership;
- Promoting opportunities for staff to take part in physical activity, rest and relaxation;
- Ensuring staff feel safe in the work place.

2.9.2 The progress we made in 2021-22

Supporting staff wellbeing is a key focus of the partnership especially as a result of the pandemic which has placed significant pressure on our workforce. The way staff have been working has changed significantly with home working becoming the norm for large groups of employees. During 2021-22, the HSCP recruited a Health and Wellbeing Lead Officer who is undertaking a scoping exercise across the wider health and social care landscape. This role has been specifically designed to acknowledge the growing pressures and challenges upon the health and social care workforce, and to create resources, tools and services to support the health and wellbeing of all staff and volunteers who work for and support the HSCP.

Headline performance data includes:

- 61% response rate for our staff engagement survey (iMatter) – despite challenges of pandemic

- Composite 'Employee Engagement Index' score was 78% up from 75% at the previous survey
- 88% of staff agreed that "My manager cares about my health and wellbeing" – up from 85% and best score to date
- 72% agreed that "I feel involved in decisions in relation to my job" – up from 69%
- 75% agree that "I am given the time and resources to support my learning growth" – down slightly from 77%

2.9.3 How we delivered in 2021-22

Our local **East Renfrewshire HSCP Wellbeing Group** continued to run during 2021-22 with links to both the National and NHSGGC wellbeing groups. The group developed a regular **newsletter** and cascaded information to ensure colleagues across the across the partnership, including colleagues within primary care, independent and third sector had access to **information and support** in order their workforces wellbeing and resilience was enhanced. We are continue to develop and refresh a series of positive measures to promote staff wellbeing throughout the year. The HSCP Wellbeing Group is chaired by Head of Recovery and Intensive Services who also holds the national health and wellbeing **champion role** and contributes to discussions at a national level.

During 2021-22 we have worked to implement our wellbeing plan **'YOU care…WE care too'** to support our workforce to cope with the continuing emotional and physical impact following the pandemic. The plan identifies four strategic objectives / outcomes and has a supporting action plan.

- Overview and Communication - Staff have access to resources and information that can improve their wellbeing;
- Resilience and connectedness - Build resilience across HSCP ensuring all employees feel connected to their team or service and embed health and wellbeing culture across HSCP;
- Promotion of physical activity, rest and relaxation - Opportunities for staff to take part in physical activity are promoted across the HSCP and opportunities for rest and relaxation are provided;
- Staff feel safe in their workplace - Appropriate measures are in place to ensure staff feel safe in the workplace.

In January 2022, a dedicated **Health and Wellbeing Lead Officer** came into post at the partnership. The post holder undertook a scoping exercise across the partnership to determine staff health and wellbeing challenges and needs, including a **staff health and wellbeing survey** - issued Feb 2022. Findings from staff wellbeing survey (160 responders) indicated a variety of health and wellbeing needs and requests for support across HSCP.

In response to the staff feedback a **Summer of Wellness programme** was designed and launched in June. 32 separate health and wellbeing activities were made available for staff to become involved in. Partnerships were developed with NHSGGC Live Active staff and SMART Gym (social interest company) to provide ongoing fitness instructors for the Summer of Wellness free fitness classes at both Health and Care Centres to all staff/volunteers.

Other key areas of activity that have taken place during the year include:

- Dedicated **health and wellbeing webpage** was made available on the HSCP staff intranet.
- 1 to 1 **staff wellbeing conversations** offering holistic wellbeing advice, support and signposting.
- **Team wellbeing conversations** (resulting in our first team wellbeing day for the CAMHS team in July 2022).

- Development of **outside spaces** at both health centres for staff use (including wellbeing activities) - work ongoing from March 2022. The Community Payback Team are supporting development of outside balcony spaces at Health and Care Centres.
- Development of staff **wellbeing champion network** (9 members currently - Aug 2022).
- **Act of kindness initiative** began in March 2022 (and is ongoing) where staff can nominate a colleague for a small gift.
- **Financial wellbeing infographic** for HSCP staff/volunteers developed. This is a joint project between the HSCP, Council and the Money Advice and Rights Team (MART).

2.10 Public protection

National Health and Wellbeing Outcomes contributed to:
NO7 - People using health and social care services are safe from harm

2.9.1 Our strategic aims and priorities during 2021-22

Ensuring people are safe is a vital part of our work. We take a multi-agency approach to deliver our community planning outcomes:

- Residents are safe and supported in their communities;
- Children and adults at risk are safer as a result of our intervention.

Our aim is to **ensure residents are safe and supported in their communities**, through:

- Prevention - People, communities and services actively promote public protection;
- Identification and Risk Assessment - Services know who is most at risk and understand their needs;
- Interventions - Communities and individuals are supported to manage and reduce risk;
- Monitoring and Reviewing Risk - Services effectively measure progress and identify further problems quickly.

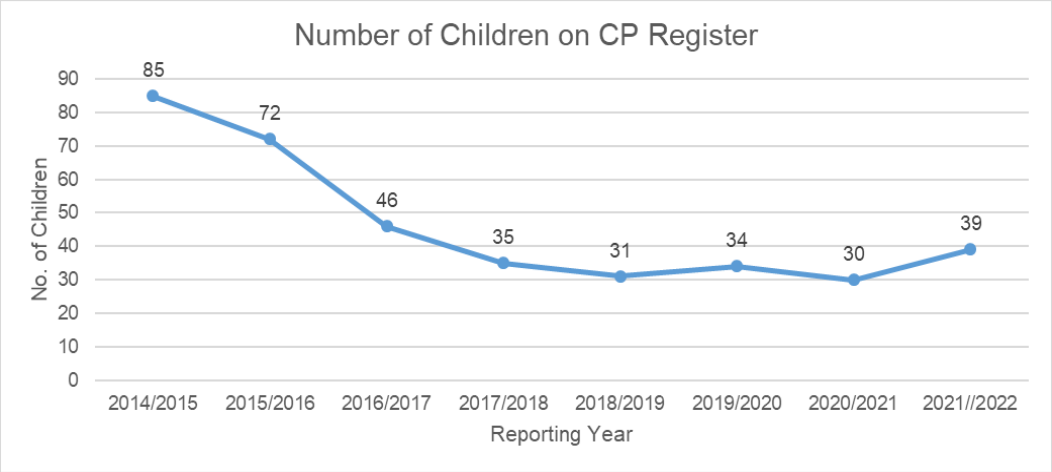
During the challenge of the pandemic our focus remained the safety and reduction of harm for children and adults. We have seen an increase in child protection referrals in particular of children who have a diagnosis of autism and or complex needs. Despite the increase in referrals, registration numbers have been retained at a relatively low level, indicating that many of the families coming through the child protection referral route are in need of increased supports rather than child protection plans.

We have maintained our Adult Support and Protection response throughout the pandemic and kept adult at the heart of what we do.

2.9.2 How we delivered in 2021-22

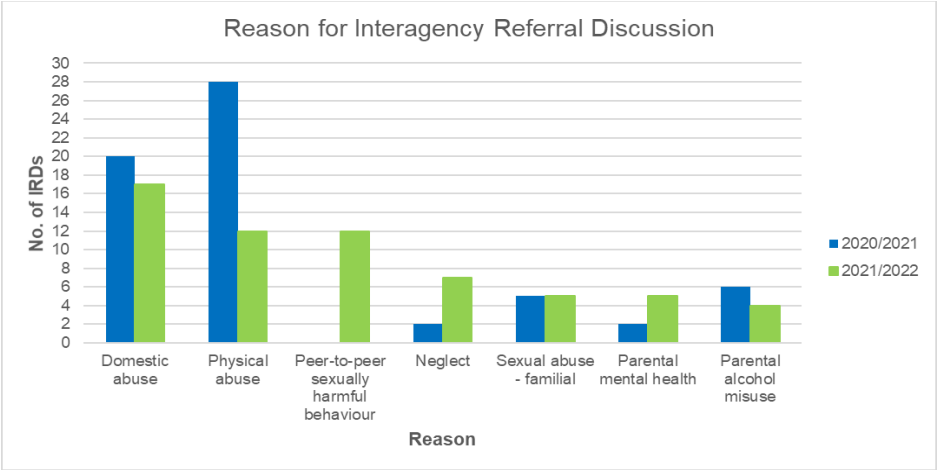
Supporting children

The number of children on East Renfrewshire's **Child Protection Register** was 39 in 2021/22. This is an increase of 30% on the previous year. This contrasts with the national data where there was a decrease of 20% in the year 2020/21. However, we note that there is a gap of one year in reporting periods so there may be an increase nationally for the year 2021/2022. In addition to robust management and audit activity, we continue to benchmark against comparator authorities to ensure that the rate of registration activity is proportionate and necessary.



During the period April 2021 – March 2022, we undertook 127 **Interagency Referral Discussions (IRD)** (between social work, police, health and where appropriate education services) in respect of 197 children. This is an increase on the previous year and is most likely due to the restrictions being lifted and the ongoing impact of the pandemic.

The most common reasons for initiating an IRD during 2021/22 are shown in the chart below. The highest reason for an IRD in the reporting period was domestic abuse. There has been a decrease in IRDs for domestic abuse, physical abuse and parental alcohol misuses. There has been a significant increase in peer-to-peer sexually harmful behaviour, neglect and parental mental health.

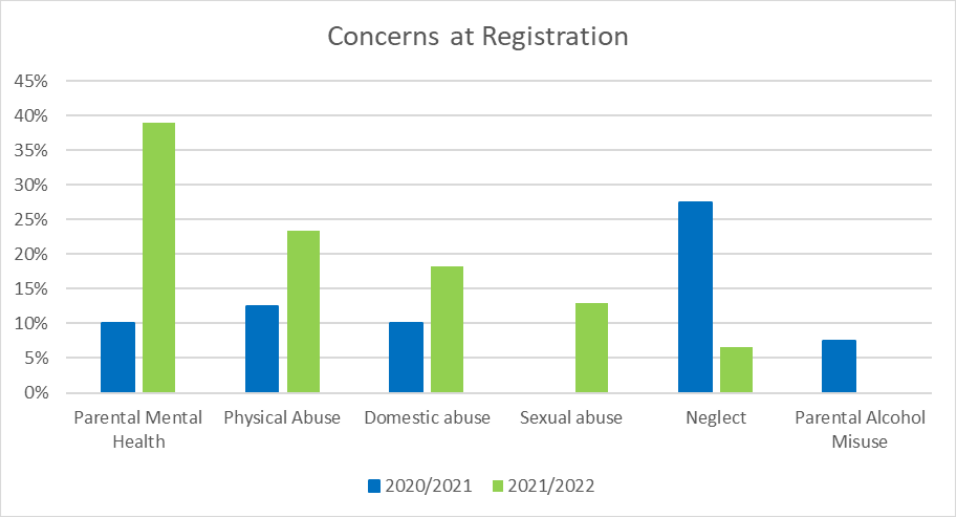


Of the 197 children and young people subject to Interagency Referral Discussions, approximately half were subject to a child protection investigation. Of these children and young people 38% went on to have an initial or pre-birth child protection case conference. Of those children and young people just under half were subject to an initial / pre-birth child protection case conference, with 55% having their names placed on the child protection register. This is a decrease on the previous year of 27%. This equates to approximately 13% of all the children and young people who were subject to an Initial Referral Discussion, which is close to the 14% from the previous year.

Concerns Identified at Registration

The proportion of children who were registered for parental mental health has increased significantly. This is a clear indication of the impact of the pandemic on parents' mental health. There was also an increase in children who were registered for physical and domestic abuse.

There was a decrease children being placed on the register for neglect and parental alcohol misuse.



During 2021-22 our programme of IRD audits reported significant strengths in our practice, including:

- 88% of Interagency Referral Discussions focussed on identifying, analysing and reaching a clear conclusion about the risk of significant harm.
- 85% of Interagency Referral Discussions considered the historical information relevant to the concern being discussed.
- 77% of Interagency Referral Discussions had clear reasons for subsequent actions and had a clear immediate safety plan respectively.
- 83% of Interagency Referral Discussions were able to reach a clear conclusion of risk.
- The average score in relation to the overall quality of the Interagency Referral Discussion was 'Very Good' (5/6).

Supporting adults

Between 1st April 2021 and 31st March 2022 there were a total of 805 **inquiries** undertaken by Council Officers (Adult Service Social Workers) of which 182 progressed to investigations. Within the previous reporting period 2020/21 there were 857 inquiries carried out and 224 investigations. This demonstrates that there has been a decrease of 6% (52) in the number of inquiries and of 19% (42) of the number of investigations undertaken compared to the previous period. This is consistent with the changing course of the Coronavirus (Covid-19) pandemic which had driven a significant increase in Adult Support and Protection activity in the previous period.

Of those inquiries carried out during 2021/22, 25% were received from third sector organisations delivering care and support to people in their own homes. This is consistent with last reporting period (27%) and provides assurance that the identification of harm by providers has been maintained. The slight decrease (2%) may be a result of the loosening of restrictions as we move into the recovery phase of the Coronavirus (Covid-19) pandemic.

For the period 2021/22 there were 182 **Adult Support and Protection investigations** that involved 164 individuals, a 19% decrease from 2020/21. This year's rate is similar to investigations in reporting year 2019/20. The conversion rate from inquiry to investigations in this reporting year was 23%, down from 26% in the previous year.

Through the Adult Support and Protection Quality Assurance framework we have considered the application of the three point test by council officers and manager oversight. This process

has not highlighted any concerns regarding conversion. We have delivered significant training for council officers which has promoted defensible decision-making and person centred planning in Adult Support and Protection which builds upon the strengths of the adult and their network. This has resulted in increased coproduction and collaboration with adults, their carers and key people in their life. We believed that has been factor in this continued low rate of conversion. This will be further explored through service user feedback and engagement.

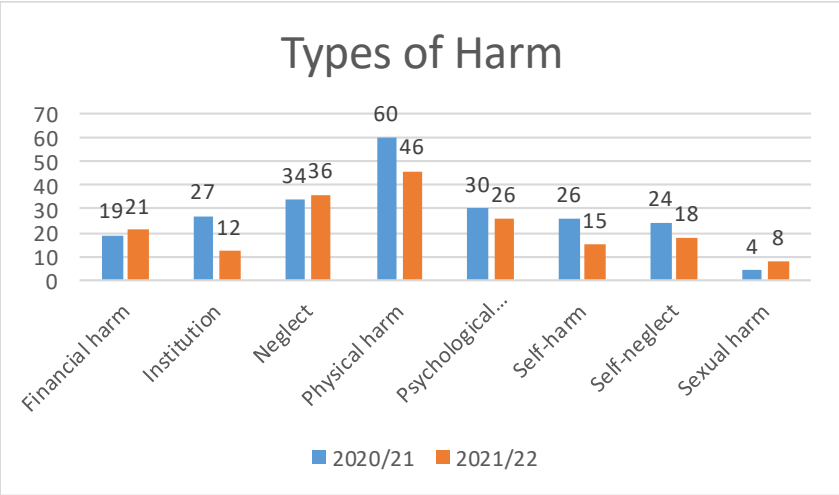
Type of Harm

The breakdown of types of harm in the reporting period is as follows:

- Neglect, which increased to 20% of total investigations, previous 15%,
- Sexual Harm, which increased to 4.4% of total investigations, previously 1.8 %
- Financial Harm increased from 8.5% to 11.5%.

Physical harm remains the most common harm experienced by adults, accounting for 24% of investigations, down from 27% in 2020/21. Institutional harm accounted for 7% of investigations, down from 12% in 2020/21. The instances of institutional harm were much higher in 2020/21 due to two large scale investigations within care homes, there have been no large scale investigations in this period.

Financial harm has slightly increased since 2020/21 when it was 9% of the total investigations and in 2021/22 constituted 12%. East Renfrewshire Council Trading standards team have been engaged in consistent awareness raising in the community in recent years and this was promoted throughout the course of the pandemic.

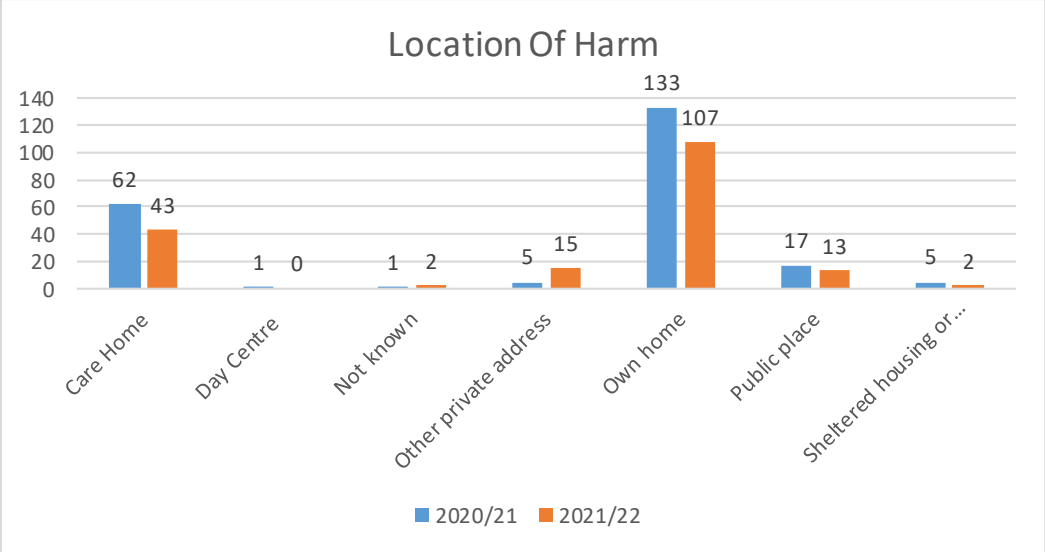


The adults most affected continues to be those with dementia, who make up 34% of all investigations, this is the same rate as 2020/21.

Location of harm

The primary location of harm in 2021/22 in 59% of investigations was within the adult's home. This is has remained static since 2020/21 (59%).

In 2021/22 Care Homes were the second highest location of harm in 23% of investigations. This is a decrease compared to the reporting period 2020/21 when this location of harm was identified in 28% of investigations. This reduction is expected as the increase in the last reporting period was driven by the large scale investigations in two care homes.



In 2021/22 we have continued to strengthen our use of **protection plans**. We have delivered specific training for the assessment and management of risk in Adult Support and Protection. This training provided guidance on effective protection planning and was well-received. This will be followed up in 2022/23 with workshops on the completion of Adult Support and Protection paperwork, including the Protection Plan to promote best practice.

The pattern of **referrals to advocacy** has been more effectively tracked in this reporting period and built upon the increased referral rate to advocacy witnessed in 2020/21. There are now increased strong links at a senior management level between our Advocacy Project colleagues and the Health and Social Care Partnership which has informed our ongoing improvement journey to ensure we have systems that are seamless to ensure adults get the correct level of support.

The use of virtual technology established in the first year of the pandemic has continued with recent moves toward face to face contact with service users as we have progressed into the recovery phase of our response to the Coronavirus (Covid-19) Pandemic.

Adult Support and Protection Improvement Activity

In this period our Adult Support and Protection team, has greatly strengthened our response to Adult Support and Protection activity. The team have provided practical support and guidance and strengthened relationships between locality services and external partners.

As part of our commitment to ongoing improvement, in spring 2021 we undertook a planned review of the Adult Support and Protection procedures. The review findings identified areas of improvements and changes were introduced to the Adult Support and Protection procedures which were relaunched in July 2021. These changes included:

- Promoting the role of professional decision making and defensible decision.
- Clarifying interface between adult and child protection through a joint process.
- Supported collaboration and engaged with partners.
- Improved oversight of investigations and case conferences.
- Improved recording and reporting of Domestic Abuse / Domestic Violence.
- Improved recording around advocacy.
- Specific recording around delay by council officer, to support recording of defensible decision-making and professional judgement.

We implemented the Adult Support and Protection Quality Assurance framework in April 2021. This has provided assurance of practice and governance throughout Adult Support and Protection activity.

The Adult Protection Committee continue to be updated and appraised of the improvement activity by the lead officer through their report which provides analysis and assurance supported by quarterly data reporting.

2.11 Hosted Services – Specialist Learning Disability Service

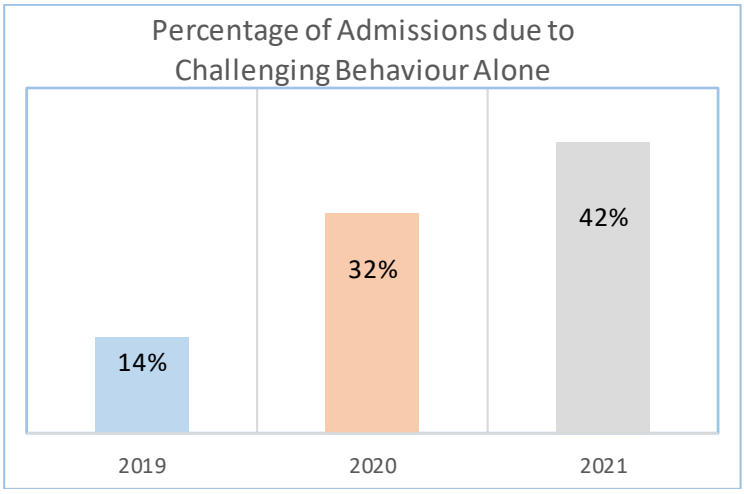
We continue to host the **Specialist Learning Disability Inpatient Service** that supports people requiring a hospital admission. The service works in partnership to manage demand and ensure appropriate support is available in the community on discharge.

The service has operated at full capacity throughout the pandemic despite many challenges related to the Covid-19 pandemic. In response to the pandemic we increased staffing levels and took a GGC wide approach to contingency through Board-wide collaboration. Over the year the service maintained good staff attendance and importantly achieved good infection control in challenging environments.

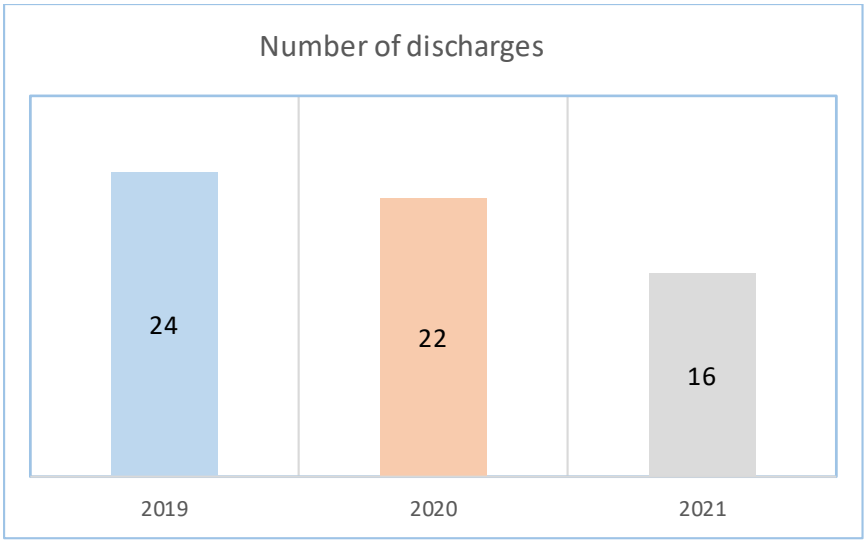
Beds were mainly occupied by people who were admitted due to mental illness (58%). However, there was an increase in admissions due to challenging behaviour alone from previous years (42% compared to 32% in 2020). There has also been an increased profile of patients with complex needs.

Delayed discharge caused significant issues, with a number of patients having no discharge plan for a significant period of time; nor a home to return to. The reasons for delay were due to no suitable accommodation and/or no providers in place and/or providers in place having real difficulty with recruitment.

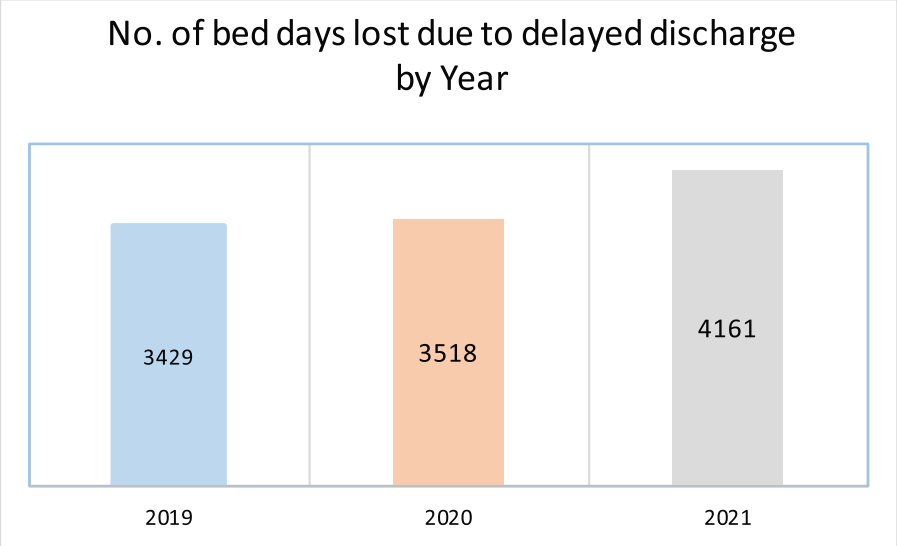
People are still more likely to be discharged within a reasonable timescale if their primary reason for admission is due to mental ill health.



Latest complete performance data for the service relates to Jan-Dec 2021. The chart above shows admissions relating to challenging behaviour. There was a 10% increase in proportion of admissions due to challenging behaviour alone compared with the previous years (42% up from 32% in 2020) and a significant increase since 2019. This may be due to a reduction in community supports and provider staffing issues during the pandemic resulting in some community services being less able to support those with the most challenging behaviour.

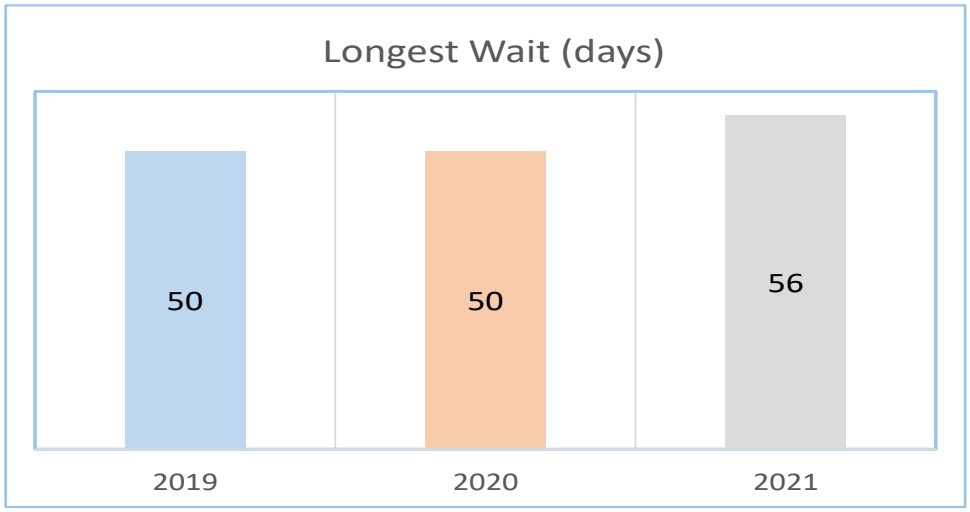


The service saw a decrease in the number of discharges to 16 for the year. The average length of stay for those patients discharged in 2021 was 294 days with a range of 12-694 days. For patients able to be discharged back home during 2021 the average length of stay was 106 days (range 12-211 days) and for patients requiring a new placement to be discharged to during 2021 the average length of stay was 407 days (range 190-694 days).



There was a 15% increase in beds days lost due to delayed discharge between 2020 and 2021. This reflected weaker performance on discharge planning with just 33% of inpatients having a discharge plan in place at the end of December 2021. This was a significant reduction from 67% for the previous year.

At the end of the year, 16 inpatients were noted to not have a home/community placement to return to. This is over half the patient group and reduces the ability of the service to successfully manage patient flow. The majority of placement breakdowns originating from Glasgow City and Renfrewshire HSCPs.



The longest wait to access a bed increased from 50 to 56 days for the year. As a result of continuous occupancy, the service is often unable to directly admit several people requiring specialist learning disability assessment and treatment. During the year, a group of people were removed from the waiting list as admission was no longer required or an alternative had been established.

3. Financial performance and Best Value

National Health and Wellbeing Outcomes contributed to:
NO9 - Resources are used effectively and efficiently in the provision of health and social care services

3.1 Introduction

Within this section of the report we aim to demonstrate our efficient and effective use of resources. Our Annual Report and Accounts 2020-21 is our statutory financial report for the year. We regularly report our financial position to the IJB throughout the year.

3.2 Financial Performance 2021/22

The annual report and accounts for the IJB covers the period 1st April 2021 to 31st March 2022. The budgets and outturns for the operational services (our management accounts) are reported regularly throughout the year to the IJB, with the final position summarised:

Service	Budget	Spend	Variance (Over) / Under	Variance (Over) / Under
	£ Million	£ Million	£ Million	%
Children & Families	14.102	14.122	(0.020)	(0.14%)
Older Peoples Services	23.500	21.596	1.904	8.10%
Physical / Sensory Disability	5.655	5.624	0.031	0.55%
Learning Disability – Community	16.033	15.575	0.458	2.86%
Learning Disability – Inpatients	8.822	8.822	-	0.00%
Augmentative and Alternative Communication	0.226	0.226	-	0.00%
Intensive Services	13.472	15.187	(1.715)	(12.73%)
Mental Health	5.361	5.225	0.136	2.54%
Addictions / Substance Misuse	2.135	2.114	0.021	0.98%
Family Health Services	27.704	27.704	-	0.00%
Prescribing	16.588	16.588	-	0.00%
Criminal Justice	0.016	0.011	0.005	31.25%
Finance and Resources	22.632	22.615	0.017	0.08%
Net Expenditure Health and Social Care	**156.246**	**155.409**	**0.837**	**0.54%**
Housing	0.398	0.398	-	-
Set Aside for Large Hospital Services	27.892	27.892	-	-
Total Integration Joint Board	**184.536**	**183.699**	**0.837**	**0.54%**

The £0.837 million operational underspend (0.54%) is marginally better than the reporting taken to the IJB during the year and this underspend will be added to our budget phasing reserve. The main variances to the budget were:

- £1.904 million underspend in within Older Peoples Nursing, Residential and Daycare Services. This reflects the ongoing trend of reduction in care home admissions but does offset the increase in community activity; predominantly Care at Home.
- £1.715 million overspend within Intensive Services as our Care at Home costs reflect that we continued to operate a near full service in the second year of the pandemic. This is

the position after we applied £0.826 million of winter funding to meet the increases in demand and complexity within this service.

- £0.458 million underspend within Learning Disability Community Services from a combination of staff turnover and running costs.

We received full Covid-19 support for unachieved savings during the year as the continued focus on response meant we still did not have capacity to progress the work required to deliver redesign.

The financial performance table above includes the £8.945 million we spent on Covid-19 activity and as this was fully funded by the Scottish Government there is nil impact on the operational variance of each service.

The IJB receives regular and detailed revenue budget monitoring throughout the year.

In addition to the expenditure above a number of services are hosted by other IJBs who partner NHS Greater Glasgow and Clyde and our use of those hosted services is shown below for information. This is not a direct cost to the IJB.

2020/21 £000	SERVICES PROVIDED TO EAST RENFREWSHIRE IJB BY OTHER IJBs WITHIN NHS GREATER GLASGOW AND CLYDE	2021/22 £000
451	Physiotherapy	435
43	Retinal Screening	43
352	Podiatry	474
285	Primary Care Support	289
325	Continence	342
594	Sexual Health	600
1,168	Mental Health	990
867	Oral Health	789
346	Addictions	350
197	Prison Health Care	209
158	Health Care in Police Custody	171
4,644	Psychiatry	3,846
9,430	**Net Expenditure on Services Provided**	**8,538**

We also host the Specialist Learning Disability In-Patient Services and Augmentative & Alternative Communication (AAC) services on behalf of the other IJBs within the NHS Greater Glasgow & Clyde. The cost of these two hosted services are met in full by East Renfrewshire. The use by other IJBs is shown below for information.

2020/21 £000	LEARNING DISABILITY IN-PATIENTS SERVICES HOSTED BY EAST RENFREWSHIRE IJB	2021/22 £000
5,855	Glasgow	5,655
1,942	Renfrewshire	1,993
795	Inverclyde	551
691	West Dunbartonshire	310
-	East Dunbartonshire	-
9,283	Learning Disability In-Patients Services Provided to other IJBs	8,509
11	East Renfrewshire	313
9,294	**Total Learning Disability In-Patients Services**	**8,822**

2020/21 £000	AUGMENTATIVE AND ALTERNATIVE COMMUNICATION HOSTED BY EAST RENFREWSHIRE IJB	2021/22 £000
89	Glasgow	97
33	Renfrewshire	22
3	Inverclyde	26
3	West Dunbartonshire	4
19	East Dunbartonshire	22
147	AAC Services Provided to other IJBs	171
19	East Renfrewshire	40
166	**Total AAC Services**	**211**

3.3 Reserves

We used £3.937 million of reserves in year and we also invested £14.204 million into earmarked reserves, with the majority of this increase from Scottish Government ring-fenced funding (£11.933 million). The year on year movement in reserves is summarised:

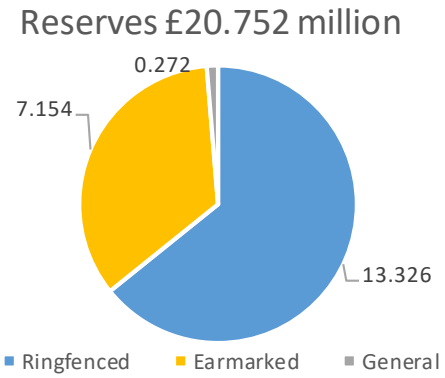
Reserves Movement	£ Million	£ Million
Reserves at 31 March 2021		10.485
Planned use of existing reserves during the year	(3.937)	
Funds added to reserves during the year	14.204	
Net increase in reserves during the year		10.267
Reserves at 31 March 2022		20.752

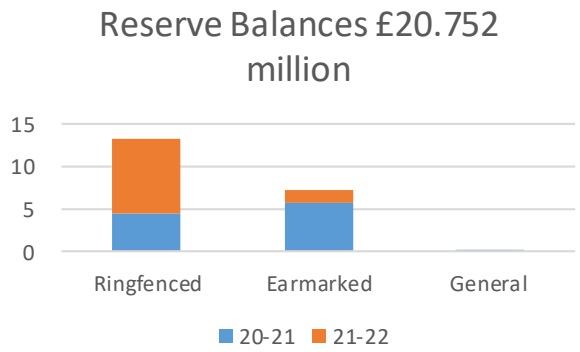
The purpose, use and categorisation of IJB reserves is supported by a Reserves Policy and Financial Regulations, both of which were reviewed in September 2021.

The reserves of the IJB fall into three types:

- Ring-fenced: the funding is earmarked and can only be used for that specific purpose
- Earmarked: the funding has been allocated for a specific purpose
- General: this can be used for any purpose

The current balance of £20.752 million for all reserves falls in these three reserves types:





Ring-Fenced Reserves

The majority of the increase in reserves relates to specific ring-fenced funding we have received from the Scottish Government during 2021/22 with £11.933 million added during the year and £3.153 million used. We can only spend this funding on those initiatives that the funding supports; the majority of this increase relates to Covid-19 and this will support the ongoing response to the pandemic in 2022/23.

We only spent £0.008 million of non Covid-19 ring-fenced reserves during the year and we are working on plans to utilise the balances within the scope of each area of activity during 2022/23 as we work towards recovery.

The increase in ring-fenced funding during 2021/22 is not unique to East Renfrewshire and mirrors the national position.

Earmarked Reserves

Our earmarked reserves are in place to support a number of projects, provide transitional funding for service redesign, provide bridging finance for in year pressures, add capacity to support service initiatives and to support longer term cost smoothing and timing of spend across multiple years.

Within our earmarked reserves we spent £0.785 million supporting service pressures and delivering on projects as planned. We added £2.272 million mainly from our operational underspend (£0.837 million) and in year CAMHS funding (£0.888 million) which we will use to support this service in 2022/23. The balance relates to a number of smaller projects and initiatives with the detail provided at Note 8 (page 60-61).

General Reserves

Our general reserve remains unchanged at £0.272 million and is well below the optimum level at a value of 2% of budget we would ideally hold. The general reserve is currently 0.15% of the 2021/22 revenue budget.

Given the scale of the financial challenge we have faced pre pandemic the IJB strategy to invest where possible in smoothing the impact of savings challenges has not allowed any investment into general reserves. We have recognised whilst this means we are below our policy level, the prioritisation has been on long term sustainability and minimising the impact of savings over time on those services we provide. We received Covid-19 support for unachieved savings during the pandemic and we expect to utilise the budget phasing reserve in 2022/23 as we work to deliver our legacy savings on a recurring basis.

In the event our operational costs exceed budget in 2022/23 we may need to un-hypothecate (i.e. un-earmark) reserves to meet costs.

The use of reserves is reported to the IJB within our routine revenue reporting.

3.4 Prior Year Financial Performance

The table below shows a summary of our year-end under / (over) spend by service and further detail can be found in the relevant Annual Report and Accounts and in year reporting.

	2021/22	2020/21	2019/20	2018/19	2017/18	2016/17	2015/16
SERVICE	(Over) / Under £ Million	(Over) / Under £ Million	(Over) / Under £ Million	(Over) / Under £ Million	(Over) / Under £ Million	(Over) / Under £ Million	(Over) / Under £ Million
Children and Families	(0.020)	0.410	0.637	0.800	0.083	0.537	0.604
Older Peoples & Intensive Services	0.189	0.327	(0.866)	(0.228)	0.153	(0.046)	1.763
Physical / Sensory Disability	0.031	0.099	0.030	0.056	(0.167)	(0.280)	(0.345)
Learning Disability - Community	0.458	(0.267)	(0.095)	(0.047)	(0.214)	0.986	(1.801)
Learning Disability - Inpatients	0	0	0.002	0.123	0	0	0
Augmentative & Alternative Communication	0	0	0	N/A	N/A	N/A	N/A
Mental Health	0.136	0.192	0.189	0.419	0.409	0.393	0.354
Addictions / Substance Misuse	0.021	0.052	0.013	0.032	0.018	0.123	0.085
Family Health Services	0	0	-	0.008	0	0	0
Prescribing	0	0	(0.311)	(0.428)	0	0	0
Criminal Justice		0.011	-	0.039	0.011	0.013	0.027
Planning and Health Improvement	0.005	0.065	0.098	0.074	0.001	0.039	0.029

Management and Admin / Finance & Resources	0.017	(0.056)	0.238	(0.190)	0.483	(0.144)	(0.335)
Planned Contribution to / from Reserves	0	0		(0.398)	(0.600)	**	0
Net Expenditure Health and Social Care	**0.837**	**0.833**	**(0.065)**	**0.260**	**(0.177)**	**1.622**	**0.381**

** In 2016/17 we agreed to carry forward our planned underspend to reserves to provide flexibility to allow us to phase in budget savings including our change programme.

3.5 Best Value

The IJB has a duty of Best Value and this includes ensuring continuous improvement in performance, while maintaining an appropriate balance between the quality of those services provided by the HSCP and the cost of doing so. We need to consider factors such as the economy, efficiency, effectiveness and equal opportunities. The IJB ensures this happens through its vision and leadership and this is supported and delivered by:

3.6 Future Challenges

The IJB continues to face a number of challenges, risks and uncertainties in the coming years and this is set out in our current Medium-Term Financial Plan (MTFP) for 2022/23 to 2026/27 and our Strategic Plan for 2022/23 to 2024/25. These key strategies also inform our strategic risk register and collectively support medium-term planning and decision making.

In the MTFP published in March 2022 the funding gap in future years could range anywhere from £0 to £5.7 million per year, excluding unknown factors, recent inflation implications and any additional savings requirements in future years.

The current scale of costs pressures now look closer to £9 million to £13 million in 2023/24 and £4 million to £9 million in the following two years. This takes into account the impact of pay, inflation, utilities costs and other economic impacts since April 2022. Therefore the

funding gap has significantly increased. The actual funding gap and therefore savings requirement on the IJB will be dependent on the funding settlement for each year.

The investment in health and social care by the Scottish Government was welcomed by the IJB and whilst the majority of this new funding supports specific policy decisions such as the living wage for care providers, we were able to mitigate to some degree our pressures, including pre-pandemic savings.

Despite this investment the 2022/23 budget settlement fell within the poor settlement range of scenario planning assumptions with cost pressures of just over £14.4 million, funding uplifts of £11.3 million and therefore required savings of £3.1 million. We were able to identify £0.5 million of immediately achievable savings so our current savings challenge for 2022/23 is £2.6 million.

The budget for the year 2022/23 was agreed by the IJB on 16th March 2022 and recognised that we have legacy savings of £2.6m from before the pandemic and that the landscape has changed, particularly around demand and complexity, the ability to introduce new charges or increase criteria for care package support. Our reserves strategy, in place pre the pandemic, should see us through the year as we work towards gaining efficiencies from our Recovery & Renewal programme and also by managing, as best we can, the budget we have allowed for to meet increased demand. We are not anticipating Covid funding for unachieved savings in 2022/23.

The Recovery and Renewal Programme is a significant area of work that spans multiple years. We have recently restarted this as part of our recovery. At present there are 25 projects with 9 currently live and we expect further projects will be added over time. Our case recording system replacement project is one of the most significant and recruitment is underway to ensure key posts can support delivery.

There are currently 3 projects that should support delivery of savings as a combination of cash and efficiencies, which in turn should allow us to manage demand and release budget.

- Care at Home redesign (phase 2) – staffing and balance of in-house and purchased care
- Replacing the Scheduling system for Care at Home – more efficient use of resources
- Learning Disability redesign – use of technology as an alternative to sleepovers and more individualised approach from outreach work; better outcomes

These projects were paused as part of our response and will recommence imminently

In setting this budget the IJB recognised the scale of the challenge; that we were still in response mode; that there are still many unknowns as we work our way towards recovery and the impact and implications from the plans for a national care service are unknown.

The 2022/23 budget recognises that we may require to invoke financial recovery planning if we cannot close our funding gap on a recurring basis.

Demographic pressures remain a very specific challenge for East Renfrewshire as we have an increasing elderly population with a higher life expectancy than the Scottish average and a rise in the number of children with complex needs resulting in an increase in demand for services.

Economy; The consequences of Brexit did not manifest in any specific issues during 2021/22 however given this period remained far from normal this will continue to be monitored. The impacts of the war in Ukraine and economic factors such as possible shortages in supplies, inflation, fuel and utilities are all of concern and will be closely monitored throughout the coming year.

Any changes relating to the NCS will be analysed and reflected in our future plans.

We have successfully operated integrated services for over 17 years so we have faced a number of challenges and opportunities over the years. However our funding and savings challenge take no account of this history. Whilst we have agreed a population based approach for future (NHS) financial frameworks and models this does not address the base budget.

Prescribing Costs: The cost of drugs prescribed to the population of East Renfrewshire by GPs and other community prescribers is delegated to the IJB. This is a complex and volatile cost base of around £16 million per year. During 2021/22 the volume of items prescribed began to increase to the pre-pandemic trend; the post Covid-19 implication is not yet clear in terms of complexity of need, population demand and mental health impacts.

Delayed Discharge: In order to achieve the target time of 72 hours we continue to require more community based provision. The medium-term aspiration is that the costs of increased community services will be met by shifting the balance of care from hospital services. The work to agree a funding mechanism to achieve this remains ongoing with NHS Greater Glasgow and Clyde and its partner IJBs through an Unscheduled Care Commissioning Plan.

Care Providers: The longer term impact on the sustainability of the care provider market following Covid-19 is unknown and we continue to work closely with all our partners to work through issues, support where we can and look to develop the best way of working building on our collaborative and ethical commissioning approach as we move forward. This will build on our work to date, including the use of national contractual frameworks along with the implications from the NCS; this may impact on how we commission services.

We will fully implement our plans for continued use of the winter and Social Work Capacity funding during 2022/23 and we will continue to implement our model for interim care including the development of our intensive support model at Bonnyton care home. This creates a step up/step down service locally, to avoid unnecessary hospital admissions and timely discharge to home/homely settings. For Care at Home, the additional resources address the ongoing demand pressures we are experiencing, increase frontline staff as well as management and support, and increase capacity for the Home First model and Technology Enabled Care. We are continuing to enhance the capacity of our multi-disciplinary teams across the HSCP including: developing our multi-disciplinary Front Door model and leadership arrangements; additional capacity for social work and our Care Home and Community Review Team; support for the wider NHSGGC frailty hubs; and increased capacity for frailty practitioners, data and quality analysis and peripatetic business support.

The funding to strengthen Adult Social Work has allowed us to create additional leadership posts within Communities and Wellbeing. This has provided us an opportunity to create a dedicated transition team to support young people with complex needs in the transition to adulthood, and Long Term Conditions team to support the local residents with long term conditions as we recover from the pandemic.

We intend to develop our performance and financial reporting in more detail at a locality level to allow fuller reporting and understanding of future trends and service demands and include Covid-

19 implications and scenarios. We were not able to progress this work during 2021/22 as our focus remained on response.

We plan to deal with these challenges in the following ways:

- Our Recovery and Renewal Programme has restarted and will be implemented in 2022/23 and beyond and regular reports will be taken to the IJB.
- We will update our Medium-Term Financial Plan on a regular basis reflecting the ongoing impact of Covid-19, the economic climate and any impact from the NCS as these become clearer. This will allow us to continue to use scenario-based financial planning and modelling to assess and refine the impact of different levels of activity, funding, pressures, possible savings and associated impacts. This will also inform our planning for our 2023/24 budget.
- We will continue to monitor the impacts of Covid-19, Brexit, economic and inflationary factors along with operational issues through our financial and performance monitoring to allow us to take swift action where needed, respond flexibly to immediate situations and to inform longer term planning.
- We will continue to report our Covid-19 activity costs through the NHS Greater Glasgow and Clyde Mobilisation Plan and to the IJB. At this stage we do not expect any further support for non-delivery of savings. This will include how we transition as funding will reduce / cease over time.
- We will continue to work through our Care at Home redesign as part of our Recovery and Renewal Programme recognising the context of significant increase in demand for services, including increased complexity of needs due to the pandemic.
- We will continue to progress and report on our Strategic Improvement Plan until fully complete; work on this was not a priority during the ongoing pandemic response.
- We will complete the review of our Integration Scheme; work had been undertaken pre pandemic and was then put on hold.
- We routinely report our performance to the IJB with further scrutiny from our Performance and Audit Committee and our Clinical and Care Governance Group. The service user and carer representation on the IJB and its governance structures is drawn from Your Voice which includes representatives from community care groups, representatives from our localities and representatives from equality organisations including disability and faith groups. We intend to develop our performance reporting during 2022/23.
- Workforce planning will support identifying our current and future requirements. Recruitment and retention of staff is key to all service delivery and we have mitigated as far as possible by minimising the use of temporary posts and developing our workforce and organisational learning and development plans. Given the overwhelming response to the pandemic over a prolonged period our staff are tired both physically and mentally and the wellbeing of our workforce is paramount.
- Governance Code; we have robust governance arrangements supported by a Governance Code.
- The IJB continues to operate in a challenging environment and our financial, risk and performance reporting continue to be a key focus of each IJB agenda.

The future challenges detailed above and our associated response include the main areas of risk that the IJB is facing. The uncertainty of the longer term impact of Covid-19 on our population and the capacity for the HSCP and its partners to deliver services and implement our Recovery and Renewal programme whilst maintaining financial sustainability remain significant risks.

4. Performance summary

4.1 Introduction

In the previous chapters of this report we have focused on the key areas of work carried out by the HSCP over the course of 2021-22 including crucial activities as we responded to and have started to recover from the pandemic. In this final chapter we draw on a number of different data sources to give a more detailed picture of the progress the partnership has been able to make against our established performance indicators. Our quantitative performance for 2021-22 reflects the continuing challenges being faced from the pandemic during the Covid-19 pandemic.

The sections below set out how we have been performing in relation to our suite of Key Performance Indicators structured around the strategic priorities in our Interim Strategic Plan 2021-22. We also provide performance data in relation to the National Integration Indicators and Ministerial Steering Group (MSG) Indicators. Finally, we provide a performance summary relating to recent inspections of our in-house services.

4.2 Performance indicators

Key to performance status	
Green	Performance is at or better than the target
Amber	Performance is close (approx 5% variance) to target
Red	Performance is far from the target (over 5%)
Grey	No current performance information or target to measure against

Direction of travel*	
↑	Performance is IMPROVING
–	Performance is MAINTAINED
↓	Performance is WORSENING

*For consistency, trend arrows **always point upwards where there is improved performance** or downwards where there is worsening performance including where our aim is to decrease the value (e.g. if we successfully reduce a value the arrow will point upwards).

Strategic Priority 1 - Working together with children, young people and their families to improve mental wellbeing								
Indicator	**2021/22**	**Current Target**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
Percentage of children and young people subject to child protection who have been offered advocacy. *(INCREASE)*	**62%**	100%	63%	n/a	n/a	n/a	n/a	↓
Percentage of children with child protection plans assessed as having an increase in their scaled level of safety at three monthly review periods. (INCREASE)	**84%**	100%	87.5%	n/a	n/a	n/a	n/a	↓
Percentage of children looked after away from home who experience 3 or more placement moves *(DECREASE)*	**1.8%**	11%	1.2%	0.0%	1.4%	1.2%	7.1%	↓
Children and young people starting treatment for specialist Child and Adolescent Mental Health Services within 18 weeks of referral *(INCREASE)*	**55%**	90%	61%	78%	74%	89%	90%	↓
Child & Adolescent Mental Health - longest wait in weeks at month end *(DECREASE)*	**41**	18	35	33	34	35	31	↓
Accommodated children will wait no longer than 6 months for a Looked After Review meeting to make a permanence recommendation *(INCREASE)*	**94%**	95%	74%	94%	83%	100%	n/a	↑
Balance of Care for looked after children: % of children being looked after in the Community (LGBF) *(INCREASE)*	n/a	Data only	**91.1%**	94.9%	98.0%	93.6%	91.5%	↓
% Child Protection Re-Registrations within 18 months (LGBF) *(DECREASE)*	n/a	Data only	**0**	15.8%	7.7%	0%	9%	↑

Strategic Priority 1 - Working together with children, young people and their families to improve mental wellbeing								
Indicator	**2021/22**	**Current Target**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
% Looked After Children with more than one placement within the last year (Aug-Jul). (LGBF) *(DECREASE)*	n/a	Data only	**20%**	18.8%	24.5%	29.1%	19.6%	↓

Strategic Priority 2 - Working together with people to maintain their independence at home and in their local community								
Indicator	**2021/22**	**Current Target**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
Number of people self directing their care through receiving direct payments and other forms of self-directed support. *(INCREASE)*	**458**	600	551	575	514	491	364	↓
Percentage of people aged 65+ who live in housing rather than a care home or hospital *(INCREASE)*	**97%**	97%	97%	97%	95.9%	96.6%	96.8%	-
The number of adults (18+) receiving personal care at home or direct payments for personal care, as a percentage of the total number of adults needing care. *(INCREASE)* NI-18	n/a	62%	**58%**	57%	64%	64%	63%	↑
People reporting 'living where you/as you want to live' needs met (%) *(INCREASE)*	**89%**	90%	91%	88%	92%	84%	79%	↓
SDS (Options 1 and 2) spend as a % of total social work spend on adults 18+ (LGBF) *(INCREASE)*	n/a	Data Only	**8.69%**	8.44%	8.15%	7.5%	6.6%	↑
Percentage of people aged 65+ with intensive needs receiving care at home. (LGBF) *(INCREASE)*	n/a	62%	**62.2%**	57.6%	57.5%	62.5%	61.1%	↑

Strategic Priority 2 - Working together with people to maintain their independence at home and in their local community								
Indicator	**2021/22**	**Current Target**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
Percentage of those whose care need has reduced following re-ablement *(INCREASE)*	**60%**	60%	31%	67	68	62	64	↑

Strategic Priority 3 - Working together to support mental health and well-being								
Indicator	**2021/22**	**Current Target**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
Mental health hospital admissions (age standardised rate per 1,000 population) *(DECREASE)*	n/a	2.3	**1.4**	1.6	1.5	1.5	1.5	↑
Percentage of people waiting no longer than 18 weeks for access to psychological therapies *(INCREASE)*	**76%**	90%	74%	65%	54%	80%	56%	↑
% of service users moving from drug treatment to recovery service *(INCREASE)*	**9%**	10%	6%	16%	22%	12%	9%	↑
Achieve agreed number of screenings using the setting-appropriate screening tool and appropriate alcohol brief intervention, in line with SIGN 74 guidelines. *(INCREASE)*	**0**	419	5	33	93	331	468	↓
Percentage of people with alcohol and/or drug problems accessing recovery-focused treatment within three weeks. *(INCREASE)*	**95%**	90%	95%	89%	95%	87%	96%	-

Strategic Priority 4 - Working together to meet people's healthcare needs								
Indicator	**2021/22**	**Current Target**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
People (18+) waiting more than 3 days to be discharged from hospital into a more appropriate care setting including AWI *(DECREASE)* (NHSGGC data)	**7**	0	2	2	4	4	4	↓
Acute Bed Days Lost to Delayed Discharge (Aged 18+ including Adults with Incapacity) *(DECREASE)* (MSG data)	**4,546**	1,893	2,342	1,788	2,284	1,860	2,704	↓
No. of A & E Attendances (adults) *(DECREASE)* (NHSGGC data)	**11,654**	Data only	9,854	12,748	12,943	12,587	12,503	↓
Number of Emergency Admissions: Adults *(DECREASE)* (NHSGGC data)	**7,372**	Data only	6,217	6,859	6,801	6,916	6,908	↓
No. of A & E Attendances (adults) *(DECREASE)* (MSG data)	**16,877**	18,335	13,677	20,159	20,234	19,344	18,747	↓
Number of Emergency Admissions: Adults *(DECREASE)* MSG	**7,894**	7,130	7,281	7,538	7,264	7,432	8,032	↓
Emergency admission rate (per 100,000 population) for adults *(DECREASE)* NI-12	**9,549***	11,492	9,210	10,439	10,345	10,497	11,427	-
Emergency bed day rate (per 100,000 population) for adults *(DECREASE)* NI-13	**104,390***	117,000	96,914	105,544	110,0628	119,011	121,099	↑
Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges) *(DECREASE)* NI-14	**82***	100	98	78	79	79	83	↑
A & E Attendances from Care Homes (NHSGGC data) *(DECREASE)*	**252**	400	236	394	429	541	n/a	↓
Emergency Admissions from Care Homes (NHSGGC data) *(DECREASE)*	**141**	240	154	233	261	338	166	↑

Strategic Priority 4 - Working together to meet people's healthcare needs								
Indicator	**2021/22**	**Current Target**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
% of last six months of life spent in Community setting *(INCREASE)* MSG	**89.5%****	86%	89.8%	88.3%	86.2%	85.0%	85.8%	-

* Full year data not available for 2021/22. Figure relates to 12 months Jan-Dec 2021. Data from PHS release, 12 July 2022

**Provisional figure for 2020/21

Strategic Priority 5 - Working together with people who care for someone ensuring they are able to exercise choice and control in relation to their caring activities								
Indicator	**2021/22**	**Current Target**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
People reporting 'quality of life for carers' needs fully met (%) *(INCREASE)*	**92%**	72%	91%	92%	78%	72%	70%	↑
Total combined % carers who feel supported to continue in their caring role *(INCREASE)* NI 8	**28.4%**	Data only	n/a	35.3%	n/a	37.5%	n/a	↓

Strategic Priority 6 - Working together with our partners to support people to stop offending								
Indicator	**2021/22**	**Current Target**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
Community Payback Orders - Percentage of unpaid work placement completions within Court timescale. *(INCREASE)*	**81%**	80%	75%	71%	84%	92%	96%	↑
Criminal Justice Feedback Survey - Did your Order help you look at how to stop offending? *(INCREASE)*	**100%**	100%	92%	100%	100%	100%	100%	↑

Strategic Priority 6 - Working together with our partners to support people to stop offending								
Indicator	**2021/22**	**Current Target**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
% Positive employability and volunteering outcomes for people with convictions. (INCREASE)	**56.5%**	60%	66%	65%	55%	n/a	n/a	↓
% Change in women's domestic abuse outcomes *(INCREASE)*	**87%**	70%	84%	79%	64%	65%	66%	↑
People agreed to be at risk of harm and requiring a protection plan have one in place. *(INCREASE)*	**100%**	100%	100%	100%	100%	n/a	n/a	-

Strategic Priority 7 - Working together with our communities that experience shorter life expectancy and poorer health to improve their wellbeing								
Indicator	**2021/22**	**Current Target**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
Breastfeeding at 6-8 weeks most deprived SIMD data zones *(INCREASE)*	n/a	25%	**7.5%**	15.4%	22.9	27.3	17.2	↓
Increase the number of smokers supported to successfully stop smoking in the 40% most deprived SIMD areas. (This measure captures quits at three months and is reported 12 weeks in arrears.) *(INCREASE)*	**60**	16	66	74	6	20	27	↓
Premature mortality rate per 100,000 persons aged under 75. (European age-standardised mortality rate) *(DECREASE)* NI-11	**333**	Data Only	334	295	308	301	297	↓
Percentage of adults able to look after their health very well or quite well *(INCREASE)* NI-1	**92%**	Data Only	n/a	94%	n/a	94%	n/a	↓

Strategic Priority 8 - Working together with staff across the partnership to support resilience and well-being								
Indicator	**2021/22**	**Current Target**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
% Staff who report 'I am given the time and resources to support my learning growth'. *(INCREASE)*	**75%**	90%	n/a	77%	76%	70%	n/a	↓
% Staff who report "I feel involved in decisions in relation to my job". *(INCREASE)*	**72%**	Data Only	n/a	n/a	69%	n/a	n/a	↑
% Staff who report "My manager cares about my health and well-being". *(INCREASE)*	**88%**	Data Only	n/a	n/a	85%	n/a	n/a	↑

Organisational measures								
Indicator	**2021/22**	**Current Target**	**2020/21**	**2019/20**	**2018/19**	**2017/18**	**2016/17**	**Trend from previous year**
Percentage of days lost to sickness absence for HSCP NHS staff *(DECREASE)*	**6.9%**	4.0%	5.5%	7.3%	6.8%	8.5%	7.2%	↓
Sickness absence days per employee - HSCP (LA staff) *(DECREASE)*	**14.7**	12.4	13.6	19.1	16.4	13.0	13.6	↓
Percentage of HSCP (NHS) complaints received and responded to within timescale (5 working days Frontline, 20 days Investigation) *(INCREASE)*	**70%**	70%	100%	56%	67%	100%	63%	↓
Percentage of HSCP (local authority) complaints received and responded to within timescale (5 working days Frontline; 20 days Investigation) *(INCREASE)*	**71%**	100%	65%	72%	72%	81%	68%	↑

4.3 National Integration Indicators

The Core Suite of 23 National Integration Indicators was published by the Scottish Government in March 2015 to provide the basis against which Health and Social Care Partnerships can measure their progress in relation to the National Health and Wellbeing outcomes. As these are derived from national data sources, the measurement approach is consistent across all Partnerships.

The Integration Indicators are grouped into two types of measures: 9 are based on feedback from the biennial Scottish Health and Care Experience survey (HACE) and 10 are derived from Partnership operational performance data. A further 4 indicators are currently under development by NHS Scotland Information Services Division (ISD). The following tables provide the most recent data for the 19 indicators currently reportable, along with the comparative figure for Scotland, and trends over time where available.

4.3.1 Scottish Health and Care Experience Survey (2021-22)

Information on nine of the National Integration Indicators are derived from the biennial Scottish Health and Care Experience survey (HACE) which provides feedback in relation to people's experiences of their health and care services. The most recent survey results for East Renfrewshire relate to 2021-22 and are summarised below.

The results show that we performed better than the Scottish average for seven of the nine indicators and performed close to the national rate for the remaining two. While performance declined for all of the indicators at the national level since the previous survey, we saw improving performance for five of the nine indicators.

National indicator	2021/22	Scotland 2021/22	2019/20	2017/18	2015/16	East Ren trend from previous survey	Scotland trend from previous survey
NI-1: Percentage of adults able to look after their health very well or quite well	**91.9%**	90.9%	94%	94%	96%	↓	↓
NI-2: Percentage of adults supported at home who agreed that they are supported to live as independently as possible	**80.4%**	78.8%	78%	74%	80%	↑	↓
NI-3: Percentage of adults supported at home who agreed that they had a say in how their help, care, or support was provided	**73.8%**	70.6%	75%	64%	77%	↓	↓
NI-4: Percentage of adults supported at home who agreed that their health and social care services seemed to be well co-ordinated	**65.1%**	66.4%	62%	60%	69%	↓	↓
NI-5: Total % of adults receiving any care or support who rated it as excellent or good	**75.5%**	75.3%	70%	77%	82%	↑	↓
NI-6: Percentage of people with positive experience of the care provided by their GP practice	**69.7%**	66.5%	85%	84%	88%	↓	↓
NI-7: Percentage of adults supported at home who agree that their services and support had an impact on improving or maintaining their quality of life	**83.6%**	78.1%	78%	76%	79%	↑	↓
NI-8: Total combined % carers who feel supported to continue in their caring role	**28.4%**	29.7%	35%	37%	45%	↑	↓
NI-9: Percentage of adults supported at home who agreed they felt safe	**90.5%**	79.7%	81%	82%	82%	↑	↓

Data from PHS release, 12 July 2022

4.3.2 Operational performance indicators

National indicator	2021/22	Scotland 2021/22	2020/21	2019/20	2018/19	2017/18	2016/17	Trend from previous year
NI-11: Premature mortality rate per 100,000 persons	**338***	471* (2021)	334*	259*	308*	301*	297*	-
NI-12: Emergency admission rate (per 100,000 population) for adults	**9,549****	11,636	9,210	10,439	10,345	10,497	11,427	↓
NI-13: Emergency bed day rate (per 100,000 population) for adults	**104,390****	109,429	96,914	105,544	110,0628	119,011	121,099	↓
NI-14: Emergency readmissions to hospital within 28 days of discharge (rate per 1,000 discharges)	**82****	110	98	78	79	79	83	↑
NI-15: Proportion of last 6 months of life spent at home or in a community setting	**89.4%****	90.1%**	89.8%	88%	86%	85%	86%	-
NI-16: Falls rate per 1,000 population aged 65+	**25.6****	23.0**	21.5	22.6	23.4	22.4	21.2	↓
NI-17: Proportion of care services graded 'good' (4) or better in Care Inspectorate inspections	**78.9%**	75.8%	84%	84%	84%	88%	88%	↓
NI-18: Percentage of adults with intensive care needs receiving care at home	**65%***	65%* (2021)	58%*	57%*	64%*	64%*	63%*	↑
NI-19: Number of days people spend in hospital when they are ready to be discharged (per 1,000 population)	**347**	761	189	156	170	117	228	↓
NI-20: Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency	n/a	24.1% (2019/20)	n/a	**21.1%**	20.8%	22.4%	22.2%	↑

Data from PHS release, 12 July 2022. *Calendar years.
Full year data not available for 2020/21. Figure relates to 12 months Jan-Dec 2021. N.b. Scotland fig is Jan-Dec 2021 for comparison.

The indicators below are currently under development by Public Health Scotland.

National indicators in development
NI-10: Percentage of staff who say they would recommend their workplace as a good place to work
NI-21: Percentage of people admitted to hospital from home during the year, who are discharged to a care home
NI-22: Percentage of people who are discharged from hospital within 72 hours of being ready
NI-23: Expenditure on end of life care, cost in last 6 months per death

4.4 Ministerial Strategic Group Indicators

A number of indicators have been specified by the Ministerial Strategic Group (MSG) for Health and Community Care which cover similar areas to the above National Integration Indicators.

MSG Indicator	2021/22	Target 21/22	2020/21	2019/20	2018/19	2017/18	2016/17	2015/16	Trend from previous year
Number of emergency admissions (adults)	**6,851***	7,130	6,517	7,538	7,264	7,432	8,032	7,922	↓
Number of emergency admissions (all ages)	**7,894***	8,331	7,281	8,645	8,246	8,513	9,199	9,123	↓
Number of unscheduled hospital bed days (acute specialties) (adults)	**65,453***	57,106	58,333	62,861	60,953	62,967	62,901	58,271	↓
Number of unscheduled hospital bed days (acute specialties) (all ages)	**67,058***	58,899	59,593	59,764	64,407	64,769	64,455	60,064	↓
A&E attendances (adults)	**16,877**	18,335	13,697	20,159	20,234	19,344	18,747	18,332	↓
A&E attendances (all ages)	**24,270**	25,299	17,843	27,567	27,850	27,011	25,888	25,300	↓
Acute Bed Days Lost to Delayed Discharge (Aged 18+ including Adults with Incapacity)	**4,546**	1,893	2,342	1,788	2,284	1,860	2,704	2,366	↓
% of last six months of life spent in Community setting (all ages)	**89.5%****	86%	89.8%	88.3%	86.2%	85.0%	85.8%	85.6%	–
Balance of care: Percentage of population at home (supported and unsupported) (65+)	n/a	Data only	**96.6%**	96.5%	95.9%	95.8%	95.7%	95.6%	–
Balance of care: Percentage of population at home (supported and unsupported) (all ages)	n/a	Data only	**99.1%**	99.2%	99.0%	99.0%	99.0%	99.0%	–

Data from PHS release, 2 August 2022. (MSG Indicators)

*Full year data not available for 2021/22. Figure relates to 12 months Jan-Dec 2021.

**Provisional figure for 2020/21

4.5 Inspection performance

East Renfrewshire HSCP delivers a number of in-house services that are inspected by the Care Inspectorate. The following table show the most up to date grades as of 31 August 2022.

Key to Grading:
1 – Unsatisfactory, **2 –** Weak, **3 –** Adequate, **4 –** Good, **5 –** Very Good, **6 –** Excellent

Service	Date of Last Inspection	Quality of Care and Support	Quality of Environment	Quality of Staffing	Quality of Management & Leadership
Adoption Service	11/10/2019	5	Not assessed	5	Not assessed
Barrhead Centre	23/02/2018	6	Not assessed	Not assessed	6
Fostering Service	11/10/2019	5	Not assessed	5	Not assessed
Care at Home	25/06/2021	4	Not assessed	Not assessed	Not assessed
HSCP Holiday Programme	21/07/2017	6	Not assessed	Not assessed	5
Thornliebank Resource Centre	07/04/2016	4	Not assessed	Not assessed	4
HSCP Adult Placement Centre	25/10/2019	5	Not assessed	5	5

The Care Inspectorate launched the new evaluation framework in July 2018, which is based on the Health and Social Care Standards. Bonnyton House and Kirkton were inspected under the new quality inspection framework.

Service	Date of Last Inspection	How well do we support people's wellbeing?	How good is our leadership?	How good is our staff team?	How good is our setting?	How well is care and support planned?
Bonnyton House	01/07/2022	4	4	5	5	4
Kirkton	23/7/2019	5	Not assessed	Not assessed	Not assessed	5

The quality framework for children and young people in need of care and protection, published in August 2019.

Service	Date of Last Inspection	Evaluation of the impact on children and young people			
Joint Inspection for children at risk of harm	February – July 2022	6			

Evaluation of the impact on children and young people - quality indicator 2.1

For our inspections of services for children at risk of harm, we are evaluating quality indicator 2.1. This quality indicator , as it applies to children and young people at risk of harm considers the extent to which children and young people:

- feel valued, loved, fulfilled and secure
- feel listened to, understood and respected
- experience sincere human contact and enduring relationships
- get the best start in life.

Evaluation of quality indicator 2.1: Excellent

Appendix One - National Outcomes

The National Health and Wellbeing Outcomes prescribed by Scottish Ministers are:

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 reasonably 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 support to reduce 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.

The National Outcomes for Children are:

- Our children have the best start in life and are ready to succeed.
- Our young people are successful learners, confident individuals, effective contributors and responsible citizens.
- We have improved the life chances for children, young people and families at risk.

The National Outcomes for Criminal Justice are:

- Prevent and reduce further offending by reducing its underlying causes.
- Safely and effectively manage those who have committed offences to help them reintegrate into the community and realise their potential for the benefit of all.