2022/2025

EAST RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

# Working Together for East Renfrewshire –

# A Three Year Strategic Plan for Health and Social Care

**CONSULTATION DRAFT**

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# 1. Introduction

Welcome to the third Strategic Plan for East Renfrewshire Health and Social Care Partnership. The plan sets out the shared ambitions and strategic priorities of our partnership; and how we will focus our activity to deliver high quality health and social care to the people of East Renfrewshire. The plan covers the period 2022-25 and builds on our one-year 2021-22 'bridging plan' that was developed to support planning during our pandemic response phase.

Our strategic planning activity is taking place during an exceptionally challenging period for the partnership as we continue to support local residents through the Covid-19 pandemic and begin our recovery from the impacts of the crisis. The partnership continues to find itself in a period of change with significant uncertainty for the months and years ahead. At the same time, it is essential that we fully understand the lasting impacts of the pandemic as we work to deliver our strategic aims and objectives.

Our response to the pandemic has 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 over the course of this strategic plan.

While the plan sets out fundamental strategic priorities for health and social care such as supporting people to living independently and well at home, supporting better mental health and wellbeing, and ensuring access to high quality local health care services we continue to operate in the context of the pandemic. Our plan will be reviewed annually, building on the experiences and new learning as we continue our recovery.

This plan is based on strong evidence of local needs and despite practical challenges has been developed through a highly participative process drawing in voices from our partners in the community, third and independent sectors as well as people with lived experience and unpaid carers. As an inclusive partnership we will continue to engage widely as we review the delivery of our commitments in this plan and work to bring in fresh and innovative ideas as we move forward.

# 2. Our ambition, vision and priorities

## 2.1 Our ambition

This is a pivotal time for health and social care in Scotland and it is the ambition of East Renfrewshire Health and Social Care Partnership to meet the challenges we face and embrace new opportunities with a renewed commitment to innovation and high quality services and supports, designed and delivered in partnership with local people and partners.

We want to ensure that health and care supports available in East Renfrewshire meet the needs, values and personal ambitions of the people who live here. We want supports to be truly person-centred, focused on human rights and empowering people to thrive at whatever stage they are at in life.

Building the health and social care system we want to see requires strong collaboration and over the life of this plan we will work to further strengthen collaborative practices, building on examples such as our digital partnership and local delivery of the Communities Mental Health and Wellbeing Fund.

Our focus is on prevention and early intervention, with a range of supports in place to meet health and care needs early, preventing deterioration and helping people avoid crisis situations. As a broad and inclusive partnership our ambition is to maximise the supports and opportunities that are available for local people in the community, supporting prevention and working to tackle health inequalities across our communities. Through collaborative and ethical commissioning we will work with communities, third sector organisations and our independent sector providers, championing the most innovative and effective ideas and approaches.

Our health and care system depends on those that provide care and support, both paid and unpaid. Our ambition in East Renfrewshire is to increase recognition of the role that unpaid carers play, and ensure that the supports needed by carers are in place. As a partnership our workforce are our greatest asset. We want to ensure that those providing invaluable health and care services are happy and motivated; and feel respected and fulfilled in their role for years to come.

## 2.2 Listening to the experiences of people in East Renfrewshire

To support the development of this Strategic Plan we carried out a highly participative engagement process during 2021 designed and delivered in partnership with our third and independent sector partners. A wide range of views were shared with us by people with lived experience, unpaid carers, staff and management at support providers, HSCP staff and officers from internal and external partner organisations. Some of the most prominent issues raised in relation to our strategic themes are given below along with the response we take as a partnership.

| **Supporting people to maintain independence** | |
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| **What people told us** | **How we respond as a partnership** |
| • We need to move beyond the mindset of traditional services – look at innovative options for support.<br>• We need to be serious about prevention and stopping people reaching crisis. We need to expand what's available in the community – and communicate what's available to those that need support.<br>• We need to make sure that services are 'joined-up' and support providers are talking to each other.<br>• We need to make sure we're making the best use of digital technology.<br>• We need to fulfil our commitment to expanding choice and control. We need a more effective framework needed around Self-directed Support – clarity on supports and criteria.<br>• We need more collaborative working between support providers and with other partners – e.g. training, finance, and approaches to recruitment. | • We are committed to the principles and priorities set out in the Independent Review of Adult Social Care and the initial proposals for a National Care Service including: the commitment to person-centred, right-based approaches; more collaborative working and 'joined-up' approaches that focus on the experiences of individuals; and expanding choice and control through full delivery of self-directed support.<br>• We will develop and delivery our Commissioning and Market-shaping Plan to support this strategy. Through collaborative practices we will develop and expand local market provision.<br>• In partnership with our local providers' forum we will explore practical steps for more collaborative working between local support providers.<br>• We will promote and support the expanded use of digital communication technology for access to health and care supports; and promote use of health monitoring systems to support self-management of conditions. |

| Supporting better mental health and wellbeing | |
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| **What people told us** | **How we respond as a partnership** |
| • Essential that we support and promote resilience and self-management – across a range of groups – e.g. elderly, disabled, men, young people, shielding group, carers.<br>• More strengths based support – building on people's lived experiences.<br>• We need to ensure peer to peer support continues and is built on going forward.<br>• Encourage prevention – self-awareness and understanding around mental wellbeing.<br>• We need to make sure we are giving individuals time/space – listening and directing to most appropriate support.<br>• We need to tackle stigma – getting messages across; embed with managers and staff.<br>• Communication and awareness of services before crisis; sharing resources across our partnership and more widely. There is an increasing group of people not connected to services – they need to know what to do when they require support.<br>• Some people have benefited from greater community connectedness during the pandemic – we should build on positive experiences. | • Working collaboratively with our wider community planning partners we are focused on supporting better mental wellbeing and resilience across our communities. Led by the third sector, innovative approaches are being supported through the Communities Mental Health and Wellbeing Fund.<br>• We are focused on preventative approaches and will build on the strengths of approaches such as community link workers in GP practices and our peer support programme.<br>• Through information and advice provision, digital communications, and greater awareness across services we will work to ensure access to the right mental health supports at the right time.<br>• Through collaborative practices we will develop and expand local market provision for mental health and addiction supports.<br>• Learning from our experiences during the pandemic, we will take full advantage of opportunities from digital technology to increase contact and improve access to mental health and addiction services. |
| **Meeting local healthcare needs – and addressing health inequalities** | |
| **What people told us** | **How we respond as a partnership** |
| • Better information and access to support – raising awareness of what is available.<br>• Need choice and flexibility for health and wellbeing - Services must fit people rather than people fitting services. | • We are committed to working collaboratively to improve the health and wellbeing of our population. We are focused on delivering targeted health improvement interventions in communities experiencing greater health inequalities. With our community planning partners we are working to |

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| • We need to see services coming together and working collaboratively.<br>• We need to refocus our efforts on wider health improvement activity. Need to return to pre-pandemic screening programmes<br>• We must promote the prevention agenda through interventions such as Talking Points, community link workers, support for self-management. And recognise that loneliness / isolation is a massive issues for health and wellbeing.<br>• Need to improve support for learning disabilities post pandemic – and return to collaborative practices.<br>• Health inequalities – need to look at wider issues of poverty and housing. Significant health inequalities for people with physical and learning disabilities – exacerbated during the pandemic – delays, disruption to clinics.<br>• There needs to be a focus on how we organise as communities to support health and wellbeing. | tackle the root causes of health inequalities including child poverty, housing and employment; working to promote health literacy and self-management; and working to strengthen community resilience and capacity.<br>• We are focused on preventative approaches and will continue to develop the support provided by Talking Points, community link workers, and physical health interventions delivered in partnership with the Culture and Leisure Trust.<br>• In collaboration with NHS Greater Glasgow and Clyde we work to improve person-centred pathways for those accessing healthcare supports.<br>• We are committed to early intervention and prevention for people with long-term conditions; minimising unplanned hospital use; and improving support in the community for people leaving hospital. |
| **Supporting unpaid carers** | |
| **What people told us** | **How we respond as a partnership** |
| • We need to be creative – shift from traditional approaches and shift thinking on what's possible for families.<br>• Collaborative working between organisations and better engagement / communication with unpaid carers is imperative.<br>• We need to develop the availability of regular short breaks – many families at breaking point following the pandemic.<br>• We need to build clarity/understanding on definition of breaks – wide ranging in length and nature – supporting carers as individuals. | • In partnership with East Renfrewshire Carers Centre, we will work collaboratively with local carers in designing new, more flexible approaches to support.<br>• We are committed to developing the range of short-break options and increasing availability for carers to allow them to continue in their caring role. Listening to the needs and experiences of carers, we will work collaboratively with providers to expand the range of options available.<br>• We will work to widen understanding of caring, and the challenges faced by unpaid carers in East Renfrewshire through information and training. |

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| • We need to help people recognise their role and identify as carers – and overcome any barriers/stigma.<br>• We need to return to face-to-face peer support for unpaid – this has important social aspect. | • As we move beyond the pandemic, we will ensure that vital informal supports are re-established and strengthened as appropriate to the needs of local carers. |
| **Supporting staff wellbeing** | |
| **What people told us** | **How we respond as a partnership** |
| • We need to recognise and reward the incredible contribution of our staff and the pressures they are under - before, during and after the pandemic.<br>• Important to recognise the wider mental health issues among staff (across our wider partnership).<br>• We need to support our staff with new ways of working and adapting to a new landscape following the pandemic.<br>• There is a need for flexibility and balance - providing staff autonomy.<br>• We need to embed and sustain new meaningful supports for staff without stigma.<br>• We need to focus on the wellbeing of staff e.g. through wellness sessions and 'champions' to take forward wellbeing issues alongside our management structures.<br>• There should be better communication and sharing of resources across partnership – tapping into available supports.<br>• We need to build on the raised profile and wider recognition of staff in care sector as a result of the pandemic.<br>• We need to develop the skills of our managers to provide support – and have appropriate open conversations with staff.<br>• We need to ensure we keep people connected where they are still working remotely. | • Across the partnership our workforce as gone above and beyond to continue delivering vital support to local people during extremely challenging circumstances. We are entirely focused on supporting the wellbeing of our staff – and committed to embedding successful approaches as normal practice.<br>• We have put in place new structures and new channels for communication and we will review and develop these approaches moving forward.<br>• In the context of the pandemic, we are supporting managers to ensure team members feel connected and can access different levels of support for mental and emotional wellbeing.<br>• Opportunities for physical activity, rest and relaxation will continue to be developed and promoted and will be available for staff across the wider partnership. |

**Supporting staff wellbeing**


**Supporting unpaid carers**


First things that come to mind


**Tackling health inequalities and meeting people's healthcare needs**


**Supporting independent living**

## 2.3 Our partnership

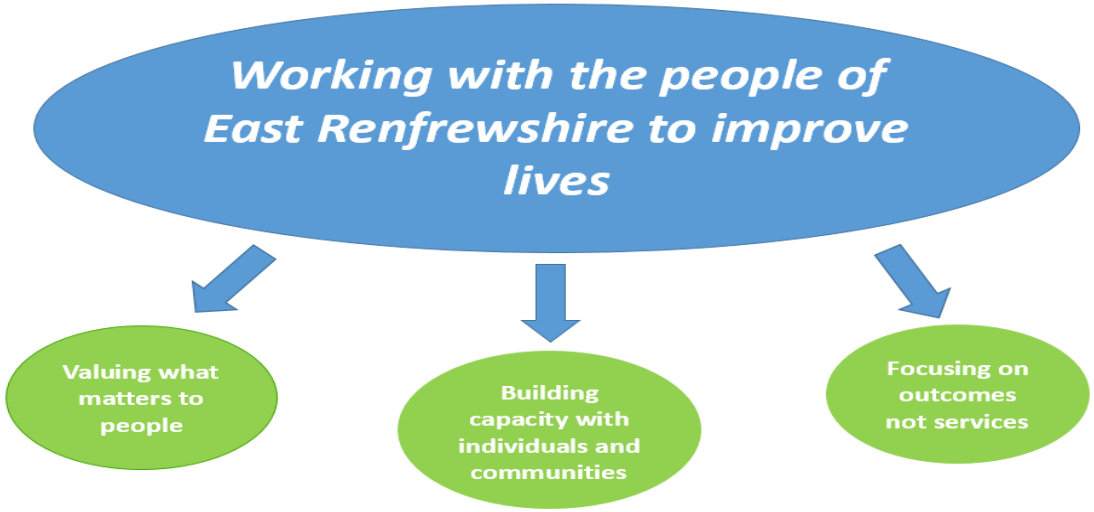
Under the direction of East Renfrewshire's Integration Joint Board (IJB), our HSCP builds on a secure footing of a 16 year commitment to health and social care partnership in East Renfrewshire. Our experiences throughout the Covid-19 pandemic have reinforced the benefits of working together as a broad and inclusive partnership. Moving forward we will further strengthen our supportive relationships with independent and third sector partners. It is also essential that we recognise the increased levels of participation in our communities and informal support within neighbourhoods that have developed in response to Covid-19. Our partnership must extend beyond traditional health and care services to a long-term meaningful partnership with local people and carers, volunteers and community organisations.

## 2.4 Our long-term 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 and remains unchanged for this iteration of our Strategic Plan.

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*




## 2.5 Our strategic priorities

In line with our vision and the wider priorities for our partnership, we have reviewed our strategic priorities. While our high-level strategic focus remains unchanged and the majority of our priorities from our previous 3-year (2018-21) plan will continue, we are building a wider focus on mental health to include community wellbeing. We have also added a strategic priority relating to the wellbeing of our workforce. Our strategic priorities are discussed in more detail at Section 3 and our operational planning will reflect how these priorities will be pursued as we recovery from the pandemic.

## 2.6 Delivering our strategy as we move beyond the Covid-19 pandemic

The plan covers 2022-25, a period in which we will continue to respond to the impacts of the pandemic as well as building our recovery based on learning and understanding of the shifting needs and priorities our East Renfrewshire residents.

As a broad and inclusive partnership we will continue to meet the needs of those directly impacted by Covid-19, including those receiving care and support and their carers. The continuing delivery of the local Covid-19 and flu vaccination programme is of particular importance to residents and will remain a significant focus for our resources in the short and medium term. We will also continue to support NHSGGC to deliver the vaccination programme as efficiently as possible for East Renfrewshire residents. New models and delivery approaches established in response to the challenges of the pandemic will continue as we deliver on the commitments in this plan.

At the same time we will take forward our Recovery and Renewal Programme. The programme will seek to ensure that the lessons learned during the pandemic are used to inform our recovery as well as bring transformational change to the delivery of services in the future.

Recovery and Renewal Programme – aims and objectives:

- To establish a comprehensive programme of recovery and renewal to support key areas of change and development across the HSCP
- Support the operational challenges faced by the partnership as a result of the pandemic
- Focus on wellbeing and support of staff and those who use our services
- Build on the lessons learned and new ways of working during the response and initial recovery phase
- Work with those who use our services and our partners to develop and enhance services
- Delivery of financial efficiencies and savings and potential realignment of resource
- Be informed by and inform the delivery of current and future HSCP strategic plans

## 2.7 Our engagement process

To support the development of this Strategic Plan we carried out a highly participative engagement process designed and delivered in partnership with our third and independent sector partners. Our 'Festival of Engagement' ran between August and October 2021 and in spite of the practical challenges of the pandemic drew in the voices of people with lived experience, unpaid carers, staff and

management at support providers, HSCP staff and officers from internal and external partner organisations. Full details of the engagement and learning coming from it can be viewed in our supporting Summary of Engagement document.


The engagement process was led by our multi-agency Participation and Engagement Group, delivered in line with the principles set out in the East Renfrewshire Health and Social Care Participation and Engagement Strategy 2020-23. Partner organisations supported facilitation of engagement events and over the three months we conducted 20 focus groups and workshops (principally delivered online with some face-to-face groups) involving nearly 200 participants. Workshops focused on key themes and were designed to be fun and participative using tools such as instant online polls (via mobile phones). Those unable to attend events or wishing to give individual views had the opportunity to complete short online surveys in relation to the engagement themes.


Following development of a draft strategic plan a full public consultation exercise was carried out between November 2021 and January 2022. The engagement process has provided the partnership with a wealth of knowledge on the experiences and challenges being faced by those receiving support, unpaid carers and those delivering support in East Renfrewshire. This knowledge informs the priorities set out in this high-level strategy and will inform the operational plans that support it as well as our other thematic strategic plans.

Ongoing engagement with our communities is an essential part of our work. Through the Participation and Engagement Group we will continue to ensure that our engagement processes are robust, well-coordinated and reflect best practice. In East Renfrewshire engagement is recognised as a shared responsibility across our wider partnership and we will continue to ensure that as many voices as possible inform our planning and delivery.

## 3. Our strategic priorities

We have reviewed our performance in relation to the strategic priorities in our previous Strategic Plan (see Section 6), assessed our demographic profile and the lessons learned from the Covid-19 pandemic, and in consultation with key stakeholders and communities we have reviewed our strategic priorities and areas of focus within these. The majority of our high-level priorities remain unchanged from our previous three-year plan but we agreed in 2020 to widen our focus on mental health to include community wellbeing and have added a strategic priority relating to the wellbeing of our workforce.

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

Our multi-agency approach to supporting the needs of children and young people in East Renfrewshire is set out in *"At Our Heart"* our Children and Young People's Services Plan 2020-2023. Improving the mental and emotional wellbeing of children and young people will continue to be one of the highest priorities for East Renfrewshire Health and Social Care Partnership (HSCP) as we go forward in future years.

Together all partners in East Renfrewshire are building an approach to mental health support for children, young people and families that will ensure they receive the right care and interventions at the right time and in the right place. A co-production event which included children, young people and parents/carers supported relationship-based and nurturing approaches which bridge the gap between school and home. There was a shared view that in many instances help for a child or young person would be best placed in the context of the child's family network. From this it was agreed to develop a blended model of support which would incorporate new as well as existing approaches.

The Covid-19 pandemic has exacerbated the circumstances of many children, young people and families, and we are now seeing a significant rise in the number of those experiencing challenges with their mental health and wellbeing. In response to this a multi-stakeholder Healthier Minds Service approach aligned to school communities has been developed to identify and ensure delivery of mental wellbeing support to promote children and families' recovery. This will work alongside our existing Family Wellbeing Service which links to GP practices and the CAMHS service. In addition, our Healthier Minds Framework is an evidence-based guide for children, young people, families and practitioners, outlining ways to support mental wellbeing in a holistic way and provides information about service and resources that can help at different stages in time.

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". As outlined in the Children and Young People's Plan 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.

| Mental and emotional wellbeing is improved among children, young people and their families | |
|---|---|
| **Our contributions to delivering this outcome** | **How we will measure our progress** |
| Protect our most vulnerable children, young people and families<br><br>Deliver on our corporate parenting responsibilities to our care experienced children and young people by fully implementing The Promise<br><br>Respond to the mental and emotional health and wellbeing needs of children and young people<br><br>Ensure children and young people with complex needs are supported to overcome barriers to inclusion at home and in their communities | % of children with child protection plans assessed as having an increase in their level of safety<br><br>% of children subject to child protection who are offered advocacy service<br><br>% Looked After Children with more than one placement within the last year<br><br>% of young people in transition to young adulthood with a transition plan by age of 16 |
| **Key activities during 2022-25**<br>• Implementing the new Healthier Minds service linked to schools and communities<br>• Support engagement and participation through East Renfrewshire Champions Board and Mini Champs<br>• Work in partnership with children, young people and their families to implement the recommendations of the Independent Review of Care Report (The Promise).<br>• Offer Family Group Decision Making at the initial referral stage through Request for Assistance (s12 duties)<br>• Embed the Signs of Safety practice principles across all child and family interventions<br>• Fully implement new Scottish Child Interview Model (SCIM), alongside key partner agencies ensuring trauma informed support from referral to recovery | |

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

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 aware that many older people, residents who were required to shield during the pandemic 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 in East Renfrewshire 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. We will continue to build on this collaborative working going forward to increase the community supports and opportunities available. Recognising the impacts of the pandemic on individuals we will ensure that the people we support receive timely review and reassessments as we move through the pandemic.

We will make best use of technology and health monitoring systems to support independence and self-management. With our partners we will support digital inclusion and the roll out of the AskSARA web based assessment and advice on equipment and solutions to support daily activities. We will support the increased use of digital technology, telephone and Near Me technology to support remote consultations and enable services to continue seeing patients in new ways. We will ensure that digital technology is used only as appropriate to the needs of the people we work with.

***"We need to focus on how we work together as a whole partnership under the 'umbrella' of the HSCP"*** *Support staff*

***"It's about feeling respected and trusting the support that's there - not just 'going along with things'. It's about being understood and support providers seeing beyond 'the mask'"*** Unpaid carer

We are committed to increasing choice and control and delivering the full potential of Self-directed Support. We will continue to review and embed our outcome-focused assessment tool and our individual budget calculator and ensure that people who require support have as much choice and control as they wish in relation to their supports. We will work collaboratively to ensure that we have an effective delivery framework in relation to supporting individuals and enabling innovative approaches. We will support our partner providers and in-house services to develop their business/service plans to adapt to these new approaches. As we recover from the pandemic we will build on our strong local partnerships and social

enterprise approach, encouraging innovation that supports people to live independently in the community and offers alternatives to residential care.

As more people live longer with more complex conditions it is important that we work collaboratively with housing to support independent living in our communities. We will continue to work with colleagues in East Renfrewshire Housing Services and local housing providers to better understand local needs and discuss future models of housing, technology and support.

| **People are supported to maintain their independence at home and in their local community** | |
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| **Our contributions to delivering this priority** | **How we will measure our progress** |
| More people stay independent and avoid crisis though early intervention work<br><br>The people we work with have choice and control over their lives and the support they receive. | Number of people engaged though Talking Points events and support<br><br>Referrals to preventative support through Talking Point engagement<br><br>% of people whose care need has reduced following re-ablement/rehabilitation<br><br>Number of people self-directing their care through receiving direct payments and other forms of self-directed support.<br><br>Percentage of people reporting 'living where you want to live' needs fully met.<br><br>% of people aged 65+ with intensive needs receiving care at home<br><br>Percentage of people aged 65+ who live in housing rather than a care home or hospital |

**Key activities during 2022-25**

- Promote the range of local supports and opportunities available through the Community Hub and Talking Points
- Establishing greater choice and innovation by developing the local market for provision
- Review and refresh our roll out of individual budget calculator and access to self-directed options
- Promote the use of AskSARA and other digital opportunities that support independence
- Support use of digital technology, telephone and Near Me technology
- Improve links and pathways between our rehabilitation and re-ablement services
- Work with housing providers to refresh our housing need assessment and consider future housing opportunities

## Working together to support mental health and wellbeing

In our previous plan our strategic priority had a focus on recovery for people experiencing mental ill health. In response to the impact of the pandemic we have extended this priority to working together to support mental health and wellbeing across our communities.

The experience of the Covid-19 pandemic has impacted on emotional wellbeing for people in all walks of life, and will continue to do so. Many of us have been anxious or worried about our health, our family and friends, and changes to our way of life. Some individuals, families and communities have struggled significantly over the period. 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 recognise that there are often close links between individuals' mental health and substance use. Therefore, it is important that alcohol and drugs services have close connections with our mental health services in East Renfrewshire. We will continue to focus on harm reduction working to minimise drug related deaths and harms impacting local people.

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. We are working on improving access to psychological therapies to ensure individuals receive the right support at the right time. We will continue to test and develop the impact of lived experience in the delivery of services such as peer support and its contribution to individual's recovery journeys, alongside formal services.

> ***"One approach won't fit for everyone – it's about being open minded and flexible and treating everyone as an individual."***
> Support provider

We have committed to working together with community planning partners on activities that support mental wellbeing and resilience across our communities, with Voluntary Action taking a leading role. Over the life of this plan we will continue to support the promotion of positive attitudes on mental health, reduce stigma and support targeted action to improve wellbeing among specific groups. Supporting the wellbeing and resilience of our staff and volunteers is critical to ensuring they can support residents effectively. We will continue our partnership working with primary care and Recovery Across Mental Health in which link workers in all of our GP practices offer social and psychological interventions to improve wellbeing.

***"Helping people have resilience isn't always about services - often it's recognising small things we can do for ourselves and for one another."*** Local resident

***"Promoting self – management doesn`t mean you are on your own."*** Local resident

| **People are supported to look after and improve their own mental health and wellbeing** | |
|---|---|
| **Our contributions to delivering this priority** | **How we will measure our progress** |
| Individuals can access a range of supports on their journey to recovery from mental health and addiction issues<br><br>Wellbeing is enhanced through a strong partnership approach to prevention and early intervention<br><br>Staff and volunteers have the skills, knowledge and resilience to support individuals and communities | Percentage of people waiting no longer than 18 weeks for access to psychological therapies<br><br>Percentage of people waiting no longer than three weeks from referral to alcohol / drug treatment<br><br>Mental health hospital admissions (age standardised rate per 1,000 population)<br><br>Positive outcomes for individuals supported through link worker interventions<br><br>Positive outcomes for individuals receiving peer support<br><br>*Wellbeing measures – to be agreed* |

**Key activities during 2022-25**

- Ensure appropriate access to primary care mental health services
- Develop and deliver the programme of activity supported by Action 15 funding
- Implement the priorities set out in the Greater Glasgow and Clyde Mental Health Strategy in East Renfrewshire and the Coronavirus mental health - transition and recovery plan
- Support holistic link worker service through all GP practices
- Develop local peer support service
- Reflect and build on innovative ways services have been delivered during the pandemic (including digital solutions)
- Support mental health and wellbeing interventions delivered through local wellbeing partnership activity
- Enhancing alcohol/drugs service provision to support Rights, Respect and Recovery and the Drugs Mission to prevent drug-related deaths

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

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. This should allow local GPs to spend more time in clinically managing patients with complex care needs.

> ***"Better and quicker access to specialist services can help deal with problems early and result in an appropriate action plan"***
> Local resident

During the pandemic we have strengthened our partnership working and opportunities for shared clinical conversations between the consultants and clinical leaders in hospitals and the GP as the expert medical generalists in the community. 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. We have seen increasing use of digital communication as people interact with healthcare providers including, for example, extensive use of Near Me video appointments. We will take an evidence-based and inclusive approach to supporting the anticipated change in the way our communities access healthcare. This means ensuring wider access to digital communication technologies, keeping pace new approaches and opportunities and making sure a suite of options are available for those requiring alternatives.

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. We will support the delivery of NHSGGC board-wide initiatives to help those experiencing frailty including the frailty pathway, Home First and other approaches supporting older people to stay well at home. 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 joint programme is focused on three key themes:

- **early intervention and prevention** of admission to hospital to better support people in the community;
- **improving hospital discharge** and **better** supporting people to transfer from acute care to community supports;
- **improving the primary / secondary care interface** to better manage patient care in the most **appropriate** setting.

| **People's healthcare needs are met with support provided in the right way, by the right person at the right time.** | |
|---|---|
| **Our contributions to delivering this priority** | **How we will measure our progress** |
| Early intervention and prevention of admission to hospital to better support people in the community | No. of A & E Attendances<br>Number of Emergency Admissions<br>A & E Attendances from Care Homes<br>Emergency Admissions from Care Homes<br>Occupied Bed Days (Adult – non-elective) |
| Improved hospital discharge and better support for people to transfer from acute care to community supports | People waiting more than 3 days to be discharged from hospital<br><br>Bed days lost to delayed discharge |
| Improved primary / secondary care interface to better manage patient care in the most appropriate setting | % of last six months of life spent in Community setting<br><br>Percentage of people admitted to hospital from home during the year, who are discharged to a care home<br><br>Number of clients supported into intermediate care |

**Key activities during 2022-25**

- Improve quality and quantity of Anticipatory Care Plans and Emergency Care Information Summaries
- Progress local out of hours response arrangements to support implementation of Urgent Care Resource Hub.
- Implement discharge to assess protocol.
- Implement frailty pathway and initiatives to address frailty
- Improve process for AWI patents learning from mental welfare commission recommendations and GGC wider review
- Develop and test enhanced community support and intermediate care models in partnership with HSCPs across Glasgow
- Continue support to local care homes and other supported living providers through safety and professional assurance arrangements.

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

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 Carers 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.

> ***"It's important to know there are people out there, who can, will and want to help you"*** Carer

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 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.

Our engagement for this plan reemphasised the importance of flexible and innovative approaches to the provision of breaks from caring. This will remain a focus for the partnership over the life of this plan. We will work collaboratively with providers to develop the range of options available; and we will make sure that carers are aware of and have access to appropriate breaks.

> ***Having the opportunity to hear from other carers is great, and although problems and situations may be different the message you take home is "you are not alone".*** Carer

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.

| People who care for someone are able to exercise choice and control in relation to their caring activities | |
|---|---|
| **Our contributions to delivering this priority** | **How we will measure our progress** |
| Staff across the partnership are able to identify carers and value them as equal partners | Percentage of carers who feel supported to continue in their caring role. (NI8) |
| Carers can access accurate information about carers' rights, eligibility criteria and supports | People reporting 'quality of life for carers' needs fully met (%) |
| More carers have the opportunity to develop their own carer support plan | Carers offered support to develop their own personal support plans |
| More carers are being involved in planning the services that affect them and in strategic planning | Services involving carers in their design and planning process |

**Key activities during 2022-25**

- In partnership with Carers Centre provide information and training to raise awareness of the impact of caring and requirements of Carers Act.
- Publicise our clear prioritisation framework for support and implement consistently
- Work with providers to review and modernise our approach to breaks in light of Covid-19 requirements
- Ensure that carers and support organisations are aware of the scope and different types of replacement care and short-break provision available.
- Develop tools and supports to help carers identify the impact of their caring role and plan how best to meet their needs
- Work with partners to ensure supports are available to carers to minimise the impact of financial hardship as a result of caring.
- Implement carers' support planning including planning for emergencies with individual carers.
- Work together with partners to ensure carers are being involved in planning the services that affect them

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

We will 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 criminal justice service will continue to promote the range of community justice services that we deliver and, in response to the challenges posed by the pandemic period, will identify and develop opportunities for the unpaid work element of community payback orders to meet the needs of the local community. We will build on the innovative approaches that have been developed during the pandemic and ensure we have the capacity to help people can complete unpaid work hours.

We will 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 criminal justice system have access to the services they require, including welfare, health and wellbeing, housing and employability.

We are aware of the impact of the pandemic on people experiencing domestic abuse. As part of our community planning work to protect people from harm and abuse, we have established and will continue to support a Multi-Agency Risk Assessment Conference (MARAC) in East Renfrewshire for high-risk domestic abuse victims. Over the course of 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.

| People are supported to stop offending and rebuild their lives through effective community justice pathways | |
|---|---|
| **Our contributions to delivering this priority** | **How we will measure our progress** |
| People have improved access to through-care and a comprehensive range of recovery services.<br><br>The risk of offending is reduced though high quality person centred interventions<br><br>Effective arrangements are in place to identify and manage risk<br><br>Effective interventions are in place to protect people from harm | % of people reporting community payback order helped to reduce their offending<br><br>Offenders completing unpaid work requirements<br><br>Positive employability and volunteering outcomes for people with convictions<br><br>Change in women's domestic abuse outcomes<br><br>People agreed to be at risk of harm have a protection plan in place |

**Key activities during 2022-25**

- Using appropriate assessment tools to identify risk and need
- Delivering a whole systems approach to diverting both young people and women from custody
- Delivering accredited programmes aimed at reducing reoffending
- Working with local partners to ensure a range of beneficial unpaid work placements are taken up
- Providing a range of services for women who experience domestic abuse
- Working in partnership with people at risk of harm to assess their needs and provide appropriate support

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

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. We will work to ensure that the health improvement activities we support are accessible, well communicated, and flexible; driven by the needs of local people.

> ***"Prevention work is key, now more than ever. The decline in general health following the pandemic is noticeable for many."*** Support provider

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. We will support equalities activities being taken forward under NHSGGC recovery and remobilisation planning including mainstreaming of changes shown to be effective in reducing inequalities.

> ***"We need to highlight inequalities and redress the current gaps for some of our most vulnerable individuals and families; to support families affected by poverty, mental health issues and addictions."*** Support provider

This priority also reflects our longer-term ambitions for East Renfrewshire. 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, promote health literacy and strengthen community resilience. We will continue to promote digital inclusion with a particular focus on supporting people to live well independently; and play a proactive role in managing their health and wellbeing.

| Minimise health inequalities and improve life chances working in collaboration with our communities | |
|---|---|
| **Our contributions to delivering this priority** | **How we will measure our progress** |
| Increase in activities delivered in partnership which support prevention and early intervention, improve outcomes and reduce inequalities.<br><br>Health inequalities will be reduced by working with communities and through co-produced targeted interventions | Male life expectancy at birth in 15 per cent most deprived communities<br><br>Female life expectancy at birth in 15 per cent most deprived communities<br><br>Premature mortality rate per 100,000 persons aged under 75.<br><br>% increase in exclusive breastfeeding at 6-8 weeks in most deprived SIMD data zones<br><br>Smokers supported to successfully stop smoking in most deprived SIMD data zones<br><br>Cancer screening uptake in most deprived SIMD data zones<br><br>Alcohol brief interventions delivered |
| **Key activities during 2022-25**<br>• Work to understand the needs of the population and address longer term impacts of Covid-19 on our communities and protected characteristic groups<br>• Work in partnership to build the capacity of community organisations, groups and individuals to deliver their own solutions for recovery from the coronavirus pandemic<br>• Deliver tailored health improvement programmes and activities in communities with greater health inequalities and disproportionate effects of Covid-19 | |

- Continue to explore additional funding opportunities to support targeted health improvement interventions
- Continue to support local activity to tackle Child Poverty and mitigate its effects
- Work to ensure people in our most disadvantaged community are able to access digital opportunities that support independence and wellbeing
- Work with our partners to tackle inequalities and support residents with a number of long term conditions such respiratory illness, cardiovascular disease and obesity to provide physical and psychological health benefits
- Implement the Women's Health Plan and Maternal and Infant Nutrition Framework
- Lead on the development of the HSCP's Wellbeing Strategy for health and social care staff and implement staff wellbeing activities.

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

In consultation with staff and stakeholders we added support for resilience and staff wellbeing as a new strategic priority during the pandemic, and this remains a key area of focus for our new 3-year plan. Working together with staff and our partners we will continue develop and embed positive practices and interventions to promote staff wellbeing over the life of the plan. We will work to ensure that this priority is delivered across the wider partnership with advice, support and activities made available as widely as possible.

> ***"It's important that we continue to support flexibility in the ongoing situation - as home life has been disrupted for staff as well as work life."***
> Support provider

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. 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.' The plan identifies four strategic objectives / outcomes and 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.

> ***"A key challenge is sustaining things going forward; especially low level interventions that can help with prevention"***
> Support provider

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.

| **Staff resilience and wellbeing in supported across the partnership** | |
|---|---|
| **Our contributions to delivering this priority** | **How we will measure our progress** |
| Staff have access to resources and information that can improve their wellbeing<br><br>Staff feel connected to their team or service and we embed a health and wellbeing culture across the partnership<br><br>Opportunities are promoted for staff to take part in physical activity, rest and relaxation<br><br>Staff feel safe in the work place | Number of activities promoted<br><br>Participation rates in health and wellbeing activities for staff<br><br>iMatter feedback from staff, including:<br>*"My manager cares about my health and well-being"*<br>*"I am given the time and resources to support my learning growth"*<br>*"I feel involved in decisions in relation to my job"* |
| **Key activities during 2022-25**<br>• Ensure that all staff have access to universal information with regard to health and wellbeing across the partnership's services, including staff working from home<br>• Develop leadership competencies across management in order to focus on resilience across the partnership<br>• Ensure regular wellbeing conversations with staff and teams<br>• Promote relaxation and physical activity opportunities across the partnership<br>• Ensure all physical environments are adapted to be Covid-19 compliant | |

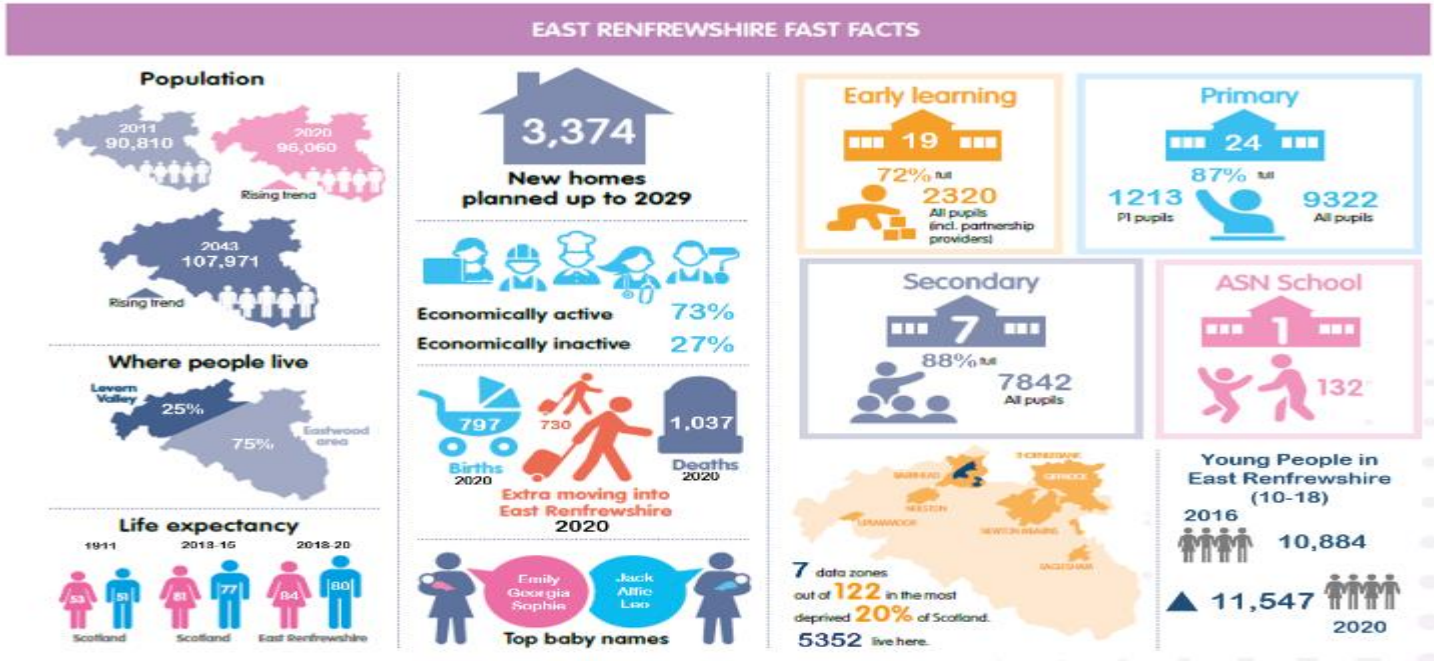
# 4. East Renfrewshire's current context

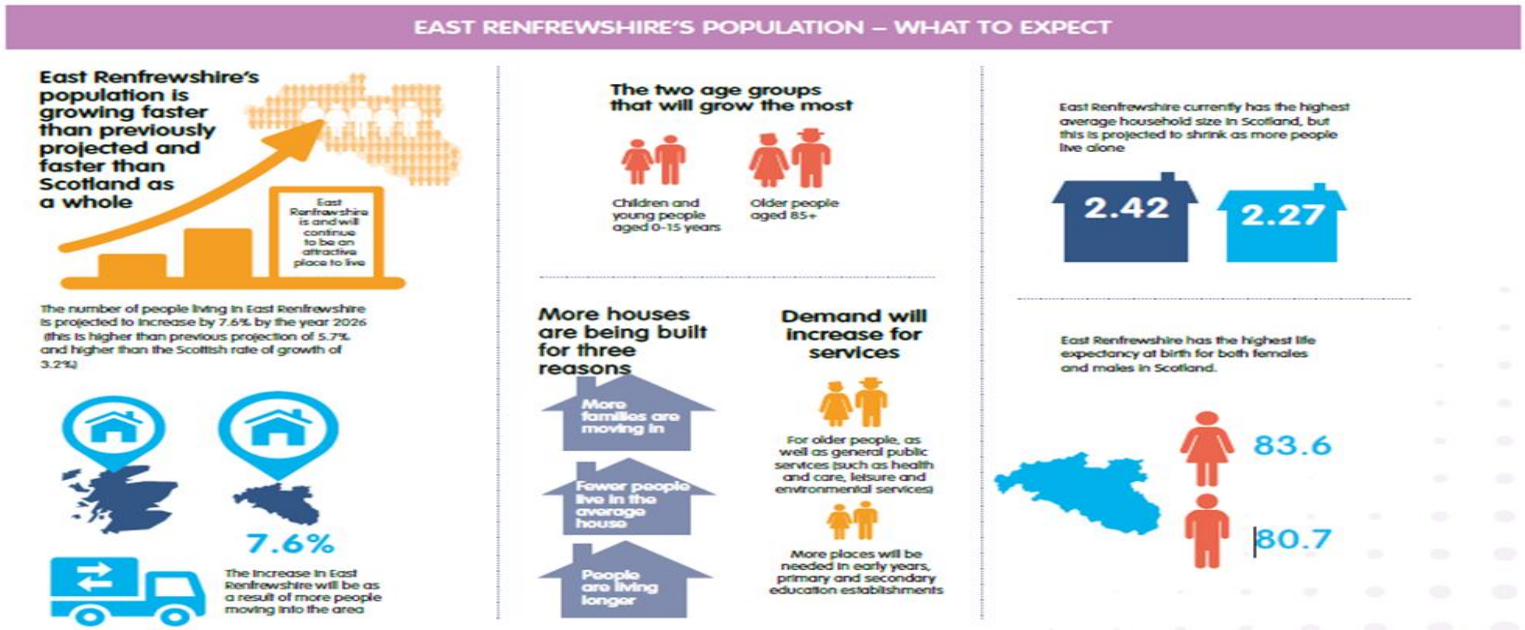
This section summarises our current context in relation to East Renfrewshire's demographic and health profile, future challenges and the impacts we are seeing from the Covid-19 pandemic, and our wider planning context for recovery.

## 4.1 East Renfrewshire's demographics

Detailed needs assessment work has been carried out to support the development of this plan and our full Joint Strategic Needs Assessment is available as a supporting document. A full socio-demographic profile has been developed for East Renfrewshire and covering our two localities (Eastwood and Barrhead) giving information on population, households, deprivation, health profile, life expectancy and use of services. This section provides an overview.

### 4.1.1 Population






East Renfrewshire's population is growing and there is particular growth for our younger and older residents, who are the greatest users of universal health services.

There has been significant growth in our most elderly population with a 44% increase in the number of residents aged 85 years and over 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.

### 4.1.2 Deprivation

Overall, East Renfrewshire is one of the least deprived local authority areas in Scotland. However, this mask the notable discrepancies that we see across the area with some neighbourhoods experiencing significant disadvantage.

The table below shows that more than half of East Renfrewshire's population (55%), and 67% of the Eastwood population live in SIMD datazones that are among the 20% least deprived in Scotland. All of East Renfrewshire's neighbourhoods that are among the 20% most deprived are concentrated in the Barrhead locality with a quarter of the population living in these datazones.

| Indicators | Data Type | Time Period | Eastwood Locality | Barrhead Locality | East Renfrewshire HSCP | Scotland |
|---|---|---|---|---|---|---|
| Population in least deprived SIMD quintile | % | 2020 | 67 | 17 | 55 | 20 |
| Population in most deprived SIMD quintile | % | 2020 | 0 | 25 | 6.4 | 20 |

### 4.1.3 Health outcomes and inequalities

In line with the socio-demographic profile we see differing health outcomes for the populations in our two localities. While life expectancy at birth is above the Scottish average for East Renfrewshire as a whole, it remains below average in the Barrhead locality. Early mortality rates and the prevalence of long-term conditions including cancers are also higher for Barrhead.

Data also shows poorer outcomes for the Barrhead local in relation to the percentage of the population prescribed medication for anxiety, depression and psychosis. Hospital admission related to alcohol and drugs are also higher for Barrhead.

| Indicators | Data Type | Time Period | Eastwood Locality | Barrhead Locality | East Renfrewshire HSCP | Scotland |
|---|---|---|---|---|---|---|
| Male average life expectancy in years | mean | 2014-2018* | 81.7 | 76.3 | 80.7 | 77.1 |
| Female average life expectancy in years | mean | 2014-2018* | 84.8 | 80.2 | 83.6 | 81.1 |
| Early mortality rate per 100,000 | rate | 2016-2018 | 51 | 90 | 62 | 110 |
| Population with long-term condition | % | 2018/19 | 19 | 22 | 21 | 19 |
| Cancer registrations per 100,000 | rate | 2015-2017 | 606 | 636 | 615 | 632 |
| Anxiety, depression & psychosis prescriptions | % | 2018/19 | 16 | 20 | 17 | 19 |

Data also shows discrepancies across the two localities in our objective to reduce unplanned hospital use with poorer performance in the Barrhead locality for most measures. However, people at the end of life are more likely to be supported in their community during the last six months of life compared with the Eastwood locality. The Barrhead locality records a higher rate of mental-health related emergency admissions to hospital and unplanned bed days.

### 4.2 Impacts from the Covid-19 pandemic and future challenges

This section considers the impacts of Covid-19 and the changes we have made as a partnership. We continue to learn lessons as we move through and beyond the pandemic period. We also outline what we consider some of the key challenges we face following the pandemic and in light of other external factors facing the partnership.

#### 4.2.1 Direct impacts of Covid-19

- **Impacts of increasing poverty on health and wellbeing.** While the full economic consequences of the pandemic are still developing it is clear that there have been negative consequences for businesses and employment prospects nationally and locally. The evidence clearly links economic disadvantage with poorer physical and mental health outcomes and we have seen the unemployment rate rise in East Renfrewshire. The 18-25 age group has been particularly impacted with the proportion of this group claiming unemployment related benefits increasing significantly.
- **Potentially worsening health inequalities.** National evidence shows that the pandemic has had a disproportionate impact for disadvantaged communities and specific vulnerable groups. The loss of social support during the pandemic due to diminished or interrupted care and support has made disabled people, black and minority ethnic people, older people and children and young people more vulnerable. We have also seen at the UK level, that disadvantaged neighbourhoods and areas with poorer, high-density housing have been particularly badly affected by the pandemic.
- **Negative impacts on mental health and wellbeing.** Evidence indicates that the Covid-19 pandemic has impacted on increased social isolation, distress, anxiety, fear of contagion, depression and insomnia in the general population. Studies have concluded there will be significant longer-term impacts on mental health and wellbeing. For some of the population this could exacerbate pre-existing psychiatric disorders and heighten risks of suicidal behaviour. A number of key groups are at higher risk of adverse

mental health outcomes. These include front line staff, women, people with underlying health conditions, children and young people (up to age 25). Locally, we know that families and people we support have reported worsening mental wellbeing.

- **Increased frailty and vulnerability.** Although the HSCP has succeeded in maintaining the vast majority of services throughout the pandemic we have been required to adapt provision and prioritise those in greatest need, particularly during the tightest lockdown restrictions. Some service areas have seen increasing levels of need, frailty and vulnerability among the individuals they are working with where lower level, preventative interventions have been reduced, and increased carer stress.
- **Impacts of ongoing Covid-19 restrictions.** It is unclear how long restrictions such as physical distancing will need to remain in place. These has impacted the way we are able to deliver our services, limiting the numbers of people we can bring into buildings and restricting face-to-face contact and group supports. Alternative approaches are in place and we are working with our partners to re-establish our services and preventative supports as rapidly as possible.
- **Impacts on the wellbeing and capacity on staff.** The Covid-19 pandemic has placed huge demands on the health and care workforce with frontline staff dealing with the immediate consequences of the pandemic and teams having to adjust to radically different ways of working. Staff teams have also had to work with reduced capacity as a result of sickness absence or staff self-isolating during the crisis. Given the level of stress staff are under and potential for staff to feel isolated it is essential that we continue to support staff resilience and connectedness.

### 4.2.2 Changes and opportunities as a result of Covid-19

- **Changing patterns of service use.** The pandemic period has seen new ways that people engage with services with increased use of telephone and video contact. In some instances such as 'wellness calls' people have been able to engage with services in quicker and more convenient ways. We must ensure that we understand people's expectations and preferences when accessing services and make sure that any positive changes to service delivery are retained (while not excluding any groups e.g. those without access to digital technology).
- **Stronger communication across the partnership.** As a partnership the pandemic has brought into sharp focus our shared goals and the shared level of commitment across partner organisations. We have seen increasingly supportive working relationships between statutory, independent and third sector partners. There have been better lines of communication between health professionals, including access to expert consultant advice for GPs, other primary care professionals and care home staff.
- **High levels of community and third sector activity.** Since the emergence of the Covid-19 we have seen high levels of support and participation in our communities. At the height of the pandemic we saw a local surge in residents offering their time as

volunteers as well as informal support within neighbourhoods. The experience of the pandemic has reinforced the crucial role of the community and third sectors in delivering essential support to our residents.

- **Capacity for change and innovation.** Over the course of the pandemic we have seen incredible resilience, commitment and creativity from staff. We have seen innovation and collaboration, between partner organisations and with our communities. This capacity for change and innovation will underpin our activity as we move forward.

### 4.2.3 Future challenges for the partnership

This section sets out some of the key challenges that the partnership faces as we embark on our new Strategic Plan, in the context of the Covid-19 pandemic and other external factors.

- **Increasing and changing service demand pressures.** In the immediate aftermath of the Covid-19 pandemic we are seeing significant increases in demand across service areas and higher levels of complexity among the people we are working with. This includes: higher volume of referrals to adult and child protection; increased CAMHS referrals and increase cases allocated to our children's social work teams; increased referrals to Care at Home services (and capacity pressures on partner providers) and higher levels of frailty and complexity among those accessing adult services. We continue to monitor demand pressures as we move through and beyond the pandemic.
- **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.
- **Delivering a balanced budget.** The funding gap in future years could range anywhere from £0 to £4.7 million per year, excluding unknown factors and any additional savings requirements in future years. The resulting funding gap will be dependent on the funding settlement for each year. There are still many financial unknowns as we work our way towards recovery and the impact and implications from the plans for a National Care Service are currently unknown. Further information on our financial resources is available in our Medium-Term Financial Plan for 2022/23 to 2026/27 and our Annual Report and Accounts.
- **Minimising delayed discharges from hospital.** 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.

- **Meeting our 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. The post Covid-19 impact on prescribing in the medium to long term is unclear. During 2020/21 the volume of items prescribed reduced by 4.8% over the year as a result of the pandemic. The post Covid-19 implication is not yet clear in terms of complexity of need, population demand and mental health impacts.
- **Supporting the care market and our local 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 move to national contractual frameworks along with the implications from the independent review of adult social care which may impact on how we commission services.
- **Impact of Brexit.** The consequences of Brexit have not manifested in any specific issues to date although there are some anecdotal concerns in relation workforce vacancies particularly among partner providers. However, given we remain in a comparatively volatile period, this will continue to be monitored and working groups with partners remain active.

### 4.3 Our planning context

East Renfrewshire Health and Social Care Partnership operates within an evolving framework of legislation, regulations and national guidance that shape our responsibilities to the people of East Renfrewshire and influence how we deliver our services. The Partnership is committed to incorporating and aligning the key elements of national, regional and local policies in the planning, design and delivery of our services. This section highlights some of the key planning considerations that influence our current strategic direction.

#### 4.3.1 A Fairer, Greener Scotland: Programme for Government 2021-22

Published in September 2021, A Fairer, Greener Scotland sets out the Programme for Government and recognises the priority continues to be addressing the impact of Covid-19 as the single greatest public health crisis of our lifetimes and the impact on our health, economy and society. The programme also recognises the need to prioritise the recovery of our health and social care services – rebuilding capacity, and establishing a new form of care which people can access in a way, place, and time which works for them. It requires us to redouble efforts to tackle the inequalities that continue to blight our society –eradicating poverty and discrimination,

and ensuring opportunity is never limited by economic or social circumstance. The programme also focuses on securing an economic recovery which is green and fair – for everyone and in every part of Scotland – and delivers the Scottish Government's ambition to become a net-zero nation.

### 4.3.2 NHS Greater Glasgow and Clyde Remobilisation Plan

The NHS Greater Glasgow and Clyde Remobilisation Plan is the current operational plan for the health board area setting out planned activity in relation to key priority areas. It covers a number of activity areas of particular relevance to the HSCP including supporting staff wellbeing, recognising the importance of providing on-going support to promote both physical and psychological wellbeing over the coming year and looking to embed systems of support for the longer term.

The remobilisation plan sets out the approach to full remobilisation across adult services including the provision of advice, support and guidance to Care Homes, provision of services to support people in their own homes including care at home, respite and day care services, whilst ensuring that safety remains the top priority at all times. The plan is clear that lessons learned and innovative approaches developed during the pandemic, irrespective of setting, should be maintained and examples of best practice shared and adopted across IJBs.

The plan supports the continuing safe delivery of (non-Covid) essential services in parallel with the response to Covid-19. It recognises that optimisation of self-care and an expansion of the role of primary care/community-based services will be a key element of the new "business as usual" following the pandemic. Key areas of activity include: enhancing the interface between primary and secondary care (including the development of Community Care and Treatment Room Services); sustaining Covid-19 pathways; primary care support to the essential roles/functions of care homes and care at home; responding to any increased demand for rehabilitation services (including potential impact of long Covid); and provision of key services in community including pain management, dentistry, and eye care.

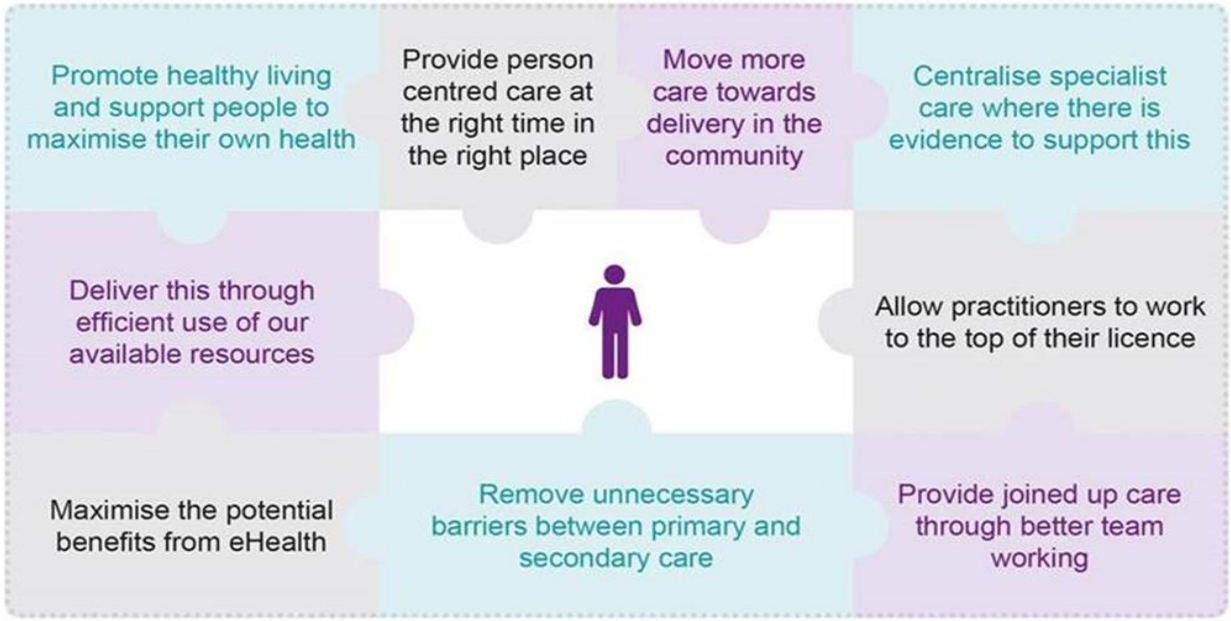
The Remobilisation Plan supports a whole system approach to mental health and wellbeing in response to the mental health impacts of Covid-19, addressing the challenges that the pandemic has had, and will continue to have, on the population's mental health. In line with the national Coronavirus (COVID-19): Mental Health - Transition and Recovery Plan, the Scottish Government will support

Boards and IJBs to remobilise services and to improve performance against the CAMHS and Psychological Therapies waiting times standards.

The plan aims to ensure that provision reflects the service user perspective and experience across the whole health and social care system, and is structured around patient/service user pathways rather than service boundaries. It seeks to address the health inequalities that have been exposed and exacerbated by the pandemic and, as appropriate, embed innovative practices and new ways of working that have been evident during the pandemic response.

### 4.3.3 Moving Forward Together

Moving Forward Together (MFT) is the strategic document which describes the vision for future clinical and care services in Greater Glasgow and Clyde. The key principles established through MFT are summarised below:



Although the formal governance arrangements for MFT were stood down due the pandemic, these priorities have continue to be delivered in partnership between clinicians, service users and the public. There has been significant progress since the start of the pandemic in relation to: maximising the potential benefits from eHealth (with higher volume of remote consultations); centralising specialist care where there is evidence to support this; providing person centred care at the right time in the right place (through the redesign of urgent care and strengthening of pathways); and, removing unnecessary barriers between primary and secondary care (though the cross system approach to recovery and remobilisation planning).

### 4.3.4 Independent Review of Adult Social Care & National Care Service Consultation

The Independent Review of Adult Social Care in Scotland (chaired by Derek Feeley, a former Scottish Government Director General for Health and Social Care and Chief Executive of NHS Scotland) was published on 3rd February 2021. The principal aim of the review was to recommend improvements to adult social care in Scotland, primarily in terms of the outcomes achieved by and with people who use services, their carers and families; and the experience of people who work in adult social care.

The report put forward a bold vision for adult social care support in Scotland building on the opportunity for meaningful change as we move beyond the Covid-19 pandemic.

***Everyone in Scotland will get the social care support they need to live their lives as they choose and to be active citizens. We will all work together to promote and ensure human rights, wellbeing, independent living and equity.***

It calls for new thinking and a new positive narrative around the role of social care support, recognising its 'foundational' importance in society and moving towards a human rights based approach.

| *Old Thinking* | *New Thinking* |
|---|---|
| *Social care support is a burden on society* | *Social care support is an investment* |
| *Managing need* | *Enabling rights and capabilities* |
| *Available in a crisis* | *Preventative and anticipatory* |

| | |
|---|---|
| *Competition and markets* | *Collaboration* |
| *Transactions* | *Relationships* |
| *A place for services (e.g. a care home)* | *A vehicle for supporting independent living* |
| *Variable* | *Consistent and fair* |

It also argues that we must strengthen the foundations of the social care system. This means: fully implementing positive approaches such as self-directed support and the integration of health and social care; as well as nurturing and strengthening our workforce and supporting unpaid carers.

The independent review called for some structural changes including the establishment of a National Care Service (NCS) with accountability for social care support moving from local government to Scottish Ministers. The proposed NCS would oversee improvements in the consistency, quality and equity of care and support. The report also suggests a reformed role for Integration Joint Boards in implementing the social care vision outcome measures, and delivering planning, commissioning/procurement, managing local GP contracts, as well as local planning and engagement.

The report made 53 wide-ranging recommendations in relation to the following priorities:

- Mainstreaming and embedding a human rights approach;
- Ensuring better, more consistent support for unpaid carers;
- Establishing a National Care Service (NCS) for Scotland;
- Establishing a new approach to improving outcomes through a National Improvement Programme for social care;
- Developing models of care;
- Commissioning for the public good through collaborative commissioning and a greater focus on people's needs;
- Developing fair work arrangements with national oversight;
- Improving investment with a focus on prevention rather than crisis response.

The Scottish Government subsequently put forward proposals for the establishment of a National Care Service for Scotland. The proposals go beyond the scope and recommendations of the review and set out how a National Care Service will define the strategic direction and quality standards for community health and social care in Scotland. The consultation proposes that the NCS will have

reformed local delivery boards which work with the NHS, local authorities, and the third and independent sectors to plan, commission and deliver support and services.

The consultation ran from 9th August to 2nd November 2021 and sought views from stakeholders on:

- Improving Care for People
- Establishing a National Care Service
- The Scope of the National Care Service
- Reforming Integration Joint Boards (as new Community Health and Social Care Board)
- Improving Commissioning of services
- Regulation
- Valuing people who work in social care

It is expected that the findings from the consultation exercise will have significant impacts for the delivery of social care and wider supports moving forward. We will support any changes that are adopted and will look to include these in our strategic and operational planning. During the life of this Strategic Plan we will implement any recommendations or specific actions arising from the review as requested by Scottish Government.

### 4.3.5 The Promise – the Independent Care Review for young people

The national focus on young people emphasises improving access and equality to education and employment for all our young people including our looked after young people. This aligns with the outcome of the Independent Care Review for care experienced young people –The Promise. It works with all kinds of organisations to support shifts in policy, practice and culture so Scotland can keep the promise it made to care experienced infants, children, young people, adults and their families - that every child grows up loved, safe and respected, able to realise their full potential.

### 4.3.6 East Renfrewshire Community Plan & Fairer East Ren

The East Renfrewshire Community Plan sets out how local services work together to create stronger and fairer communities together with the people of East Renfrewshire.

The Community Plan (2018-28) reflects residents' top priorities and serves as the main strategic document for the East Renfrewshire Community Planning Partnership (CPP). The Community Plan is structured around five strategic priorities:

1. Early Years and Vulnerable Young People
2. Learning, Life and Work
3. Economy and Environment
4. Safe, Supportive Communities
5. Older People and People with Long-Term Conditions

In supporting delivery of the plan, the HSCP has a specific focus on supporting vulnerable young people (Outcome 1), older people and people with long-term conditions (Outcome 5) as well as supporting Outcome 4 through our community Justice services.

The Plan also includes Fairer East Ren – our Local Outcomes Improvement Plan - as required by the Community Empowerment Act. Fairer East Ren focuses on reducing inequality of outcome across groups and communities and sets out the following strategic outcomes:

1. Child poverty in East Renfrewshire is reduced
2. Residents have the right skills, learning opportunities and confidence to secure and sustain work
3. East Renfrewshire's transport links are accessible, attractive and seamless
4. Residents' mental health and wellbeing is improved
5. Residents are safe and more socially connected with their communities

### 4.3.7 Planning in collaboration with housing

Ensuring our communities have access to good quality housing and housing related services is key to enabling people to live as independently as possible and also makes a significant contribution to reducing health inequalities locally. We have developed a shared strategic focus delivered through the Housing Contribution Statement (HCS) which we will update in line with the new East Renfrewshire Local Housing Strategy. The HCS operates as the "bridge" between strategic housing planning and that of health and social care. It constitutes an integral part of our strategic planning and identifies the contribution of the housing sector in achieving the aspirations of this plan. Housing Services contribute positively to improving the health and wellbeing of our communities and

ensuring that more people are cared for and supported at home or in a homely setting, in a way that is personal to them, respects their rights and maintains connections with important people and places.

The Local Housing Strategy (LHS) is the key planning vehicle that sets out how the Council and its partners will meet the housing requirements of people in East Renfrewshire. The priorities established in the strategy reflect those of the HSCP and set out the specific actions that the Housing Service will undertake to support independent living and the integration of health, social care and housing. The strategy provides details of the services and supports that are available to achieve this goal and provides an estimate of future specialist provision, need and delivery options. The HSCP is working collaboration with housing colleagues to support the development of the next LHS for 2022-27.

# 5. Review of progress against our strategic priorities (2018-22)

In developing our plan we reviewed the progress we have made towards the outcomes and strategic priorities set out in our previous Strategic Plan 2018-21 in collaboration with our Strategic Planning Group (SPG). The review recognised the impact of the Covid-19 pandemic in the final year of the previous Strategic Plan and during 2021-22 and the emerging lessons from the period. More information on our performance is available in our Annual Performance Plan.

## 5.1 Mental wellbeing for children and young people

We have made good progress in establishing and developing more appropriate and proportionate models to support wellbeing for children and young people with a focus on prevention and holistic support to families. Our Family Wellbeing Service which supports children and young people who present with a range of significant mental and emotional wellbeing concerns is delivering positive outcomes for individuals. The service is now well established and has expanded its reach to all GP practices. We are seeing improving outcomes for children after parent/carer completion of our Psychology of Parenting Project (PoPP). The programme offers support to families experiencing difficulties with behaviour, building confidence among parents.

We continue to perform well in keeping children safe in their local community wherever possible and acting quickly to make decisions. We have made progress with the implementation of the Signs of Safety model which focuses on developing relational interventions with children, young people, their families and carers in order to reduce risk and improve children's wellbeing. We continue to shift the balance of care and now have the highest proportion of children being looked after in the community in Scotland. Further progress has been made in ensuring our care experienced young people have a voice through our Champions Board with increased levels of participation and engagement.

## 5.2 Criminal Justice pathways

The IJB has been supporting multi-agency approaches to criminal justice through East Renfrewshire's Community Justice Outcome Improvement Plan with good progress in the establishment of stronger pathways to recovery and rehabilitative services.

High quality person centred interventions have been delivered through the Community Payback Team facilitating unpaid work, reducing the risk of reoffending and supporting individuals to overcome barriers into training and employment. We have enhanced our unpaid work service by ensuring that tasks are meaningful to communities and provide learning opportunities for service users, including improving the environment and supporting charitable and voluntary organisations. We receive regular feedback from the public on the positive impact that community payback has had on their local community.

We continue to put effective interventions in place to protect people from harm and have seen improving personal outcomes for women and children who have experienced domestic abuse.

This work needs to continue into the next strategic plan.

### 5.3 Supporting health and wellbeing in our disadvantaged communities

East Renfrewshire as a whole continues to perform well ahead of the Scottish average for life expectancy and premature mortality rates. Collaborative and targeted interventions with physical activity and health awareness have been delivered in Barrhead and Neilston. In partnership with the East Renfrewshire Culture and Leisure Trust we have been progressing our Ageing Well activity to support health and wellbeing for older residents.

Health inequalities persist in East Renfrewshire and may have been exacerbated by the impact of the pandemic. We will continue to work with our community planning partners to develop our understanding of health inequalities and target interventions appropriately.

### 5.4 Supporting people to remain independent and live well at home

Supporting independence and minimising reliance on institutional care has been a significant area of focus for the IJB during the period. We have seen good progress in the development of our preventative and community-led supports, promotion of models that increase individual choice and control, and development of innovative support for people to maintain health and wellbeing in their own homes. In particular, prior to the Covid-19 pandemic, Talking Points hubs were established across East Renfrewshire as places where people can go to have a good conversation about their health and wellbeing and be directed to the right support at the right

time. The approach has strengthened our work as a partnership, with clearer understanding among support providers of what is available across East Renfrewshire. This has resulted in increased availability of information and access to community supports.

The HSCP has introduced an 'individual budget' calculator to support self-directed support but further work is required to embed the new processes. We have made good progress in supporting independent living for people with learning disabilities including the development of a range of meaningful activities in the community. We have progressed independent living with the promotion of telecare and the expansion of our Home and Mobile Health Monitoring (HMHM) service with GP practices.

We would like to see more improvement in our performance that indicates a shift in the balance of care. Supporting people to live independently and well remains a strategic priority for the IJB and we will work to progress the most appropriate models of care, including making best use of digital opportunities to support local people.

### 5.5 Supporting recovery from mental ill-health

We continue to develop our approaches to ensure that people who experience mental ill-health can access the appropriate support on their journey to recovery. Community Link Workers have been introduced to all GP practices to support preventative and holistic approaches. Approximately 2000 people have benefitted from a wide range of physical, social and psychological interventions. We have progressed self-management through the promotion of computerised cognitive behavioural therapy (cCBT) and increased our referrals to specialised mental health services.

Available performance information for mental health remains limited and we will work to progress our understanding of local experiences through improved data and engagement. There is strong emerging evidence on the impact the pandemic is having on mental wellbeing across groups in the community. In recognition of this we will expand the scope of this strategic priority from tackling mental ill-health to supporting mental wellbeing in the community more widely.

### 5.6 Reducing unplanned admissions to hospital

Not accounting for the exceptional impact of the Covid-19 pandemic on acute care and patterns of hospital use, we have seen good progress in our development of supportive pathways out of hospital. We perform well on minimising delayed discharges and are

seeing a reduction in unplanned days spent in hospital. However, the data shows that (before the pandemic) we were not reducing the volume of emergency admissions to hospital and there had been an overall increase in the number of A&E attendances over the period of the strategy (although with modest improvement for 2019/20).

To minimise unplanned presentations at hospital we have been working closely with GP practices and at cluster level and focusing on local data (e.g. frequent hospital attenders) to support to patients and minimise use of acute services. Prior to the pandemic good collaborative working with local care homes, brought down emergency attendances and admissions from this sector. We have seen good progress in supporting people at end of life with improving performance on the proportion of time people are supported in their own homes.

Our overall performance on unscheduled care indicates that we continue to be very successful at putting support in place to allow people to return to the community after as stay in hospital. However, with attendance and admission rates not improving over the longer term, we must work to ensure that people have the appropriate level of support in the community. We must also continue to work to identify those at greatest risk and plan support accordingly.

### 5.7 Supporting unpaid carers to exercise choice and control

We have seen continued progress in our development of support for East Renfrewshire's unpaid carers working in collaboration with our local Carers Centre. Our most recent report shows 92% of carers reporting satisfaction with their quality of life. This indicator has improved consistently year on year and by 22% since 2016/17. However, the 2017/18 Scottish Health and Care Experience Survey showed that just 37% of carers felt supported in their caring role, although 70% of the people who responded were able to report a positive balance in terms of their caring role and other interests in their life. Whilst our performance is similar to that across Scotland, we know that this is an area that we can improve and we remain focused on ensuring that local people who provide unpaid care are valued and supported.

Working in partnership with the Care Collective (East Renfrewshire Carers and Voluntary Action East Renfrewshire), the HSCP has undertaken a range of activities to support the implementation of the Carers Act and establish a holistic approach to supporting local carers. We believe we have developed a sound continuum of support for improving outcomes for carers of all ages. Our local Carers Centre. Carers Centre staff have been trained in outcome-focussed, asset-based planning and Good Conversations and have

completed Adult Carer Support Plans (ACSP) with carers. Those carers identified as having a substantial or critical need for support were referred to the HSCP for further social work intervention.

The HSCP appointed a Carers Lead in 2019/20 to promote the understanding and uptake of the legislation within East Renfrewshire. The Carers Lead is taking forward the development and implementation of the new East Renfrewshire Carers Strategy. Partners are clear that ensuring choice and control remains the key strategic priority for carers in East Renfrewshire.

## 6. Resourcing our Strategic Plan

To be added following announcement of financial settlement (January 2022).

This section will set out the financial context for the three-year period including key challenges and plans for transformational change; and will set out our planned budgeting framework.

## 7. How we will measure success

Our performance reporting is fully aligned to the strategic priorities set out in this plan. In addition to regular performance reporting to our Performance and Audit Committee and Integration Joint Board, we publish Annual Performance Reports giving a retrospective look at the previous year's performance. These reports set out progress made to deliver our strategic priorities over the previous 12 months. We review our performance data against agreed local and national performance indicators, including:

- National Core Suite of Integration Indicators
- Ministerial Strategic Group (MSG), and
- Statutory Performance Indicators.

In addition to data, our performance reports draw on personal experiences, views and examples of service developments and approached to describe the improvement process and how improved outcomes are being achieved.