Renfrewshire
Health and Social Care Partnership

Strategic Plan
Consultation Draft

NHS Greater Glasgow and Clyde

Renfrewshire Council

This Plan is available at: www.renfrewshire.gov.uk/integration

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1. Introduction

1.1 This is the first Renfrewshire Strategic Plan for the delivery of health and social care services in Renfrewshire, produced by the Integration Joint Board under the terms of the Public Bodies (Joint Working) (Scotland) Act 2014. It describes how we will move towards delivering on our organisational vision - it therefore sets out the context, challenges, priorities and action plans for the new Health and Social care Partnership for the period 2016-2019.

1.2 Renfrewshire Council and NHS Greater Glasgow and Clyde have a positive and proven track record of effective joint working to improve outcomes for people who use health and social care services in Renfrewshire. Bringing adult Social Work and all former Community Health Partnership functions into a Health and Social Care Partnership (HSCP) is a further step in these joint working arrangements and places a renewed, clear focus on putting the people who use services at the heart of what we do and how we work.

1.3 Whilst the Strategic Plan builds on the successes and experience of the past, it also focuses on how we can further join and, where appropriate, integrate our services. People who need health and/or social care rarely need the help of a single specialist, team or service and we believe that improved joint working and, where sensible, integration, is vital to improving our services.

1.4 So, this Strategic Plan outlines the context in which our health and social care services operate; the needs we are seeking to respond to, the challenges we are managing and the importance of optimising the benefits of our new organisational arrangements - to change how we work, get services working effectively together and focusing our resources to deliver services that we know work well in order to respond to those in greatest need. It also examines the evidence for our strategic decisions, it uses this evidence to identify local priorities and shape our action plans.

1.5 Because of growing demand on our resources, we know that more of the same is often not an option. If we continue to deliver services only in their current form, the health and social care system will be unable to deliver the high quality services the people of Renfrewshire need. We therefore have to plan, commission and deliver services that are focused on the outcomes we must achieve and make the best use of the resources available. It is an established feature of both national and local policy that more joined up care, more self care, and targeted anticipatory and preventative approaches, must be prioritised and shape our planning if we are to manage the growing demands we face. Linked to this we must ensure a clear and consistent focus in our resource prioritisation on home and community based care reducing demands on hospital and other more specialist services where appropriate.

1.6 Other partners play a central role in creating an effective and person-centred health and social care system. We will continue to work together with family doctors (GPs), hospital services, our communities, the independent sector and the voluntary (or third) sector to progress and achieve our aims. We will also continue and develop our work with Community Planning partners (for example Development and Housing in the Council and Police Scotland) to influence the wider determinants of health to create a healthier Renfrewshire.

1.7 From this, the Strategic Plan sets out clear Care Group Action Plans. These plans will be further developed over the next year as we develop and establish our ways of working and learn how to better join up and integrate services. Priorities from these emerging plans are contained in Section 8 and are framed with clear actions and are linked to the relevant national outcomes we need to deliver on. The Care Group Action Plans also link to our HSCP Performance Framework which will drive regular reports to our IJB on the progress we are making. We will also ensure that we are planning and working in a way to ensure staff, service users, patients and partner organisations are engaged in what we do and how we work.

1.8 So, we trust this Strategic Plan provides a sound and clear basis for our new HSCP to begin its work. We have launched this for consultation knowing that it needs to adapt and mature over time and importantly, knowing that it will benefit from your feedback.

Cllr Iain McMillan
IJB Chairman

David Leese
Chief Officer

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

2. Executive Summary

The final plan will describe key priorities in an Executive Summary. These will be informed by the detail of the plan.

3. Renfrewshire – Our Profile

3.1 Renfrewshire is a diverse area of towns, villages and countryside covering 270 square kilometres and situated 7 miles west of Glasgow City. The area has excellent transport connections to the rest of Scotland and has a major airport. Scotland's largest business park is situated in Hillington, and key campuses of the University of the West of Scotland and West College Scotland are located in Paisley town centre.

3.2 Just over 170,000 people live in Renfrewshire. Over the next 20 years, the number of people aged 16-64 living in Renfrewshire is likely to fall and the number of children will remain broadly the same. A major change will be that the number of older people (over 65) will rise by 40%. 2.8% of Renfrewshire residents are members of an ethnic minority group.

3.3 Life expectancy in Renfrewshire is lower than the Scottish average.

	Males	% Change over 10 years	Female	% Change over 10 years
Renfrewshire	75.9	4.0	80.6	2.4
Scotland	77.1	3.4	81.1	2.1

There are significant variations within Renfrewshire, with male life expectancy in some areas being over 15 years lower than that in other more affluent areas.

3.4 We know that the inequalities gap in life expectancy (and in other outcomes) is influenced by the pattern of deprivation in Renfrewshire. Many of Renfrewshire's datazones are found in the three most deprived deciles, but a significant number are also found in decile 9. The most deprived datazone in Renfrewshire is in the intermediate zone of Paisley Ferguslie, and it is ranked 1 in Scotland. Renfrewshire's share of the 15% most deprived datazones has increased slightly from 4.2% in 2004 to 4.9% in 2012.

3.5 39% of the adult population of Renfrewshire are receiving treatment for at least one illness/condition e.g. high blood pressure, arthritis, asthma, diabetes, depression, coronary heart disease. This figure increases with age (17% for those aged 16-24 and 83% for those aged over 75) and in our more deprived areas.

3.6 The number of smokers (19% of the population), and those reporting exposure to second hand smoke (26% of the population) has fallen in 2014 from similar studies done in 2008 and 2011. Renfrewshire also shows improvements with fewer people reporting exceeding recommended alcohol limits and more meeting physical activity recommendations. However, around 1 in 2 are overweight or obese, with men in the 45-64 age range being the most likely to be overweight or obese (68% of the population). Where data is collected

at locality level, Renfrewshire consistently shows wide variations, reflecting the more general inequalities in the area. For example, alcohol related hospital discharges are over 25 times higher in Paisley North West than in Bishopton.

3.7 In Scotland, at least one person in four will experience a mental health problem at some point in their lives, and one in six has a mental health problem at any one time. This means that today in Renfrewshire, around 20,000 adults are experiencing a mental health problem. The recent Renfrewshire Health and Wellbeing Survey (2014) confirmed that 77% of people living in Renfrewshire were positive about their general health in a recent survey. This is an improvement from a similar study carried out in 2008. In general, satisfaction was lower among older people and in our more deprived areas.

3.8 In relation to Addictions, almost 2,800 15-64 year olds in Renfrewshire are estimated to be problem drug users. The rate of alcohol related hospital discharges in Renfrewshire has reduced slightly but remains 31% higher than the national average (981.8 per 100,000 population in 2014/15, against a national average of 671.7).

3.9 From the work of the Renfrewshire Tackling Poverty Commission, we know that there are real local challenges with poverty. In Renfrewshire, there are 30,121 children aged 0-15, 8,143 young people aged 16-19. More than 1 in 5 of our children are growing up in poverty. This ranges from 30% in Paisley North West to 13% in Bishopton, Bridge of Weir and Langbank. In Renfrewshire in 2014, 20.1% of the population reported difficulty in sometimes meeting fuel costs.

3.10 Carers in Renfrewshire are a valued and important contributor to healthcare provision. 12,868 people in Renfrewshire provide up to 50 hours of informal care per week and a further 4,576 people provide more than 50 hours of informal care per week. 10% of our population are carers in some form.

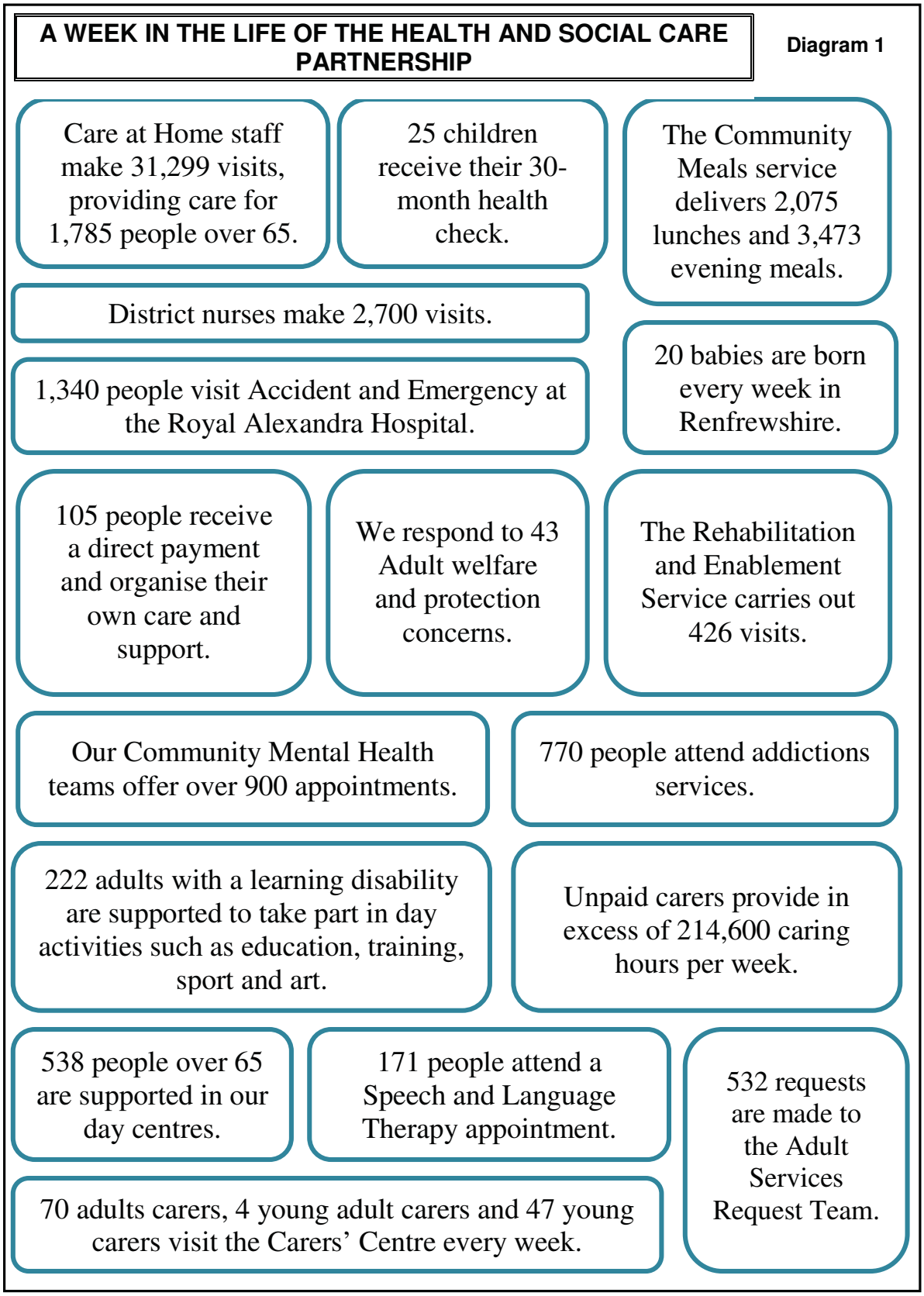
3.11 How individual and family circumstances are affected by such needs are difficult to describe but we know that our service and care responses when needed are vital to the care and support required – in our case study section of the Plan (see Appendix 1) we have attempted to describe a number of real life situations, all of which clearly show the need for highly effective and joined up community health and social care services.

3.12 We have a range of services in Renfrewshire that respond each day to the needs of local people. We have 29 GP practices, 44 community pharmacies, 19 community optometrists and 35 general dental practitioners. We also provide or commission a wide range of community based health and social care services and have a major acute hospital – the Royal Alexandra Hospital (RAH).

3.13 Also, the diagram below gives an indication of the level of activity carried out in a typical Renfrewshire HSCP week.

A WEEK IN THE LIFE OF THE HEALTH AND SOCIAL CARE PARTNERSHIP

Diagram 1



4. Renfrewshire – Our Demand and Demographic Challenges

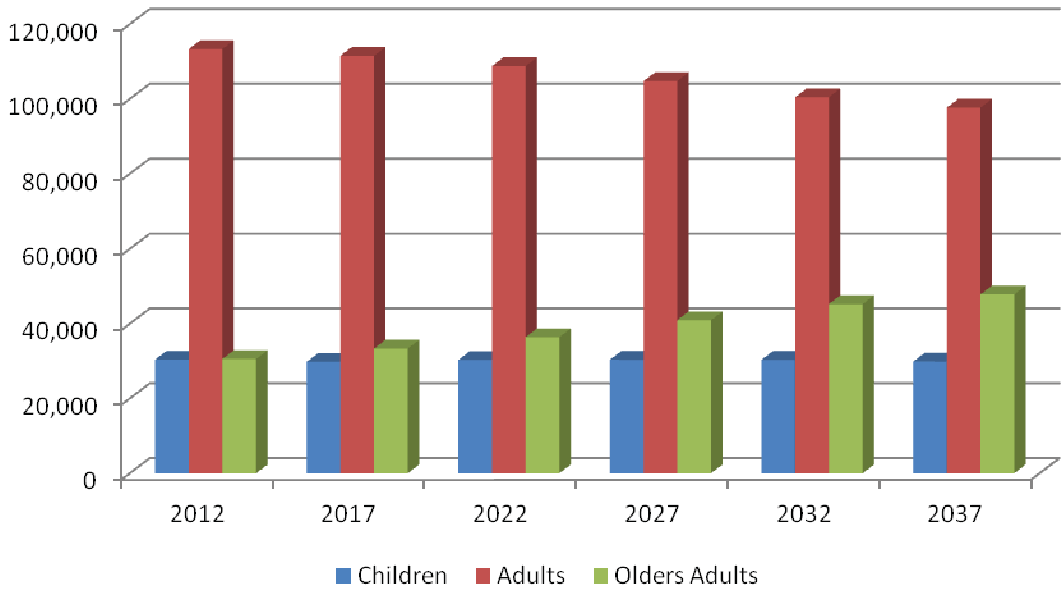
4.1 The profile, described in Section 3 above, presents a number of challenges for the services we manage. These are described in more detail below.

4.2 Older People

According to population projections published by National Records for Scotland, there will be almost 48,000 people in Renfrewshire aged 65 and over by 2037. This compares with 31,751 in 2014 and represents an increase of 51%. Over the same period, the number of people of working age is expected to fall by 13%, and the number of children will be almost unchanged over the same period.

Diagram 2

Projected population of Renfrewshire, 2012-2037



This change will have significant implications for health and social care, with demand increasing as a result of more people living into older age (when health and social care needs are likely to be more complex) whilst the number of people available to work in health and social care and/or provide unpaid care may decline.

Population projections also look at household composition. It is estimated that the number of people aged 65 and over and living alone will increase by 6% between 2015 and 2020, and by 36% between 2015 and 2035.

4.3 Learning Disabilities

In 2013, there were 819 adults with learning disabilities known to social care services in Renfrewshire. We know that:

- Over half (55%) are male;
- 65% are aged between 20 and 49.

Many people with a learning disability, particularly with a mild disability, will never come into contact with social care services and so this figure does not reflect the true number of people with learning disabilities in Renfrewshire.

- The prevalence of mental health conditions is much higher amongst people with learning disabilities than amongst the rest of the population. Diagnosable psychiatric disorders are typically present in 36% of children and young people with a learning disability, compared with a whole population rate of 8%.[1]

- People with learning disabilities are at greater risk of developing dementia than the rest of the population, and it tends to develop at a much younger age.

- There are a number of physical conditions which have been shown to be more common in people with learning disabilities than in other groups in the population. These include epilepsy, sensory impairment, respiratory disorder and coronary heart disease.

The age profile of current service users means that the next few years will see higher than usual numbers of people transferring from Children's Services to Adult Services.

Suitable accommodation to support people with learning disabilities or autism to live independently is limited. Supported accommodation, either in individual tenancies or in cluster flats, has proven to be effective but demand outstrips supply and mainstream housing is not always appropriate for this group of service users. Services providing day opportunities are running at near capacity. Resources may also be required in the future to support older people with learning disabilities and provide a specialist service.

4.4 Mental Health

It is estimated that 1 in 4 adults in the UK will experience a mental health disorder in the course of an average year and that 1 in 6 will experience one at any given time[2] . A person's mental health is not static; it may change over time in response to different life

[1] People with Learning Disabilities in England 2011 (Emerson et al)

[2] Singleton N, Bumpstead R, O'Brien M, Lee A, Meltzer H. Psychiatric Morbidity Among Adults Living In Private Households (2001)

stages and challenges. Using the 1 in 4 people estimation means that over 35,500 adults in Renfrewshire experience a mental health problem in an average year. In the 2011 Census, 5.2% of Renfrewshire's population (9,084 people) reported suffering a mental health problem. This suggests that almost three-quarters of people who may be experiencing mental health challenges either do not consider this a long-term condition or are reluctant to publicly acknowledge it.

The Scottish Public Health Observatory's profile of Renfrewshire states that 18.2% of Renfrewshire's population (30,580 people) were prescribed drugs for anxiety, depression or psychosis in 2013, against a Scottish average of 17.0%. The rate of hospitalisation for psychiatric conditions is 254.4 per 100,000 residents, which is below the Scottish figure of 291.6 per 100,000. Within Renfrewshire, there is a great deal of variation, with psychiatric admissions per 100,000 people ranging from 33.9 in Houston South to 514.7 in Paisley East.

The rate of deaths from suicide, which is strongly linked to mental health problems, is also higher than that of Scotland – 16.1 per 100,000 people, compared with 14.7 nationally. In some parts of Renfrewshire, it is considerably higher – 36.6 in Gallowhill and Hillington, and 53.3 in Paisley North West[3].

There is also a strong link between mental health problems such as depression and over-consumption of alcohol. In 2011, there were 1626 alcohol-related hospital discharges in Renfrewshire, which is a rate of 958.6 people per 10,000 of population[4]. This is significantly worse than the national rate of 748.6 people.

4.5 Physical Disability and Sensory Impairment

Disability may be defined as a physical or mental impairment that has a substantial and long term negative effect on the ability to do normal daily activities. The prevalence of disability is a direct measure of the level of need for services. Renfrewshire's prevalence of disability is shown below:

	Renfrewshire	Greater Glasgow and Clyde	Scotland
Visual Impairment	9.2%	9.6%	9.0%
Auditory Impairment	26.1%	26.3%	25.4%
Physical Disability	21.2%	22.7%	20.6%

[3] ScotPHO 2014 Health and Wellbeing profile- insert source

[4] age-sex standardised rate per 100,000 population to ESP2013

4.6 Addictions

Excessive alcohol consumption is a major risk factor for mental and physical ill health. 13.2% of Renfrewshire's adult population reported drinking in excess of recommended limits in a given week. In the year to June 2014, the rate of alcohol related hospital admissions in Renfrewshire was 10.8 per 100,000 population, slightly higher than the Greater Glasgow and Clyde rate of 10.4. The rate of drug related hospital discharges has increased by 22% since 2009/10 in Renfrewshire.

4.7 Unpaid Care

Informal or unpaid care represents an important form of health care provision. It is usually provided in the community by family members or friends.

The 2011 Census reported that 10% of people in Renfrewshire regularly provide unpaid care, with 3% providing more than 50 hours of unpaid care each week. Research published by Carers UK[5] suggested that unpaid carers save the UK government £119 billion every year by providing care that might otherwise be delivered by statutory services.

The Scottish Government is currently progressing legislation which gives local authorities new duties in relation to carer support. The legislation has a significant financial impact, as it requires additional resources for assessment and care planning, and waives the right of local authorities to charge for services which provide support to a carer.

4.8 Care at Home Service

Since 2011/12, the introduction of a reablement approach to Care at Home services has increased the number of people receiving a service and the number of hours of care provided. At present, in a typical week the service delivers around 15,500 hours of care to almost 1,800 people aged 65 and over. More than 200 of these service users will need two or more workers to attend to their needs.

Recruitment and retention of staff is a significant issue for Care at Home services. The care sector has traditionally had relatively low levels of pay and has struggled to attract and retain staff. Renfrewshire Council however actively supports payment of the living wage by its providers of care at home services to assist them in maintaining a stable workforce.

All community-based services report additional demand pressures arising from the success locally in reducing delayed discharges from hospital. Supporting prompt discharge often requires a package of community-based care and support to be available, and Care at

[5] Carers UK (2012) In Sickness and in Health

Home are consequently required to deliver service to a greater number of people. To date, there has been no direct resource transfer from the acute sector to the community sector to mitigate these pressures.

4.9 Residential and Nursing Homes

In the last two to three years, there has been an emerging over capacity in the local care home market. National and local policy has been focused on supporting people to remain in their own home as long as possible and consequently there has been a steady reduction in the number of care home placements in Renfrewshire. Demand for residential places is particularly low, since service developments now contribute to many more people being able to remain at home with complex care needs. As such, most people who require full-time bed based care have needs substantial enough to require nursing care. There are also growing numbers of people requiring specialist dementia care and an under-supply of this type of care in the local market.

4.10 Adult Protection

The volume of referrals to social work teams has steadily increased in each quarter of the last few years. The number of contacts in June 2015 was around 10% higher than 12 months previous. The staffing complement of the team has not increased in recent years and staff continue to manage increasing workloads.

The increasing workloads have included a significant rise in the number of adult protection concerns received. In July 2105, there were 149 Adult Welfare Concerns raised and 88 Adult Protection Concerns. Each of these requires initial investigation by frontline staff and many will progress further. Changes in the approach taken by Police Scotland means that, on a like for like basis, the annual volume of referrals rose from 1734 in 2013/14 to 2522 in 2014/15, an increase of 45%.

Adult services teams are generally completing between 250 and 300 assessments each month, but recent data indicates this is increasing, with 330+ per month becoming more usual.

4.11 Impact of Self-directed Support

The Social Care (Self-Directed Support) Act 2014 requires local authorities (and now the HSCP) to offer service users more choice and control over the package of care put in place to address their assessed needs. Included within this is the option for service users to choose who provides their service or to opt for a direct payment. More than half of service users who have completed the process to date have requested that the Council choose and

arrange their care for them but in the longer term it is expected that more people will want services not provided by the council or their framework providers. This could result in falling demand for services (including building-based services such as day centres) higher unit costs.

4.12 Supporting the Reduction in Delayed Discharges

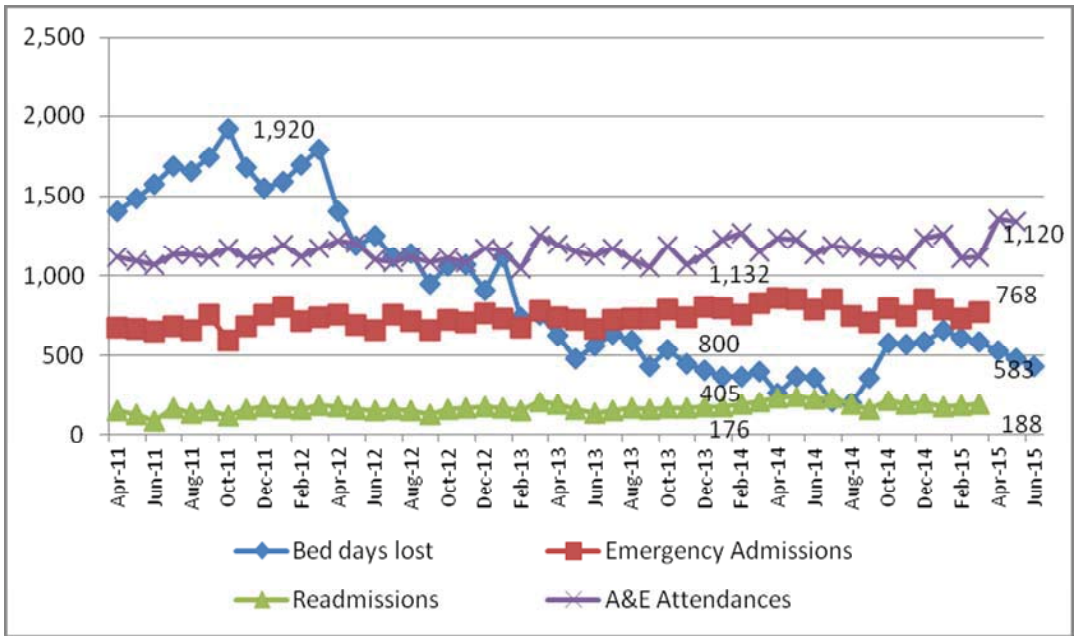
Renfrewshire has made significant progress in reducing hospital bed days lost due to delayed discharges (where a person is medically fit to leave hospital but services and supports are not in place to allow a safe discharge).

- The numbers of bed days lost per annum has reduced from 19,792 in 2011/12 to 5,835 in 2014/2015 – the equivalent of 38 beds.
- There is limited scope for further improvement since the majority of remaining delays are individuals subject to Adults with Incapacity legislation, meaning they cannot be moved until guardianships are established by the courts. This issue is considered separately below.

As noted above, supporting a reduction in delayed discharge has created additional demands in community based services, particularly care at home services. This has not seen a release of resource from the Acute hospital budgets as there has been no reduction in admissions or in attendances at Accident and Emergency (see Diagram 3 below). It is vital that we work effectively at this interface and where we can we agree how resources are used to best effect, and how more self care, anticipatory and preventative approaches can reduce demands on all services.

Diagram 3

Hospital Activity, April 2011 to June 2015



4.13 Adults with Incapacity

As noted earlier, the majority of delayed discharges are people impacted by Adults with Incapacity legislation, meaning decisions about their ongoing care cannot be made until the Courts appoint a guardian. There are also increasing numbers of people supported in the community who are subject to the same legislation. Where there is no appropriate person to act as guardian, the local authority can apply to Courts for the Chief Social Work Officer (CSWO) to be appointed as guardian. In these cases, the CSWO will delegate the day to day management to a Mental Health Officer (MHO). Renfrewshire Council has invested significantly in additional MHOs to support this work but the volume of work continues to grow. In 2014/15, the CSWO had responsibility for 89 guardianships, up from 70 in 2013/14 and 47 in 2012/13. There has been a 91% increase in such guardianships in Renfrewshire since 2002.

In addition to increasing volumes, this area of work is subject to complex and lengthy legal processes which impact on workloads. It is highly specialised work that requires an MHO to undertake.

5. Renfrewshire – Our Planning and Delivery Context

5.1 This Strategic Plan begins our journey to developing more joint and integrated services and marks a key milestone in our progress towards achieving the Scottish Government's 2020 Vision.

That vision is clear on what we must work to achieve - namely that everyone is able to live longer, healthier lives at home or at a homely setting we will have a health and social care system where:

- We have integrated health and social care.
- There is a focus on prevention, anticipation and supported self management.
- If hospital treatment is required, and cannot be provided in the community setting, day care treatment will be the norm.
- Whatever the setting, care will be provided to the highest standard of quality and safety with the person at the centre of all decisions.
- There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate with minimal risk of re-admission.

5.2 In pursuit of this vision we must ensure we deliver on the agreed 9 national health and social care outcomes. These are set out below:

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

5.3 In working to deliver on the 2020 Vision and to make real progress to deliver on the 9 outcomes we need to recognise and plan based upon a number of demands and drivers.

<u>Increasing Demand</u>

- Many of our services are facing year on year increases in demand.
- Many of the growing demands are characterised by complexity, vulnerability and the need to provide support to people in their own homes and communities at the earliest possible point.
- Further evidence of increasing demand is set out in section 5. Given this and the national 2020 Vision and health and social care outcomes we are working to deliver, it is important that investment in community based health and social care services is sustained in real terms and ideally increased. This presents a real challenge when set in the context of reducing budgets and increasing levels of demands for services.

<u>Improving Quality</u>

- There must continue to be a clear focus on the quality of services we provide and

the evidence upon which we plan, design and deliver our services. We therefore need to focus our resources on what works in order to deliver high quality care and high quality outcomes.

Utilising Resources

- We need to prioritise how we use our resources. This may mean that we need to target our spend more effectively into what we know to work in order to support those with greatest need.
- We also need to make further progress to optimise how our health and social care staff work. We are in the very early stages of developing a health and social care organisational development and workforce strategy and also exploring how to further develop staff and our teams to work together to generate real benefits from effective joint working.
- We must continue to develop a system wide, joined up, multi-disciplinary team and service working approach to best address the needs of the local population. We need therefore to be working smartly with Community planning partners in Renfrewshire, with local GPs and other community based service providers and with other HSCPs and Acute Hospital services across NHS GG&C.

Planning in Localities

- We must continue to develop our approach to how we plan based on localities within our HSCP. At this point most of our services are delivered within the two geographical areas (or localities) that are well known – Paisley and West Renfrewshire.
- In 2016/17 we will work to build a dialogue within 'clusters' or 'sub localities' across Renfrewshire and through this test how our services can work better together with local GPs and others.
- Through this we will also develop a clearer view of the geographical/locality planning required for Paisley and West Renfrewshire. Our focus is to develop our approach to locality planning and to make local joint working central to what we do over the next three years. It is vital that we nurture and develop this approach as it is through better local multi disciplinary team and service working that we believe real improvements in care for service users and patients will be secured.

Partnership Working

- How our services work with others is vital and we must further develop effective interfaces which are defined by true collaboration, mature relationships and a shared understanding, ownership and agreement of the challenges we face and shared agreement on the ways forward.
- A key interface will be how we work with Acute Hospital Services – particularly with

the RAH which provides the majority of Acute care for our Renfrewshire population.

- How we work with other Council services, particularly Children's Services is also key. There is a very positive track record of joint working and this will be built upon as we develop more effective preventative and evidence based approaches to support children and families.
- General Practice is central to highly effective, joined up health and social care. As the new GP contract comes into operation from April 2016, we must renew how our staff and teams work with GPs and the wider primary care based professionals, to optimise benefits to patients and service users. The Royal College of General Practice (RCGP) Strategy for safe, secure and strong general practice in Scotland provides a helpful framework for this.
- It is also important that Renfrewshire HSCP continues to be a dynamic partner with the 5 other HSCPs across the NHS Greater Glasgow and Clyde area. Working collaboratively with other HSCPs is central to effective whole system working – and this is essential if we are to optimise how we plan, learn and deliver best practice and the highest quality, most effective services.

Equalities Focus

- Our services must also take into account diverse groups of service users irrespective of race, age, gender, sexual orientation, disability, religion, marital status, gender reassignment and/or pregnancy/maternity.

- In April 2015 the Scottish Government added Integration Joint Boards (IJBs) to the Equality Act 2010 (Specific Duties) (Scotland) Amendment Regulations 2015. This places a duty on our IJB to consult on how the policies and decisions made affect the people who are protected under the Equality Act. This amendment requires our IJB to publish a set of equality outcomes and a report on progress it has made to mainstream the equality duty by the 30 April 2016.

- We will produce a set of equality outcomes and a mainstreaming report to meet the requirements of the legislation. We will consult with a variety of stakeholders to identify equality issues and develop our equality outcomes to complement the priority themes and care group action plans indicated in our Strategic Plan. In order to meet our equality outcomes we will produce a set of actions and indicators to ensure that our performance is transparent to all our service users and other stakeholders.

- We will also ensure new or revised policies, strategies and services are equality

impact assessed to identify any unmet needs, and to provide a basis for action to improve services where appropriate. It is also an important tool in our overall endeavours to improve effectiveness and efficiency in responding to health inequalities and improving health. An equality impact assessment has been undertaken for this Plan.

- To measure our performance we will publish our equality outcomes and information in an accessible format for the public, to show that we have complied with the Equality legislation.

6. Our Resources

6.1 Context

As set out earlier, this Strategic Plan provides the framework for the development of health and care services over the next few years and lays the foundation for us to work with partners in developing a focused approach to delivering on our priorities. In order to do this we need an agreed, clear financial framework which will support the delivery of the Plan and its associated programmes within the agreed resources available.

The functions delegated from Renfrewshire Council to the Integration Joint Board represent all Adult Social Care functions of the Council, along with the budget for these functions. In addition the Council must also delegate Housing Adaptations and Gardening Assistance budgets to the IJB. A similar range of health functions, along with the budget for these, are delegated to the Integration Joint Board by NHS Greater Glasgow and Clyde.

6.2 Budget Pressures

Renfrewshire, in common with all other HSCP areas throughout Scotland, has faced significant financial challenges in recent years, with further pressures anticipated in future years. The overall picture is one of reducing resources and increasing demands in delivering the delegated functions above. The key issues for us are:

- Reducing levels of funding from Scottish Government to parent organisation over recent years and this trend is expected to continue to 2020.
- The real effects on services of the demographic changes outlined earlier- mainly as a result of an ageing population.
- Health inequalities with large differences in life expectancy between affluent and more deprived areas, and higher than average rates of hospitalisation for a number of chronic conditions, particularly those linked to unhealthy lifestyles such as smoking, excessive alcohol consumption and drug misuse.
- We continue to face increasing costs of medications and purchased care services.
- An ageing population with a corresponding increase in co-morbidities and individuals with complex needs.
- Increasing rates of dementia.
- Increases in hospital admissions, bed days and delayed discharges.
- Increased demand for equipment and adaptations to support independent living.
- Increases in National Insurance contributions for employers.

- The increasing minimum wage and move to a living wage, leading to increased employer costs and requests for uplifts from contractors.
- Superannuation increases and the impacts of automatic pension enrolment.

NHS Greater Glasgow and Clyde is reporting significant financial challenges, particularly driven by demands on Acute hospital services along with further cost pressures pension and other pay pressures. Renfrewshire Council is facing similar pressures of demand and staff costs. In December 2015, Audit Scotland published a national report highlighting financial risks being faced by the NHS in Scotland and the consequential need for the Scottish Government and the NHS to accelerate the delivery of change and modernisation as a key response to mitigating the impact brought about by cost pressures.

6.3 Meeting the Financial Challenges Ahead

Current service provision is not sufficient to meet the future health and social care needs of the population, with the predicted rise in long term conditions and health problems associated with an ageing population. We must therefore embed new ways of working and seek to focus resources away from expensive bed based models of care into community based services. We need to critically appraise and challenge our current models of service delivery to ensure our combined resources are focused on areas of greatest need delivering the best outcomes to our service users and patient.

Over recent years, the Council's Social Work services has managed a number of demographic and financial pressures through a range of demand and cost mitigation measures in order to minimise the level of additional investment by the Council going forward. The strategy for the HSCP will adopt this approach, building on ongoing proactive work within the partnership with a focus on shifting the balance of care to community based settings.

Building on what has been set out earlier in this Plan our focus will be on:

- Linking with the 'Better Council' efficiency programme we will develop more efficient methods of service delivery focusing on outcomes and needs of patients and service users.
- Developing models of service and ways of working that support people to live longer in their own homes and communities, with less reliance on hospital and residential care.
- Continue our programme of reducing delayed discharges.
- Developing service models which are focussed on prevention and early intervention promoting community based support over residential settings.

Service reviews prioritised for the next two years reflect the national policy direction to shift the balance of care and promote independent living and person centred care. This will ensure that service users can live as independently as possible in their own homes and communities for as long as possible. Key areas proposed include reviewing:

- The approach to the way we deliver and commission care at home services to ensure that services provided are modern, flexible and efficient.
- Care home provision - in light of the changing needs of current residents and the local population with increased demand for specialist nursing and dementia placements.
- Occupational Therapy services and provision of equipment and adaptations.
- Self Directed Support.
- Embedding the requirements of the new Carer's legislation.

6.4 **Budgets**

The total financial resource available to the partnership for 2016/17 has not yet been finalised. The 2015/16 budget is summarised below.

	£m
Social Work Net Expenditure	55.5
Health Net Expenditure	147.6
	203.1

The Acute set aside budget and an allocation from housing services will be added.

The final strategic plan will give an updated budget position for 2016/17 and show an analysis of this by care group.

7. Our Strategic Priorities

7.1 This section of the Strategic Plan describes the themes and high level priorities which will direct the HSCP over the next three years. Detailed action plans by care groups, informed by previous plans and consultations will be updated and finalised by March 2016 (see Section 8). In summary our strategic priorities are set out in the following.

7.2 **Improving Health and Wellbeing**

Prevention, Anticipatory Care and Early Intervention

- We will support and advise people to take greater control of their own health and wellbeing so they maintain their independence and improve self care wherever possible.
- We will develop systems to identify people at risk of inappropriate hospital admission, and to provide them with the necessary support to remain in their own community safely for as long as possible.
- We will focus on improving Anticipatory Care planning.
- We will support the wellbeing of children and young people and provide parenting support to families.
- We will drive up the uptake of the 30-month assessment and use the information from this to maximise readiness for school and support parents.
- We are progressing toward full implementation of Getting It Right For Every Child (GIRFEC) by August 2016 to improve early identification of need.

Active Participation in Community Life

- We will enable people to become better connected with each other and encourage co-operation, mutual support and caring within their communities.
- We will continue to support and signpost patients and clients into employment services to allow them to meaningfully contribute to their community.
- We will support them to prosper by improving their financial wellbeing and ensuring there is access to appropriate financial services and support.
- We will work with third sector partners to build community capacity and to increase the local opportunities available to our population.

Addressing Inequalities

- We will target our interventions and resources to narrow inequalities and to build strong resilient communities.
- We will carry out Equalities Impact Assessments (EQIAs) on new policies and

services to remove barriers which prevent people from leading healthy independent lives.

Support and Protection

- We will work to deliver on our statutory duty to protect and support adults at risk of harm.
- Harm can be physical, sexual, emotional or financial or it can be neglect. It can also take the form of forced marriage, radicalisation or gender based violence, or can be related to harmful behaviours. It can be intentional or unintentional.
- We will continue to build on our progress to date to ensure services work to protect children. We will continue to work closely with the Council's Children's Services Directorate and with others to develop our child protection services and keep Renfrewshire's children safe.

7.3 **The Right Service, at the Right Time, in the Right Place**

Pathways through and between Services

- We will build on the local work to test new pathways between primary, secondary and community based services through the Renfrewshire Development Programme. This learning will be used to make more permanent improvements.
- For those with dementia, post diagnostic support is available and, in learning disabilities, the transition into adult services is being improved.

Appropriate Accommodation Options to Support Independent Living

- Our 10 year plan for older people services highlights the need to respond to the rising demand for smaller properties and for homes which are fully accessible. The HSCP offers the opportunity to work in partnership to influence Renfrewshire's local Housing Strategy. We will continue to improve services and systems for those who are homeless or at risk of homelessness.

Managing Long-term Conditions

- We will take the opportunities offered by emerging technology to support people to manage their own long term conditions.
- We will also focus on self management and partnership with specialist services.

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

Personalisation and Choice

- Self directed support offers people the opportunity to have greater choice and

control in the care they receive. We will continue to use the Patient Experience process and other patient feedback systems to improve services and respond to issues raised by the people who use our services.

- We will continue to adapt and improve how our services work by learning from all forms of patient and service users feedback and from significant events and incidence

Support for Carers

- Carers are key partners in contributing to many of the priorities above. We will progress the issues raised by local carers: accessing advocacy, providing information and advice and involving them in service planning.
- We will also help support the health and wellbeing of carers to allow them to continue to provide this crucial care.

8. Our Action Plans

Progress against these action plans will form the basis of our performance management arrangements and regular reports will be taken to the IJB.

1. Population Health and Wellbeing				
	Action	**Indicator**	**16/17 Target**	**National Outcome**
1.1	Support a defined number of people from the 40% most deprived areas to quit smoking for 12 weeks.	Smoking cessation - non smokers at the 3 month follow up in the 40% most deprived areas	171	5
1.2	Meet national targets for cancer screening for breast, bowel and cervical.	% uptake of breast screening % uptake of bowel screening % uptake of cervical screening (age 21-60 years)	70% 60% 80%	1
1.3	Work with partners to develop a range of physical activity options to reduce barriers to access and target less active people.	Identify and test programmes for people with mental health problems. Plan a physical activity programme for older people as a legacy.	Complete by March 2017. Complete by March 2017.	5
1.4	Test a social prescribing model in three practices.	Number of community champions recruited. Number of holistic needs assessments carried out. Number of people seen at community hub.	10 60 100	1
1.5	Implement health and homelessness standards, and actions from previous homeless service users' consultation.	Self-evaluation of the Health and Homelessness Action Plan (HHAP) showing evaluation ratings.	12 very good; 7 good Achieved 14/15	5
1.6	Increase referrals to financial inclusion and employability services.	Number of financial inclusion workshops delivered. Number of attendees	4 48	5

1. Population Health and Wellbeing			
Action	**Indicator**	**16/17 Target**	**National Outcome**
	Number of employability workshops delivered. Number of attendees Number of Healthier Wealthier Children (HWC) referrals and financial gains. HWC financial gains Increase uptake of Healthy Start	4 48 400 £700,000 Establish local baselines	
1.7 Implement a sexual health policy (with partners) for looked after and accommodated children.	Policy agreed and finalised. LAAC staff to be invited to all sexual health training. Specific LAAC training package to be offered.	Policy disseminated by June 2016. A training calendar will be available to all LAAC workers/carers by June 2016. Train 20 LAAC workers around sexual health and wellbeing.	5
1.8 Reduce unintended pregnancies for those over 20 years of age.	No. of unintended pregnancies for those over 20 years of age:	30	4
1.9 Lead the health and wellbeing actions from the Tackling Poverty Report, in particular establishing a school counselling service and a peer mentoring service across all Renfrewshire secondary schools.	Procure and oversee implementation of school counselling service. Agree individual models of peer mentoring with all schools. Establish target activity levels	April 2016 May 2016 June 2016	5

1. Population Health and Wellbeing			
Action	**Indicator**	**16/17 Target**	**National Outcome**
	for both initiatives.		
1.10 Raise awareness of mental health issues among the general population.	Understanding Mental Health: - attendees Scottish Mental Health first aid training for young people: - sessions - attendees	200 4 12	1
1.12 Develop and monitor Eat Better Feel Better (EBFB) work.	Number of Renfrewshire EBFB Network meetings. Number of EBFB interventions delivered. Number of individuals/organisations trained to deliver cookery skills courses.	4 per year 50 8	1

2. Child and Maternal Health			
Action	**Indicator**	**16/17 Target**	**National Outcome**
2.1 Continue to implement Family Nurse Partnership, as we move into year 2.	% full terms and low birth weight infants. Breastfeeding at 6 weeks infancy, at all and exclusive % clients reporting tobacco use in last 48 hours at 36 weeks gestation	5% 10% 25%	5
2.2 Increase uptake of the 30 month check and share information appropriately to maximise readiness for schools.	Percentage of children receiving 30 month check. Establish a meaningful baseline and target from referrals to parenting programmes and speech and language therapy.	85% March 2017	4
2.3 Work in partnership to support more women to breastfeed and to focus on women from more deprived areas.	% exclusive breastfeeding in 15% most deprived areas. Exclusive breastfeeding at 6-8 weeks.	20.9% (15/16) 21.4% (15/16)	5
2.4 Develop sustainable services for children who are overweight.	Number of child health weight interventions delivered.	New Mum, New You: 36 Mini Active 2-4 : 24 Children 5-16: 24	1
2.5 Continue to support a population based model of parenting programmes.	No. of staff trained in Solihull: Number of attendees at Triple P seminars (Level 2). Number of interventions at levels 3 and 4.	90% 140 200	1

2. Child and Maternal Health			
Action	**Indicator**	**16/17 Target**	**National Outcome**
2.6 Deliver Autism Spectrum Disorder waiting times target	Referral to assessment time.	18 weeks	3
2.7 Deliver CAMHS referral to treatment waiting times HEAT target.	Referral to treatment time.	12 weeks	3
2.8 Reduce speech and language therapy waiting times in community paediatrics.	Percentage of paediatric Speech & Language Therapy wait times triaged within 8 weeks Number waiting more than 18 weeks for paediatric Speech & Language Therapy assessment to appointment	100% 0	3 3
2.9 Implement recommendations from multi-disciplinary Inspection Report	Action Plan developed	May 2016	7
2.10 Reduce conceptions in young people under 20 years old.	Teenage pregnancies (15-19) at conception (crude rate/1000).	35	1
2.11 Support improvements in sexual health and relationships education in schools and community settings.	Use of sexual health DVD in schools Support schools for children with ASN (additional support needs) Training for school staff (local and NHS Board)	All 8 non denominational schools to evidence use. All ASN schools to receive copies of 'All About Us' DVD and offer of training. Direct training to 100 young people. 60 staff.	5

2. Child and Maternal Health			
Action	**Indicator**	**16/17 Target**	**National Outcome**
	Awareness sessions/training in school and other settings.	400 young people reached in school assemblies. 50 young people in community settings reached. Support 2 Freshers' Week events	
2.12 The commencement of health assessments for all children looked after at home and in kinship care.	% of health assessments carried out for all new referrals from April 2016.	80% of all new referrals will have received a health check by March 2017.	5
2.13 Work with partners in schools and Oral Health Directorate to improve child oral health in Renfrewshire.	Dental registration: 0-2 years: 3-5 years: Dental decay: Primary 1 Primary 7	 60% 86% 60% 60%	4
2.14 To ensure the establishment of a named person service for pre school children residing in Renfrewshire from August 2016. To ensure agreed process for receipt of information related to wellbeing concerns by named person.	All pre school children are allocated a named person. System is implemented for named person to receive information regarding well being concerns.	100% of preschool children are allocated a named person. August 2016.	7

3. Primary Care & Long Term Conditions			
Action	**Indicator**	**16/17 Target**	**National Outcome**
3.1 Support GPs to implement and improve Anticipatory Care planning across Renfrewshire.	Number of nursing home residents who have an anticipatory care plan	95%	3
3.2 Support Primary Care staff to deliver target number of Alcohol Brief Interventions.	Number of Brief Interventions cumulative by year	1,116	5
3.3 Address barriers to effective GP contributions to child protection case conferences.	GP reports received on time for Case Protection conferences.	90%	7
3.4 Work with GPs in clusters to pilot improved ways of working with community and social care staff.	Identification of practice clusters and key issues to be taken forward.	2 practices identified by April 2016. 6-monthly progress report	4
3.5 Develop the use of Practice Activity Reports and other data to support primary care.	Dissemination of PAR reports and production of Exception Report.	2 per year	4
3.6 Establish a single route into web based information about long term conditions.	Number of patients signed up to My Diabetes My Way Revised A-Z directory under development	Baseline to be established in Year 1. December 2016	2
3.7 Improve pathways between primary and secondary care for those with diabetes.	The implementation of a new referral system for Type 1 and 2 diabetics to the Royal Alexandra Hospital (RAH) diabetes clinic. Reduced HbA1c levels for Type 1 diabetics attending RAH Number of patients attending Conversation Maps.	June 2016 Baseline to be established in Year 1. Baseline to be established in Year 1.	4

3. Primary Care & Long Term Conditions			
Action	**Indicator**	**16/17 Target**	**National Outcome**
3.8 Support the respiratory early supported discharge initiative.	Number of patients supported.	32	2
3.9 Implement home health monitoring through the Tec Programme in partnership with East Renfrewshire HSCP.	Number of people receiving home health monitoring.	350	2

4. Older People			
Action	**Indicator**	**16/17 Target**	**National Outcome**
4.1 Increase the number of people benefiting from the Community Falls pathway. Reduce the number of falls using the Smartcare online tools in with neighbouring Health and Social Care Partnerships and Health Boards.	Number of recorded Level 1 falls screenings completed in Renfrewshire. Number of recorded Level 2 multi-factorial falls assessments completed in Renfrewshire. Number of people evaluated as part of the Smartcare Project.	50 screenings per month completed by March 2017 50 assessments per month completed by March 2017 60	2
4.2 Evidence the provision of 12 months post diagnostic support for people with dementia.	People newly diagnosed with dementia will have a minimum of 1 year's post-diagnostic support (female & male)	100%	2
4.3 Support nursing homes through the LES and liaison nurses to prevent inappropriate hospital admissions.	Emergency admissions from care homes	480	2
4.4 Maintain target levels of lost bed days.	Number of acute bed days lost to delayed discharges (inc AWI)	8,104	2
4.5 Reduce number of bed days lost due to AWI	Number of acute bed days lost to delayed discharges for Adults with Incapacity.	1,064	2
4.6 Increase the uptake of flu vaccinations in the over 65 age group.	% uptake of vaccinations in 65+ age group	78%	2
4.7 Promote the uptake of Power of Attorney.	Number of responses to Power of Attorney question within SSA. Continue to promote the uptake and use of Power of Attorney across all services within RHSCP to assist with anticipatory care planning and ongoing care management.	100 responses per month by March 2017. 15% increase in registration	3

5. Learning Disabilities			
Action	**Indicator**	**16/17 Target**	**National Outcome**
5.1 Deliver agreed number of health checks to clients with learning disabilities.	Number of health checks.	40	4
5.2 Improve oral health in this population.	Number of oral health checks.	30	4
5.3 Relaunch Renfrewshire Autism Strategy.	Action plan developed and monitored.	September 2016	4
5.4 Work with the housing and care providers and service users/carers to review the existing service model for adults with learning disabilities and identify options for redesign.	Sufficient supply of housing to meet the needs of the local population, including input to local Housing Strategy.	March 2019	2

6. Physical Disabilities			
Action	**Indicator**	**16/17 Target**	**National Outcome**
6.1 Develop and implement joint commissioning plan for adults with a physical disability or sensory impairment.	Produce Joint Commissioning Plan	March 2017	4
6.2 Service improvements around rehabilitation services.	Revised Occupational Therapy pathways. Reduced waiting times. Personal assets approach.	March 2017 Urgent – 3 working days Priority – 5 working days Routine – 9 weeks March 2017	4
6.3 Implementation of See Hear Sensory Impairment Strategy	Full implementation and recommendations from the Strategy taken forward.	March 2017	4
6.4 Implementation of Right To Speak Strategy, for the provision of communication equipment for people with physical disabilities and communication impairments.	Local implementation of Strategy recommendations. Clear protocols, pathways and criteria established for support and provision of communication equipment	March 2017 March 2017	4
6.5 Implementation of Allied Health Professionals delivery programme	Renfrewshire AHP services are developed and sustained in line with the national objectives.	March 2017	4
6.6 Work with the housing and care providers and service users/carers to review the existing service model for adults with physical disabilities and identify options for redesign.	Sufficient supply of housing to meet the needs of the local population, including input to local Housing Strategy.	March 2019	2

7. Mental Health			
Action	**Indicator**	**16/17 Target**	**National Outcome**
7.1 Ongoing review of clinical pathways in community mental health to continue to provide access to psychological therapies within the agreed standard.	Percentage of patients who started treatment within 18 weeks of referral to Psychological Therapies	90%	3
7.2 Deliver waiting time targets for primary mental health services, ensuring equality of access for all (age, sex, SIMD).	Percentage of Primary Care Mental Health Team patients referred to first appointment offered within 4 weeks Percentage of patients referred to first treatment appointment offered within 9 weeks	100% 90%	3
7.3 Deliver suicide awareness training to front line staff and implement suicide prevention policy for schools, with Children's Services.	Maintain level of 50% of staff trained.	23	7
7.4 Demonstrate changed practice in mental health inpatient and community to reduce average lengths of stay and the requirement for out of area boarding of patients.	Achieve recommended target for bed occupancy rates for Renfrewshire patients in all acute wards. All patients with length of stay over 3 months will receive Multi Disciplinary Team complex care review.	95% occupancy 100%	3
7.5 Support people in mental health and addictions services to access employment opportunities.	Total referrals: Addiction referrals: Mental health referrals:	310 110 200	5
7.6 Demonstrate changed practice in inpatient and community services as a result of listening to patient feedback e.g. Charleston Centre upgrade.	Evidence change in practice from patient conversations.	3 sessions per year	3

8. Drugs and Alcohol			
Action	**Indicator**	**16/17 Target**	**National Outcome**
8.1 Influence the availability of alcohol through partnership working with the Licensing Forum, ADP and local communities.	Number of community representatives influencing licensing decisions. Develop Joint Alcohol Policy Statement and organise Launch Event.	100 June 2017	1
8.2 Reduce harm caused by misuse of drugs and alcohol.	Alcohol related hospital stays. Drug related hospital stays. Naloxone units issued. Drug related deaths. Alcohol related deaths.	9.0 1.35 30% coverage of problem drug users. 13.0 per 100,000 population 27.5 per 100,000 population	7
8.3 Deliver Alcohol Brief Interventions in primary care and in wider settings.	Number of Brief Interventions (primary care) (older people)	1,116 40 staff trained Establish baseline	7
8.4 Maintain standard of access to services to ensure it continues to meet national waiting times targets.	% seen within 3 weeks	91.5%	3
8.5 Evidence user involvement in the development and monitoring of services.	Completion of client satisfaction surveys within all drug and alcohol services: Renfrewshire Drug Service Integrated Alcohol Team Alcohol Problems Clinic	 60 30 80	3

8. Drugs and Alcohol			
Action	**Indicator**	**16/17 Target**	**National Outcome**
	Evidence of service change	One example from each service implemented as part of You Said – We Did.	
8.6 Continue to monitor the use of the STAR Outcomes tool across drug and alcohol services.	Maintain % of individuals showing positive change across key dimensions: Drug use Alcohol use Emotional health Use of time	 40% 40% 40% 40%	4
8.7 Implement Quality Principles in core drug and alcohol services.	Number of services that have implemented/evidenced Quality Principles	6	4

9. Carers			
Action	**Indicator**	**16/17 Target**	**National Outcome**
9.1 Prepare for implementation of the new Carers' Act.	Action plan completed.	May 2016	6
9.2 Involve carers, local carer organisations, and other Third Sector organisations, as appropriate in the planning and shaping of services and support.	Evidence of involvement.	March 2017	6
9.3 Support carers to continue in their caring role	% from annual survey	87%	6
9.4 Support carers to access training opportunities relevant to their caring role	Number of carers accessing training programmes.	230	6
9.5 Increase the uptake of Carers' Assessments,	Number of self-assessments issued to carers.	150	6
9.6 Support young adult carers in the transition from young carer to young adult carer	Pathway established.	March 2017	6

10. Cross-cutting All Care Groups			
Action	**Indicator**	**16/17 Target**	**National Outcome**
10.1 Maintain or improve the number of registered services assessed as 'Good' or above by the Care Inspectorate	% of registered services assessed as Good, Very Good or Excellent	All registered services	4
10.2 Implement new guidance in relation to adult protection procedures.	Guidance produced and operational. % of MHOs trained	March 2017 100%	7
10.3 Continue to deliver services which support a shift in the balance of care towards community-based services.	% of service users with high needs (>£10k per annum) support at home. Move the balance of spend from residential/nursing to Care at Home	Baseline and target to be established Baseline and target to be established	2
10.4 Improve transition planning for service users moving between services or care groups.	Integrated pathways for transition developed for all areas of service.	March 2017	3
10.5 Develop joint strategic commissioning plans for main care groups.	Plans produced.	December 2017	9
10.6 Embed self-directed support model in locality teams.	Locality managers assume day to day management responsibility for budget monitoring and care planning for service users eligible for SDS.	June 2016	8
10.7 Implement a scheduling system within Care at Home services.	System operational.	March 17	9

11. Effective Organisation			
Action	**Indicator**	**16/17 Target**	**National Outcome**
11.1 Develop a Workforce Plan linked to the strategic priorities of the HSCP and the parent organisations.	Implementation of Workforce Plan.	March 2017	8
11.2 Implement new team structures to support increased workloads in relation to adult support and protection.	Teams established and operational.	December 2016	7

12. Hosted Services			
Primary Care Support			
Action	**Indicator**	**16/17 Target**	**National Outcome**
12.1 Support practices into new contracting arrangements for April 2016 onwards, testing new ways of working in Inverclyde and learning from 17c practices.	Ongoing with indicator under development.	Under development.	8
12.2 Develop the role of practice nurses to support emerging priorities of shifting the balance of care and supporting people to live longer in their own home.	Ongoing with indicator under development.	Under development.	8
12.3 Improve resilience planning, identifying and working with practices which need support.	Ongoing with indicator under development.	Under development.	8
Podiatry			
12.4 Improved access to podiatry services for new patients.	% of new referrals appointed within 4 weeks.	90%	3
12.5 Priority diabetic patients with active foot disease seen urgently.	% of diabetic active foot disease seen by member of Multi Disciplinary Team within 48 hours.	95%	4

1. Case Studies

What this plan means for Alice...

Alice is 78 and lives alone. Her son visits as often as he can and phones every day but he lives a few hundred miles away. She's starting to have some mobility problems and sometimes forgets things. Today she fell and broke her wrist, which means she can't manage by herself at home just now. The hospital doctor wants to admit her overnight and her son thinks the fall means she will have to move into a residential home.

With close partnership working, health and social care services are able to offer an alternative pathway which will allow Alice to recover from her injury and continue to live at home, safely, with the appropriate support to meet her needs:

- After hospital treatment and monitoring, hospital staff contact Rehabilitation and Enablement Services (RES) to get Alice home and settled for the night.
- Care at home reablement services are in place the following day. This service supports Alice with personal care and mobility, and reminds her to take her medication.
- Alice is referred to the falls management team and her GP is notified of these details. The GP refers Alice to the Memory Clinic.
- After 6 weeks of reablement, Alice's wrist has healed and she is more confident when using the stairs. Handrails have been fitted in her bathroom and she has a community alarm.

On an ongoing basis, Alice is transferred to the long-term care at home service, to support her with her medication. She is also referred to Food Train, which means that she will be able to get a weekly shop delivered to her home and she has the reassurance of knowing a volunteer will call in twice a week.

The improvement in her mobility and confidence encourages her to start going out again and her confidence is increasing. She also attends a local day centre 1 day a week. Her home has been adapted to be more suitable to her needs.

All the people who need to know about Alice's case can share information, so Alice doesn't have to keep answering the same questions. Additionally, health and social care staff have access to a directory of community groups which might interest Alice and get her out and about in her community again.

What this plan means for Becky...

Becky is a young woman who has an enduring mental health condition and is currently an in-patient in Dykebar Hospital. Nursing staff at Dykebar have supported Becky to manage her mental health condition and occupational therapy staff have supported her in community involvement. The occupational therapy staff have also supported Becky in maintaining a structured and productive weekly schedule, and social work staff are considering an application for supported accommodation.

Becky has a say in what is in her care plan and what we can provide to meet her needs.

Partnership working between health and social care services will provide:

- Services that are focused on early intervention so that Becky can get support before things reach crisis point.
- Advice, support and services to help Becky live as independently and safely as possible
- Access to tools to help Becky manage her own condition.
- A multi disciplinary team with shared information about the case so that different types of support can join up.

Our services, and our partners, will work together to keep you safe from harm and you will have a say in what's in your care plan. Our services will talk to each other so that you don't have to repeat the same information to different people and so that your journey through our services or between services is as simple as possible.

In Becky's case a peer support worker is working with her on a WRAP (Wellness Recovery Action Plan) and the physiotherapist is encouraging her to increase her physical activity.

The NetWork Service is supporting her with her vocational goals: poetry writing, making art and has facilitated her to make a film about her mental health recovery.

The service can provide support to help Becky into employment and can offer ongoing practical and emotional support to enable her to achieve and maintain work goals and aspirations.

What this plan means for Malcolm...

Malcolm is 55 years old and lives alone in a flat on the 3rd floor. He has a long term health condition, chronic obstructive pulmonary disease (COPD), which has made him housebound as he has difficulty climbing stairs. Malcolm's brother, Andy, supports him as much as he can but he works full time and is sometimes away on business trips. Andy sometimes struggles to find time to help Malcolm with his personal care and finds it difficult to concentrate at work as he is concerned about Malcolm.

Malcolm has had multiple admissions due to COPD and chest infections and was recently admitted to hospital for the 10th time this year. Hospital staff have decided to change his medication and have sent out an electronic discharge letter to the chemist who changes his medication and delivers it to his home. A letter has also been sent to his GP informing him of Malcolm's latest admission into hospital and the decisions made to change his medication.

His GP visits Malcolm in his home to see how is getting on with the new medication. However Malcolm's living conditions raised other concerns that could be impacting his health, the GP referred him to social work services as a vulnerable person. Malcolm's GP was also concerned that he was at risk of being socially isolated. A social worker was able to go out and visit Malcolm to assess his living conditions and arranged more suitable accommodation. After Malcolm settled in to his new home, he was referred to the reablement team where he was assessed for walking aids and respiratory care at home. Home care has now been put in place to help with meals and some self care and Malcolm is able to get involved in some community activities.

Close working between primary and secondary health care and social care has meant that Malcolm's health is better managed now and he is able to live safely in the community with appropriate support that meet his needs. Malcolm has also been given access to tools, such as Telehealth monitoring, to help him manage his own condition and to help him live as independently as possible.

Good communication between hospital staff, Malcolm's GP and pharmacist means that he will get the right medication and support from the right people.

Andy's caring responsibilities have also been recognised by Malcolm's GP and he has been referred to the Carers' Centre to help him get support and advice so that he can continue in his informal caring role without causing too much strain on his own life.

What this plan means for Jack...

Jack is two and a half years old and lives with both of his parents. Jack enjoys going out shopping with his grandmother and playing in the park. Jack's Health Visitor has had concerns about developmental delays since he was a few months old and has been working closely with the PANDA Unit. The Panda unit is a specialist community paediatric facility, which focuses on children with additional support needs. All referrals are screened by an on call duty clinician and a decision is made about the most appropriate service(s) for the patient.

Jack was called for his 30 month assessment which is offered to all children in Renfrewshire. A health visitor carried out a developmental assessment and concluded that Jack would benefit from nursery placement as it will provide him with the opportunity to develop his play skills, increase his confidence and independence skills and prepare him for school. The recommendations from the assessment have been sent to Jack's parents, the GP and relevant professionals in social work and speech and language therapist.

There is ongoing social work involvement with Jack and his parents and Jack's development will continue to be assessed. The PANDA unit has worked closely with social work to provide Jack's parents with a list of nurseries and they have provided advice and support to apply for a grant to enable them to buy appropriate toys for Jack.

Jack's general health appears to be good and he attends all required health appointments. However concerns that his social and emotional health needs are not being met due to his isolation and limited contact with children his own age will be monitored and appropriate services will be involved to best meet Jack's needs.

Children's health services work closely with education to provide the best support that meets the child's needs and will work closely with social work services to provide support for the parents.

Parents of children with additional support needs are supported with housing issues, DLA, grant applications. The PANDA unit can also make referrals to the Renfrewshire carers centre for additional support for the parents.

By working closely with children's services the Partnership is able to support parents and carers of children with additional support needs and plan for the transition from children's services to adult services.

2. Developing Integrated Arrangements in Renfrewshire

The Public Bodies (Joint Working) (Scotland) Act 2014 set out the arrangements and terms for the integration of health and social care. The Health and Social Care Partnership in Renfrewshire is responsible for delivering adult social care and health services and children's health services. The partnership is led by the Chief Officer, David Leese. The Integration Authority is the Integration Joint Board (IJB) and is chaired in Renfrewshire by Councillor Iain McMillan.

Integration Joint Board (IJB)

The 2014 Act sets out how the IJB must operate, including the makeup of its membership.

The IJB has two different categories of members; voting and non-voting. In Renfrewshire, the IJB has agreed that there will also be additional non-voting members to those required by law.

Current IJB members (March 2016) are noted below.

Voting Membership	
Four voting members appointed by the Council	Cllr Iain McMillan Cllr Derek Bibby Cllr Jacqueline Henry Cllr Michael Holmes
Four voting members appointed by the Health Board	Donny Lyons John Brown Donald Syme Morag Brown
Non-voting Membership	
Chief Officer	David Leese
Chief Finance Officer	Sarah Lavers
Chief Social Work Officer	Peter Macleod
Registered Nurse	Karen Jarvis
Registered Medical Practitioner (GP)	Stephen McLaughlin
Registered Medical Practitioner (non GP)	Alex Thom
Council staff member involved in service provision	Liz Snodgrass
Health Board staff member involved in service provision	David Wylie
Third sector representative	Alan McNiven
Service user residing in Renfrewshire	Stephen Cruikshank
Unpaid carer residing in Renfrewshire	Helen McAleer
Additional Non-voting Membership	
Trade union representative - Council staff	John Boylan
Trade union representative - Health Board staff	Graham Capstick

Integrating health and social care services supports the national 2020 vision:

"by 2020 everyone is able to live longer healthier lives at home, or in a homely setting and, that we will have a healthcare system where:

- We have integrated health and social care

- There is a focus on prevention, anticipation and supported self-management
- If hospital treatment is required, and care cannot be provided in a community setting, day case treatment will be the norm
- Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions
- There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission."

The 2014 Act sets out nine high level outcomes that every Health and Social Care Partnership, working with local people and communities, should deliver:

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

Renfrewshire Health and Social Care Partnership's performance will at least be measured against these nine outcomes. Our performance framework will describe the indicators to be used to assess our performance against each outcome.

The diagram below lists the legal and policy drivers which direct and influence the Health and Social Care Partnership.

Legal and Policy Drivers

There are key pieces of legislation governing health and social care. These include the ***Social Work (Scotland) Act 1968***, the ***National Health Service (Scotland) Act 1978*** and the ***Children (Scotland) Act 1995.*** These, along with other pieces of legislation and policy, set out the duties of councils and health boards in relation to people's health and wellbeing.

Legislation to assist individuals who have lost capacity to allow them to plan ahead and to support them to receive treatment and protection is a key driver of our work. This legislation includes:

- **Adults with Incapacity (Scotland) Act 2000**
- **Mental Health (Care and Treatment) (Scotland) Act 2003**
- **The Adult Support and Protection (Scotland) Act 2007**

Implementation of the ***Social Care (Self-directed Support) Act 2013*** will affect the delivery of services for people with assessed social care needs as it embeds over time. Where there is an assessed need, individuals can now have an allocated personal budget, which they can choose to take as a direct payment (cash) or to buy services and supports. The option to use local authority services is still available. It is expected that change will be gradual but it is clear that the preference of individual service users will impact on the demands for service providers.

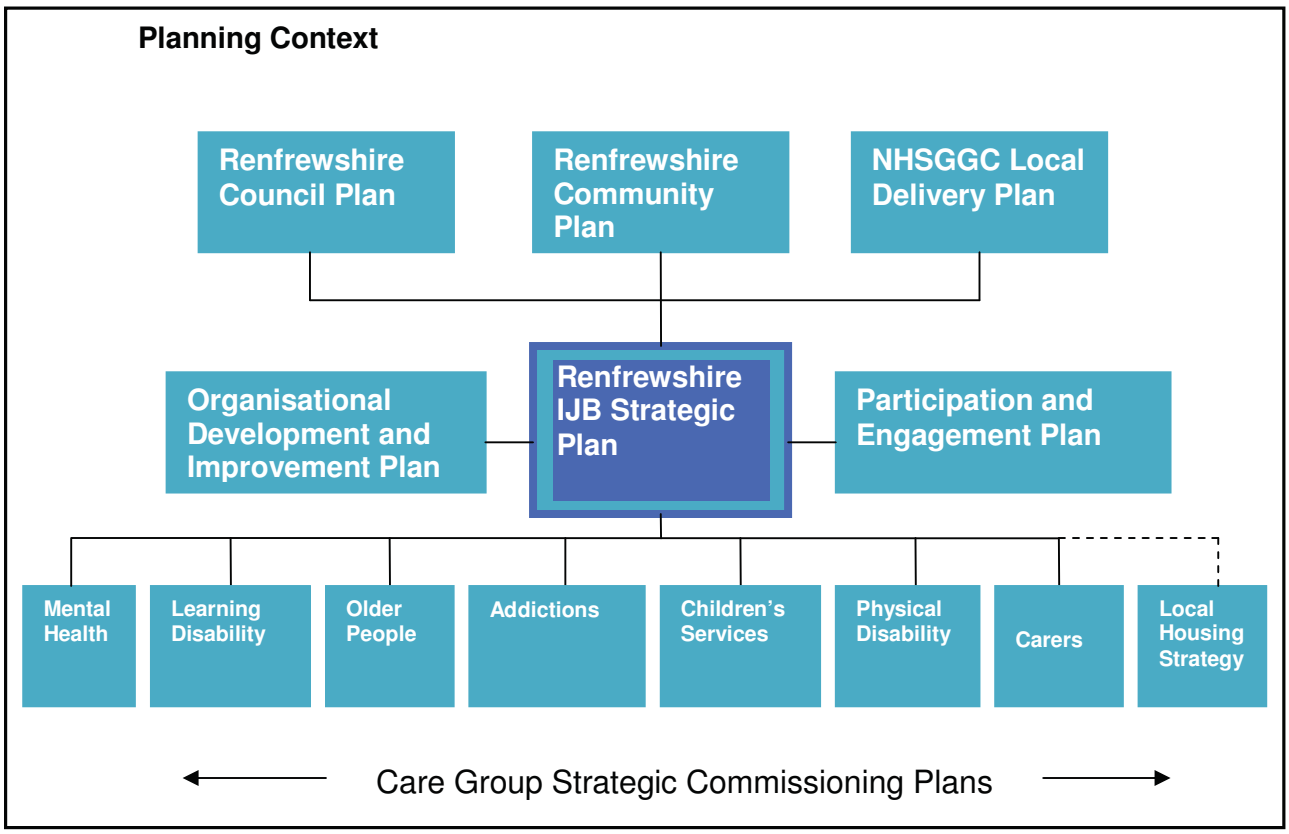
The Carers (Scotland) Bill was introduced to Parliament in March 2015. It covers a range of areas relating to supporting carers, such as Adult Carer Support Plans, Young Carers Statements and Carer Involvement. The Bill proposes a number of new duties and requirements, including a duty to support carers, the requirement to prepare a local Carers' Strategy and to involve carers in this.

The Community Empowerment (Scotland) Act 2015 received royal assent in July 2015. It aims to empower communities through ownership of land and buildings and by strengthening the community's voice in local decisions. It also supports a quickening of Public Sector Reform by focusing on achieving outcomes and improving the community planning process. This Plan is strongly linked to the Renfrewshire Community Plan so we will be mindful of any changes in this area going forward.

This Strategic Plan and the associated care group plans which are being developed use a strategic commissioning approach. Strategic commissioning has four main stages – analyse, plan, do and review. This is a cycle and which means that the work we do and the lessons we learn at each stage feed into the next. It also means that we review the Strategic Plan and associated care group plans regularly to make sure that progress is being made and identify whether there have been any changes that might mean changes are required in the next cycle.

Strategic Commissioning

Our Strategic Plan is part of the wider planning frameworks of Renfrewshire Council, the NHS Board and local Community Planning partners. The table overleaf shows other plans which link to the Strategic Plan.



The 2014 Act requires that the NHS Board and the Council include a number of functions and services in the Partnership. As a minimum, health and social work services for people aged over 18 must be included. In Renfrewshire, children's health services are also included in the Partnership, recognising the important links with Specialist Board-wide Children's Services and the family based approach which General Practice uses. Children's Social Work Services are managed within the newly formed Children's Services Directorate in Renfrewshire Council. Interface arrangements between the HSCP and this Directorate have been established to ensure that the two organisations work together to improve outcomes for children. Below is a list of functions which will be delegated to the Partnership (some are already integrated):

Renfrewshire Council services that are to be included	Greater Glasgow & Clyde Health Board services that are to be included
• Social work services for adults and older people • Mental health services • Services for adults with physical disabilities and learning disabilities • Care at home services and care homes • Drug and alcohol services • Adult protection • Domestic abuse	• District nursing services • Substance misuse services • Services provided by allied health professionals in an outpatient department, clinic or out with a hospital • The public dental service • Primary medical services (including GPs and other general practice services) • General dental services • Ophthalmic services

- Carers' support services
- Community care assessment teams
- Support services
- Adult placement services
- Health improvement services
- Aspects of housing support, including aids and adaptations
- Day services and respite provision
- Local area co-ordination
- Occupational therapy services
- Re-ablement services, equipment and telecare
- Sensory impairment services
- Gardening assistance
- Pharmaceutical services
- Out of hours primary medical services
- Community older people's services
- Community palliative care services
- Community learning disability services
- Community mental health services
- Community continence services
- Services provided by health professionals that aim to promote public health
- School Nursing and Health Visitor Services
- Child and Adolescent Community Mental Health Services
- Specialist Children's Services
- Mental Health inpatient services
- Planning and health improvement services

The 2014 Act identifies a set of hospital-based services that the IJB can shape and influence. The Partnership will not manage these services directly but will be able to shape how unplanned care is designed to support independent living and must seek to do this by working with other Partnerships across NHS Greater Glasgow and Clyde. Arrangements for how this budget will be set and how Partnerships will work together are still being formed.

Hospital-based services that are included

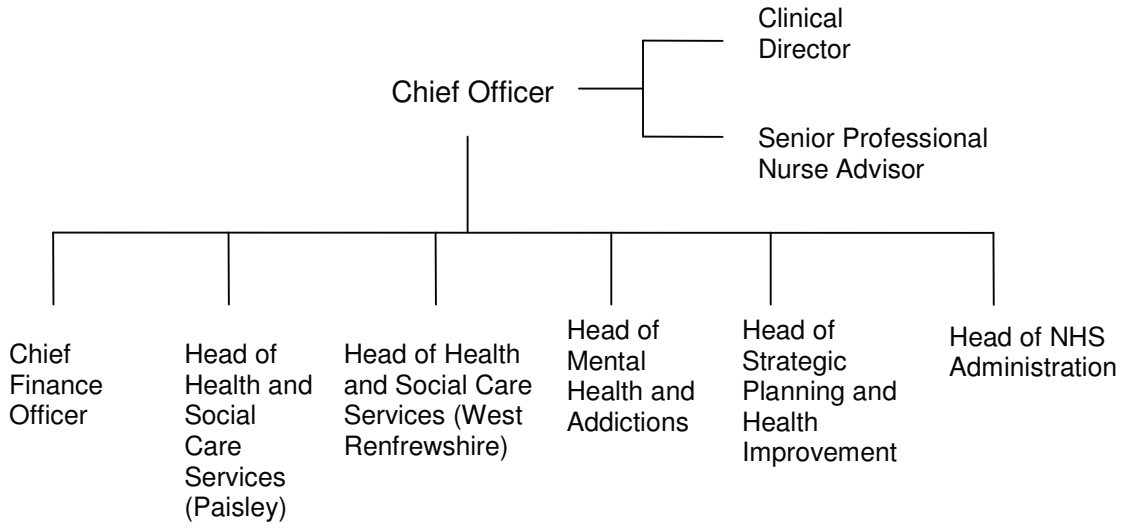
- Accident and Emergency services provided in a hospital
- Inpatient hospital services relating to the following-
  (a) general medicine
  (b) geriatric medicine
  (c) rehabilitation medicine
  (d) respiratory medicine
  (e) psychiatry of learning disability.
- Palliative care services provided in a hospital
- Services provided in a hospital in relation to an addiction or dependence on any substance

There are six Partnerships within the NHS Greater Glasgow and Clyde Board area. In some cases, a single Partnership will manage or 'host' a certain service on behalf of the whole area, with the other Partnerships having access to these to meet local outcomes. These arrangements have been in place for some time and continue to be appropriate in the new integrated environment. Where services are hosted by other Partnerships, the HSCP will be active in interface arrangements and will regularly review services.

The Renfrewshire Partnership will continue to host:
• Podiatry Services • Primary Care Contractual support (medical and optical) • Strategic Planning for out of hours GP services

Other GG&C Partnerships will host:	
Glasgow	• Continence services outwith hospital • Enhanced healthcare to Nursing Homes • Sexual Health Services (Sandyford) • Specialist drug and alcohol services & system- wide planning and co-ordination • Specialist mental health services & mental health system- wide planning and co-ordination • Custody and prison healthcare
West Dunbartonshire	• Musculoskeletal Physiotherapy • Specialist children's services
East Dunbartonshire	• Oral Health- public dental services and primary dental care contractual support
East Renfrewshire	• Specialist learning disability services & learning disability system-wide planning and co-ordination

The Chief Officer and Senior Leadership Group will lead the organisation. The management structure is shown in the diagram below:



The IJB is required to establish a local Strategic Planning Group (SPG), which is intended to be the main group representing local stakeholder interests in relation to the Strategic Plan. The role of the SPG is to act as the voice of local stakeholders and oversee the development, implementation and review of the Partnership's strategic plans. The SPG is responsible for reviewing and informing draft work produced by the Partnership in relation to strategic plans and for ensuring that the interests of their stakeholder groups are considered.

The SPG will play a key role in ensuring that the work produced by the Partnership is firmly based on robust evidence and good public involvement and will strengthen the voice of stakeholders in local communities. The current membership of the SPG is shown in the diagram overleaf.

Membership of Strategic Planning Group

Membership	Nominees
Chief Officer	David Leese
Nomination(s) by Renfrewshire Council	Anne McMillan, Corporate Planning Ian Beattie, Head of Adult Services Lesley Muirhead, Development and Housing
Nomination(s) by NHS Greater Glasgow and Clyde	Fiona MacKay, Head of Planning & Health Improvement Mandy Ferguson, Operational Head of Service Katrina Phillips, Operational Head of Service Jacqui McGeough, Head of Acute Planning (Clyde)
Health Professionals (doctors, dentists, optometrists, pharmacists, nurses, AHPs)	Chris Johnstone, Associate CD John Carmont, District Nurse Rob Gray/Sinead McAree, Mental Health Consultant Susan Love, Pharmacist Caroline Horn, Physiotherapist Lynda Mutter, Health Visitor
Social Care Professionals (social worker or provider)	Jenni Hemphill, Mental Health Officer Anne Riddell, Older People's Services Aileen Wilson, Occupational Therapist Jan Barclay, Care at Home
Third Sector bodies carrying out activities related to Health and Social Care	Stephen McLellan, Recovery Across Mental Health
Carer of user of social care Carer of user of health care	Diane Goodman, Carers' Centre Maureen Caldwell John McAleer, Learning Disabilities Carers' Forum
User of social care	Debbie Jones, Public Member
User of health care	Betty Adam, Public Member
Non commercial provider of healthcare	Karen Palmer, Accord Hospice
Commercial provider of social care	Linsey Gallacher, Richmond Fellowship (a not for profit organisation)
Commercial provider of healthcare	Robert Telfer, Scottish Care
Non-commercial provider of social care	Susan McDonald, Active Communities
Non-commercial provider of social housing	Elaine Darling, Margaret Blackwood Association
Chief Finance Officer	Sarah Lavers
Renfrewshire HSCP Comms	Catherine O'Halloran
Health TU Rep	Claire Craig
SW TU Rep	Eileen McCafferty

In the first year of operation, the Strategic Planning Group has been drawn from recognised representative bodies and existing networks. In future years, a more inclusive process to establish membership will be considered – particularly to gain representation from service users and carers.

Glossary

ADP - Alcohol and Drugs Partnership

Renfrewshire Alcohol & Drugs Partnership has responsibility for addressing drug and alcohol issues in Renfrewshire. This means that various agencies come together and work in partnership on issues related to alcohol and drugs.

AHP – Allied Health Professionals

Allied Health Professionals (AHPs) support people of all ages in their recovery, helping them to regain movement or mobility, overcome visual problems, improve nutritional status, develop communication abilities and restore confidence in everyday living skills. They work as key members of multi-disciplinary, multi-agency teams, bringing their rehabilitation focus and specialist expertise to the wider skills pool.

Aids and Adaptations

Aids and adaptations can help older and disabled people to live independently in their own homes. They can reduce the risk of falls and other accidents in the home and also reduce the need for home care or long term admission to a care home. A wide variety of aids and equipment is available to help with daily living tasks ranging from simple adapted cutlery, to Telecare alarms, specialist seating and beds. Common examples of adaptations include replacing a bath with a level access shower, or making it easier to get in and out of the home by widening doors or constructing a ramp.

Anticipatory Care

Anticipatory Care can take many forms however it is expected to help reduce avoidable and unscheduled acute admissions for people with pre-existing conditions. The purpose of advanced/anticipatory care planning is to support the individual to have greater choice, and control of care preferences through communication across the support team, across agencies and across care settings.

ASN - Additional Support Needs

The Education (Additional Support for Learning) (Scotland) Act 2004, places duties on local authorities and other agencies to provide additional support where needed to enable any child or young person to benefit from education.

Body Corporate Model

The Body Corporate Model is a model of integration where a Health Board and Local Authority both delegate the responsibility for planning and resourcing service provision for health and social care services to an Integration Joint Board, established as a separate entity. This is the model used in Renfrewshire.

Carer

A carer is someone who provides unpaid care and support to a family member, partner, relative or friend, of any age, who could not manage without this help. This could be due to age, illness, disability, long term condition, a physical or mental health problem or addiction.

Chief Officer

Where the body corporate model is adopted, a Chief Officer will be appointed to provide a single point of management for the integrated budget and integrated service delivery. They are accountable to the Integration Joint Board and to the Chief Executives of their Health Board and Local Authority for the delivery of integrated services.

Choice and control

Choice and control is about shaping services to meet people's needs, rather than allocating people to fit around services.

Community Capacity Building

Community capacity building aims to develop the capacity of local communities and increase community resilience. By supporting local people and organisations to develop their skills and focus on community activities, this approach aims to empower local residents and groups to address key issues within their community and reduce health and social care demand.

Community Planning Partnership (CPP)

The Community Planning Partnership allows a variety of public agencies to work together with the community to plan and deliver better public services which make a real difference to people's lives and to the community. The key Renfrewshire Community Planning partners are Renfrewshire Council, Police Scotland, Scottish Fire and Rescue, NHS Greater Glasgow and Clyde, Engage Renfrewshire, Renfrewshire Chamber of Commerce, University of the West of Scotland, and West College Scotland.

COPD – Chronic Obstructive Pulmonary Disease

Chronic obstructive pulmonary disease (COPD) is the name for a collection of lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease. People with COPD have difficulties breathing, primarily due to the narrowing of their airways. This is called airflow obstruction.

Co-Production

Co-production is about combining our mutual strengths and capacities so that we can work with one another on an equal basis to achieve positive change.

Data Zones

Datazones are groups of 2001 Census output areas and have, on average, populations of between 500 and 1,000 household residents. They nest within Local Authority boundaries and where possible, they have been constructed to respect physical boundaries and natural communities. As far as possible, they have a regular shape and contain households with similar social characteristics.

Demographics

The characteristics of a human population, especially with regard to such factors as numbers, growth, and distribution, often used in defining consumer markets.

Delayed Discharges

Delayed Discharges occur when a patient ready for discharge cannot leave hospital because the necessary care, support or accommodation is not available.

Delegation

Delegation is the process used to integrate functions, by giving responsibility for health and social care functions to a single body.

DLA – Disability Living Allowance

Disability Living Allowance (DLA) is a tax-free benefit for disabled people who need help with mobility or care cost.

GIRFEC – Getting It Right For Every Child

Getting It Right For Every Child (GIRFEC) is the nation approach to improving the wellbeing of children and young people in Scotland. The approach puts the best interests of the child at the heart of decision-making; takes a holistic approach to the wellbeing of the child; works with children, young people and families on ways to improve wellbeing; advocates preventative work and early intervention to support children young people and their families; believe professionals must work together in the best interests of the child.

Health Inequalities

Health Inequalities is the gap which exists between the health of different population groups such as the affluent compared to poorer communities or people with different ethnic backgrounds.

Health and Social Care Partnership

The Renfrewshire Health and Social Care Partnership is now responsible for delivering adult services in our community. The integration of health and social care means that for the first time these services are managed and developed together.

HEAT Targets

The HEAT performance management system sets out the targets and measures against which NHS Boards are publicly monitored and evaluated. HEAT is an acronym for Health Improvement, Efficiency and Governance, Access and Treatment. These are the four areas being targeted.

Independent Living

Independent Living means having the same freedom, choice, dignity and control as other citizens at home, at work and in the community. It does not necessarily mean living by yourself or fending for yourself. It means rights to practical assistance and support to participate in society and live an ordinary life.

Independent Sector

The Independent Sector encompasses individuals, employers, and organisations who contribute to needs assessment, design, planning, commissioning and delivery of a broad spectrum of social care services, which are wholly or partially independent of the public sector. The independent social care sector in Scotland includes care homes, care at home, housing support and day care services. The sector encompasses those traditionally referred to as the 'private' sector and the 'voluntary' sectors of care provision. It includes organisations of varying types and sizes, amongst them single providers, small and medium sized groups, national providers and not-for-profit voluntary organisations, associations and charities.

Integration

Integration is the combination of processes, methods and tools that facilitate integrated care.

Integrated Care

Integrated Care focuses on improving services in relation to access, quality, user satisfaction and efficiency. The aim is to enable better coordinated, joined-up and more continuous care, resulting in improved patient experience whilst achieving greater efficiency and value from health and social care delivery systems.

Integrated Resource Framework

The Integrated Resource Framework (IRF) for Health and Social Care is a framework within which Health Boards and Local Authorities can better understand the patterns of care they provide, particularly to their shared populations of people and service users.

Integration Authority

An Integration Authority is the body that is responsible for planning integrated care. It will decide which integrated services will be provided, how they will be funded and what they should look like. It can (and in many cases must) direct the Health Board and Local Authority to deliver those services.
The body that acts as the Integration Authority for a particular area will be determined by reference to the model of integration used in that area.

Integration Functions

The services that Integration Authorities will be responsible for planning are described in the Act as integration functions. The legislation sets out which NHS and social care services must, may and cannot be delegated as part of the integration arrangements.

Integration Joint Board

Where the body corporate model is adopted (as is the case in Renfrewshire) the NHS Board and Local Authority will create an Integration Joint Board made up of representatives from the Council, Health Boards, the Third and Independent Sectors and those who use health and social care services. The Integration Joint Board, through its Chief Officer, will have the responsibility for the planning, resourcing and the operational oversight of integrated services within the strategic plan.

Integration Scheme

An Integration Scheme is the agreement made between the Health Board and the Local Authority. It sets out the make-up of the Integration Authority and how it will work. The Health Board and the Local Authorities submitted their draft Integration Scheme to Scottish Ministers for approval on 1 April 2015. Integration Schemes must be reviewed by the NHS Board and Local Authority at least every five years.

Intermediate Care

Intermediate Care services support people to improve their independence and aim to provide a range of enabling, rehabilitative and treatment services in community and residential settings. The term has been defined as a "range of integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admission, support timely discharge and maximise independent living". (NSF for Older People, DOH, June 2002).

KPIs - Key Performance Indicators

The local government measure their performance and make this information available to the public so that they can assess how they are doing in providing those services which matter most to the public. They report a mix of local and national performance indicators which cover all of the core service areas. A suite of national indicators are collected from all Scottish councils and are reported by the Improvement Service. Reports on local indicators that are specific to Renfrewshire Council and their partners are also produced.

Lead Agency Model

The Lead Agency Model is a model of integration where the Health Board or the Local Authority takes the lead responsibility for planning, resourcing and delivering integrated adult health and social care services.

Locality Planning

Locality Planning is intended to keep the focus of integration on improving care in local communities. It will draw on the knowledge and experience of users of services, carers, staff and the third and independent sectors and provide the route for leadership by local clinicians and professionals from across health and social care – and, particularly, GPs – in planning service provision. Every Local Authority must define at least two localities within its boundaries for the purpose of locality planning.

LTC - Long Term Conditions

Long Term Conditions (LTC) are conditions that last a year or longer, impact on many aspects of a person’s life, and may require ongoing care and support. The definition does not relate to any one condition, care group or age category, so it covers adults and older people as well as children and mental as well as physical health issues. Common long term conditions include epilepsy, diabetes, some mental health problems, heart disease, chronic pain, arthritis, inflammatory bowel disease, asthma and chronic obstructive pulmonary disease (COPD).

LAAC – Looked After and Accommodated Children

Under the provisions of the Children (Scotland) Act 1995, Looked After Children are defined as those in the care of their Local Authority. The vast majority of looked after children have become 'looked after' for care and protection reasons. They may be looked after at home, or away from home (accommodated).

Market Facilitation

Market Facilitation is a key aspect of the strategic commissioning cycle: Integration Authorities will undertake a range of activities to promote the successful development of services to meet the needs of the local population effectively. These activities should include the development of an accurate picture of local need and markets, published as a Market Facilitation Plan.

MDT - Multi Disciplinary Team

A Multidisciplinary Team is a group of professionals from one or more clinical disciplines who together make decisions regarding recommended treatment of individual patients.

Multi-Morbidity

Multi-morbidity is used to describe when a person has two or more chronic medical conditions at the one time.

National Care Standards

The National Care Standards have been published by Scottish Ministers to help people understand what to expect from a wide range of care services. They are in place to ensure that people get the right quality of care when they need it most.

National Health and Wellbeing Outcomes

The nine national health and wellbeing outcomes provide a national framework for measuring the effect of integrated health and social care services on the health and wellbeing of individuals.

Nursing Care Home

Nursing care homes provide residents the personal care benefits of a residential care home with the addition of a qualified nurse that is on duty 24 hours a day to carry out nursing tasks.

Palliative Care

Palliative care aims to provide suitable care and support for people with a terminal illness. The main goal of palliative care is to achieve the best possible quality of life for the patient and their families.

PAR – Practice Activity Reports

A comprehensive document produced annually that shows how an individual GP practice compares to neighbouring practices and national averages. Examples of areas where data are provided include lab usage, emergency admission rates, referral rates, Accident & Emergency attendances and screening uptake rates.

Parent Organisations

The parent organisations are the main bodies in charge of the Partnership. In the case of Renfrewshire Health and Social Care Partnership, the parent organisations are NHS Greater Glasgow and Clyde and Renfrewshire Council.

Personalisation

Personalisation means starting with the individual as a person with strengths and preferences who may have a network of support and resources, which may include family and friends. Personalisation reinforces the idea that the individual is best placed to know what they need and how those needs can be best met. It means that people can be responsible for themselves and can make their own decisions about what they require, but that they should also have information and support to enable them to do so.

Person-centred

Person-centred is an approach to working with people which respects and values the uniqueness of the individual and puts the individual's needs and aspirations firmly at the centre of the process.

Planning and Delivery Principles

The principles that underpin the making of arrangements for integration, and the strategic planning of integrated services, will inform how services are planned and delivered. They explain what people using services and their carers can expect from integrated services and the behaviours and priorities expected of organisations and people planning and delivering care and support.

Quality Ambitions

The three Quality Ambitions of person-centred, safe and effective provide the focus for all our activity to support our aim of delivering the best quality healthcare to the people of Scotland and through this making NHS Scotland a world leader in healthcare quality. They explicitly reflect the things people have told us they want and need.

Quality Strategy

The Healthcare Quality Strategy for Scotland is the approach and shared focus for all work to realise the 2020 Vision. It aims to deliver the highest quality healthcare to the people of Scotland to ensure that the NHS, Local Authorities and the Third Sector work together, and with patients, carers and the public, towards a shared goal of world-leading healthcare.

Reablement

Reablement is about giving people the opportunity and the confidence to relearn/regain some of the skills they may have lost as a result of poor health, disability/impairment or entry into hospital or residential care. As well as regaining skill, reablement supports service users to gain new skills to help them maintain their independence.

RES – Rehabilitation and Enablement Services

A rehabilitation service that is able to address physical, mental health and social needs to enable people to be able to cared for at home. RES includes both health and social care professionals, split into a number of sub-teams who work together to ensure that the correct clinician is involved with the patient at the time of need. They will formulate a patient-centred care plan which is shared within the service and across relevant agencies to allow multiple professionals if necessary to be involved in the care plan.

Self-Directed Support

Self-directed Support (SDS) is the new form of social care where the service user can arrange some or all of their own support. This is instead of receiving services directly from local authority social work or equivalent. SDS allows people more flexibility, choice and control over their own care so that they can live more independent lives with the right support.

Self-Management

Self-management encourages people with health and social care needs to stay well, learn about their condition and their care and support needs, and remain in control of their own health.

Sheltered Housing

Sheltered housing is specifically designed to comfortably meet the needs of people who are aged 60 years or over. These properties are easy to maintain and offer tenants the safety of living in a secure environment, while also enabling people to retain their independent lifestyle. Sheltered properties have a communal lounge where social activities take place.

SmartCare Project

SmartCare is a new programme that aims to improve the health, care and wellbeing of older people at risk of a fall across Ayrshire & Arran, Lanarkshire and Renfrewshire/East Renfrewshire.
SmartCare is working in partnership with service users, carers, third sector organisations and service providers to design and develop a range of digital tools to support falls management and prevention. This will help to improve the communication and co-ordination of a person's care.

SSA – Single Shared Assessment

A Single Shared Assessment allows health and social care practitioners to share information in order to plan an individuals' care plan so that it is co-ordinated and avoids unnecessary duplication.

Staff Partnership

Staff Partnership (NHS) describes the process of engaging staff and their representatives at all levels in the early stages of the decision-making process. This enables improved and informed decision making, through achieving and maintaining a positive and stable employee relations culture and gaining commitment, ownership and consensus to decisions through joint problem solving. The emphasis is therefore placed on working collaboratively at all levels and becoming an exemplary employer, both to the benefit of staff but also to the benefit of patient care.

Statutory Services

Statutory services are public services that are required to be delivered by law. These services are supported by government legislation.

Strategic Commissioning

Strategic Commissioning is a way to describe all the activities involved in:
• assessing and forecasting needs
• links investment to agreed desired outcomes
• planning the nature, range and quality of future services; and
• working in partnership to put these in place Strategic Needs Assessment

Strategic Needs Assessments (SNA) analyse the health and care needs of populations to inform and guide commissioning of health, wellbeing and social care services within Local Authority areas. The main goal of a SNA is to accurately assess the health and care needs of a local population in order to improve the physical and mental health and wellbeing of individuals and communities. The SNA will underpin Strategic Plans.

Strategic Planning Group

The Strategic Planning Group (SPG) is the main group representing stakeholder interests in relation to the Strategic Plans produced by the Integration Joint Board. The group consists of representatives from the public sector, private sector, third sector and the public. The role of the Group will be to oversee the development, implementation and reviews of the strategic plans.

Supported Accommodation

Supported accomodation provides individuals with support and housing options that are suited to their needs and helps them to maintain a tenancy in the community. Supported accomodation options are available for people with physical disabilities, learnig disabilities and older people with support provided based on the client's needs to help them maintain their lifestyle and independence.

Supported Living

Supported Living is an alternative to residential care or living with family members that enables adults with disabilities to live in their own home, with the help they need to be independent. It allows people to choose where they want to live, who they want to live with and how they want to be supported.

TEC – Technology Enabled Care Programme

A major Scottish Government Programme designed to significantly increase choice and control in health, wellbeing and care services, and extend the number of people directly benefiting from TEC and support in Scotland.

Telehealth Monitoring

Telehealth or Home Health Monitoring is a way of delivering medical care at home for people with long term conditions such as Heart Failure and COPD (Chronic Obstructive Pulmonary Disease). It consists of using an electronic tablet or your own mobile phone to answer simple questions about how a patient feels. Nurses can read details and if readings are outwith normal limits, it will send an alert to the nurse who will contact the patient to discuss how better to manage conditions.

Third Sector

'Third Sector organisations' is a term used to describe the range of organisations that are neither public sector nor private sector. It includes voluntary and community organisations (both registered charities and other organisations such as associations, self-help groups and community groups), social enterprises, mutuals and co-operatives. It also includes local intermediary organisations (Third Sector 61 Interfaces), and third sector strategic intermediaries, for example Voluntary Action Scotland (who represent Scotland's 32 Third Sector Interfaces) and the Health and Social Care Alliance Scotland.

Engage Renfrewshire is our local Third Sector Interface.

Transformational Leadership

As opposed to the management of the delivery of services, Transformational Leadership relates to the ability to inspire, motivate and engage. These qualities are seen as being particularly important for times when organisations are being challenged by significant external changes. As opposed to the management of the delivery of services, Transformational Leadership relates to the ability to inspire, motivate and engage. These qualities are seen as being particularly important for times when organisations are being challenged by significant external changes.