To: **Renfrewshire Integration Joint Board**

On: **25 November 2016**

Report by: **Chief Officer**

Heading: **Strategic Plan – 2016/19**

1. Summary

1.1 This report is to present the Strategic Plan 2016/19 to the Integration Joint Board. The full plan is attached at Appendix 1.

2. Recommendation

2.1 It is recommended that the Integration Joint Board (IJB):

- Approve the Strategic Plan 2016/19.

3. Background

3.1 The IJB approved a first draft of the Strategic Plan 2016/19 in November 2015, and a second draft in January 2016. Following wide consultation, a final draft was approved in March 2016. Due to financial uncertainties around the allocation of health resources, it has not been possible to present a final plan. The financial position is now clearer, and in September 2016, the IJB noted the NHS Greater Glasgow and Clyde budget allocation for 2016/17.

3.2 The final draft plan, approved in March 2016, has now been amended to reflect the final budget position. Section 6 of the plan (Our Resources) now includes the complete budget allocation for 2016/17.

3.3 In May 2016, some additional comments were received, providing more detail and clarity about adult support and protection. These did not impact on the body of the plan, but have been incorporated in the action plans.

4. Six Month Review of the Plan

4.1 As part of our performance framework, officers in the HSCP have carried out a mid-year review of the actions noted in the Strategic Plan. This is to ensure that activity is on track to deliver the outcomes agreed.

4.2 Examples of areas where actions are already complete or where good progress has been made include:

- **Achieving the target for reducing conceptions in young people under the age of twenty.**

  The target was set at a rate of 35 per 1,000. Our rate reduced from 35.7 at March 2015 and is now similar to the Greater Glasgow and Clyde average of 30 per 1,000. Work is ongoing with schools and with the Sandyford Initiative to raise awareness of services.

- **Working with GPs in clusters to pilot improved ways of working with community and social care staff.**

  There has been good progress in establishing GP practice based locality working to progress early gains. We have taken a structured approach through a series of individual GP practice meetings and cluster based development sessions to involve and engage GPs to ensure they are part of the wider network and collaboration of team and service working. These arrangements are continuing to mature and develop during 2016/17.

- **Improved access to Podiatry Services for new patients**.

  This has been measured by the % of new referrals appointed within 4 weeks. The target was set at 90% and the average monthly performance for 2016/17 so far is 93.3%. This represents a significant improvement from an average of 18% in 2012/13 at the commencement of the single system redesign.

  In addition, a target for priority diabetic patients with active foot disease being seen by a member of the Multi Disciplinary Team with 48 hours was set at 95%. At August 2016 our performance showed 86.8% and although not yet at the target of 95%, there has been significant progress made from the baseline of 55% in April 2016.

4.3 Areas which require additional focus in the latter part of the year include:

- **Meeting the national targets for breast, bowel and cervical cancer screening.**

  The target for bowel screening is 60% and the percentage uptake in Renfrewshire in 2015 was 53.3%. The rate for females is 59.1%, higher than the rate for males at 53.4%. We have promoted bowel cancer awareness with all GP Practice Managers and 3 Social Prescribers detailing resources and support available from the Health Improvement Team.

  The cervical screening national target is set at 80%. The uptake rate in Renfrewshire is 77% which is above the Greater Glasgow and Clyde rate of 72.3%. The rate in Renfrewshire has decreased though from 79.5% in 2012. Work is continuing to raise more awareness via posters and signposting local Social Work

Departments, Community Addiction Teams and Homeless Teams to additional resources.

Although, both bowel and cervical screening are below target, our uptake rate for breast screening is above the 70% target at 73.6%.

- **Increasing the uptake of flu vaccinations in the over 65 age group.**

The target for 2016/17 is 78%. The rate for 2015/16 in Renfrewshire was 73.7% and we hope to see an increase in the uptake rate in 2016/17. The uptake of flu vaccinations is promoted via the GP Forum and the District Nursing Service vaccinates all who require vaccination within their caseload. The Care Home Liaison Nurse supports the care homes to vaccinate their own residents.

- **Increasing the uptake of Carers' Assessments.**

The target for 2016/17 is 150 assessments completed for adults (18+). At the mid-year point, we are below target with 32 assessments completed. The HSCP works with the Carers' Centre and partner agencies to ensure local carers are supported via assessment and care management processes. Currently the views and needs of carers are captured in the Standardised Shareable Assessment (SSA) and the care plan for the person being cared for. We promote carers' assessments via the Carers' Centre and assessments are also offered within the Renfrewshire dementia post diagnostic support service.

4.4 This mid-year review will inform the next iteration of the Strategic Plan for 2017/18.

5. Easy Read Version

5.1 The Strategic Planning Guidance for HSCPs requires the production of an easy read version of the plan. The Strategic Planning Group has been key to developing this version and it has been tested with this group. It will be further tested in terms of accessibility to ensure that best practice is followed.

5.2 Following approval of the Final Plan, the easy read version will be made available to staff, partners and other stakeholders.

Implications of the Report

1. **Financial - None**
2. **HR & Organisational Development – None**
3. **Community Planning –** The plan reflects the priorities of the Community Plan and in particular the activity of the Community Care, Health and Wellbeing Thematic Board.
4. **Legal –** The Strategic Plan, that has been produced co-productively and has been formally consulted on, is a duty of the Public Bodies (Joint Working) (Scotland) Act 2014
5. **Property/Assets – None**
6. **Information Technology – None**

7. **Equality & Human Rights –** A full Equality Impact Assessment has been carried out on the Strategic Planning process. No negative impacts on equality groups or potential for infringement have been identified arising from the recommendations contained in the report.
8. **Health & Safety – None**
9. **Procurement – None**
10. **Risk – None**
11. **Privacy Impact – None.**

List of Background Papers

- Strategic Plan First Draft (brought to IJB 20th November 2015)
- Strategic Plan Consultation Draft (brought to IJB 15th January 2016)
- Strategic Plan Final Draft (brought to IJB 18th March 2016)

Author: Fiona MacKay
Head of Strategic Planning and Health Improvement

Renfrewshire
Health & Social Care
Partnership

Strategic Plan

2016 - 2019

Our Vision:

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

NHS Greater Glasgow and Clyde

Renfrewshire Council

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

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1. Introduction

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

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. Additionally, in the Appendices, we set out case studies and details of the integration arrangements, services to be devolved to the IJB and a description of the governance structure. Appendix 3 summarises our Housing Contribution Statement which describes the key role which housing services have in supporting people to live longer in their own community.

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. This is evidenced by recent inspection reports. 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. Critical to our success will be working effectively with partners, including housing and social care providers and community groups. The Strategic Planning Group (SPG) which includes many of these stakeholders has been central to the development of this plan, bringing an appropriate level of challenge and scrutiny to the process.

1.4 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 Due to 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. Adult and child protection remain significant features of what we do and how we work.

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 Housing partners 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.

Cllr Iain McMillan
IJB Chairman

David Leese
Chief Officer

Publications in Alternative Formats

We want the Strategic Plan to be available to everyone and we are happy to consider requests for this publication in other languages or formats such as large print. An Easy Read version is also available.

Please call 0141 618 6166
Or email: Renfrewshire.HSCP@ggc.scot.nhs.uk

If you'd like to read more about the Housing Contribution Statement, please click on the link below:

Housing Contribution Statement: **www.renfrewshire.gov.uk/integration**

2. Executive Summary

Our Priorities

1. Improving health and wellbeing
2. The Right Service, at the Right Time, in the Right Place
3. Working in partnership to treat the person as well as the condition

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 is home to Glasgow International 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 51%. 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	% Improvement over 10 years	Female	% Improvement 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 18 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 (1-3), 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 There are just over 81,000 households in Renfrewshire. The number of households is projected to increase by 8% from 2012 to 2029. The rise in household numbers is due to people increasingly living in smaller households, linked to an ageing population and more single parent families.

3.6 The total housing stock in Renfrewshire is just under 84,000. Two thirds of the stock is owned, 24% social rent and 10% rented privately. Overall there are 669 sheltered housing units and 212 Very Sheltered and Extra Care units (including 10 specialist dementia units within one Extra Care development in Johnstone). In 2014/15, 517 new homes were built in Renfrewshire.

3.7 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.

3.8 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.

3.9 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.

3.10 In relation to Alcohol and Drugs Misuse, 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). We will continue to work in partnership to deliver a recovery orientated system of care.

3.11 From the work of the Renfrewshire Tackling Poverty Commission, we know that there are real local challenges with poverty and that the link between poverty and poor health is strong. In Renfrewshire, there are 30,121 children aged 0-15 and 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.

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

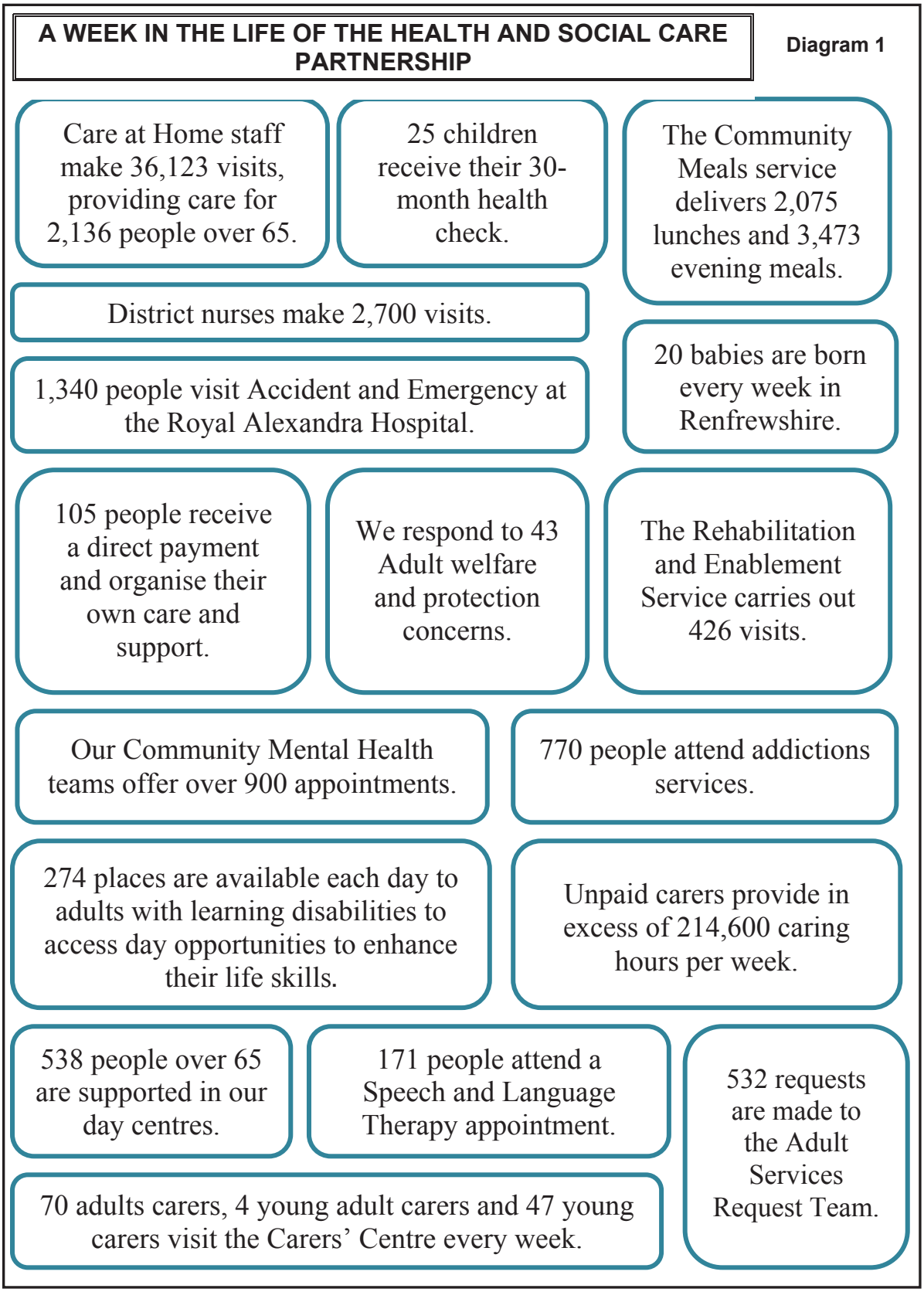
population are unpaid carers.

3.13 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).

3.14 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, presents a number of challenges for the services we manage and for our partner organisations. These are described in more detail below.

4.2 Acute

The Clinical Services Review, led by NHS Greater Glasgow and Clyde, made a compelling case for change in the way in which secondary care is delivered and in the partnership with Primary Care and Community Services. The Renfrewshire Development Programme (RDP) tested new models of care at the interface between secondary, primary and community care. The lessons from this initiative are now being applied across the Greater Glasgow and Clyde area. The Chest Pain Unit has reduced average lengths of stay from 22 hours to 3.6 hours saving 1,325 bed days at the RAH. The Older Adult Assessment Unit enables earlier access to geriatric assessment, reducing average length of stay by 10 days per patient. The Community Inreach Team, which extends RES Service to cover out of hours, Care at Home and transport, supports the Older Adult Assessment Unit and will be re-assessed in the next few months. The Anticipatory Care Planning initiative has generated over 700 new Key Information Summary (KIS), targeting care homes and people with dementia or a learning disability. The construction of these initiatives in Renfrewshire will ensure that patients experience timely discharge and are supported when they return to their communities by responsive health and care services as described in the National Clinical Strategy for Scotland. The HSCP will take on a new responsibility to work with hospital-based colleagues to plan and develop some hospital services, as noted below.

- Accident and Emergency services provided in a hospital.
- Inpatient hospital services relating to the following branches of medicine:
  - Geriatric medicine;
  - Rehabilitation medicine;
  - Respiratory medicine and
  - 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.
- Mental health services provided in a hospital, except secure forensic mental health services.
- Services provided by allied health professionals in an outpatient department, clinic, or outwith a hospital.

4.3 GP Services

Demand is rising in GP Services. Part of the pressure relates to the rising needs of our ageing population with increased chronic disease and also the health issues created by deprivation. Although an important strength, the open access nature of GP Services means that GPs are a point of service for a wide range of demands.

The Scottish Government's 2020 vision for Health and Social Care and the NHS Scotland Quality Strategy provide the priorities and framework in which the health service in Scotland will evolve and develop to meet future health and care requirements and to deliver safe, effective and patient centred care (see section 5.1 planning and delivery context).

Delivering this vision will require substantial changes to the way the NHS works including: more services organised around GP practices, more resources for primary care and new models of primary care delivery; widespread use of telehealth and telecare services; more people supported to die at home rather than in hospital; and care homes used more flexibly, providing better care and meeting higher levels of physical and mental frailty.

4.4 Pharmacy Services

43 of the Board's 292 Community Pharmacies are located within Renfrewshire HSCP operating as independent contractors to provide a full range of pharmaceutical care services in accordance with their NHS terms of service to meet the needs of the local population.

The Minor Ailments, Chronic Medication, Public Health and Acute Medication Services are available from all pharmacies as core elements of the pharmacy contract. Additional Services e.g. harm reduction and advice to care homes, are also provided depending on needs of the local population. Community pharmacies provide access to health care advice over extended opening hours with a pharmacist on duty in each location whilst the pharmacy is open. This complements other provision, e.g. Out Of Hours; with a facility to treat minor ailments and/or refer to other providers should this be necessary. Strategic direction for pharmacy over the next 5 years, detailed in the Prescription for Excellence document published by Scottish Government, advocates greater collaboration between services so that community pharmacies become more fully integrated into the health and social care provision.

4.5 Palliative and End of Life Care

In Scotland around 54,000 people die each year and over 200,000 people are significantly affected by the death of a loved one. Driven by population growth, the number of people

dying each year will begin to rise from 2015. By 2037 the number of people dying each year will have gone up by 12% to 61,600. It is thought that up to 8 out of 10 people who die have needs that could be met through the provision of palliative care (The Strategic Framework for Action on Palliative and End of Life Care 2016-2021, Scottish Government, Dec 2015). This Framework outlines the areas where action needs to be taken to ensure that by 2021 everyone who needs palliative care will have access to it and identifies ten commitments that the Scottish Government wish to achieve in working with stakeholders. http://www.gov.scot/Resource/0049/00491388.pdf

Hospice services are critical to this implementation and are well established in working across health and social care, from inpatient care, to care homes, community nurses to acute hospitals, often providing the key connection for patients and their families. The hospice sector has a huge amount of intelligence and experience which will ensure a smooth transition in moving commissioning of end of life and palliative services from Health Boards to Health and Social Care Partnerships. Both our hospices in Renfrewshire, Accord and St. Vincent's will be key planning partners in the developments of guidance on strategic commissioning.

Within Renfrewshire, we have a work plan which co-ordinates local Palliative Care Strategy in line with national and NHSGGC palliative care managed clinical network priorities.

In 2016/2017, we will focus on:

- Promoting awareness and consolidating implementation of NHSGGC's Guidance on End of Life Care with the emphasis on individualised end of life care plans;
- The Greater Glasgow and Clyde roll out of the community palliative care kardex to facilitate safe end of life anticipatory prescribing and administration of medicines towards the end of life;
- The continuous improvement of palliative and end of life care for people in Elderly Mental Health Inpatient settings;
- The continuous improvement of joint working between district nursing and home care services for patients at end of life;
- Testing a person centred emphasis to assessment for people with new or changing palliative care needs in primary care.
- Hospices in Renfrewshire shall continue to support cross boundary working and the development and delivery of training and education for health and social care staff to ensure they have the right knowledge, communication skills and approach when

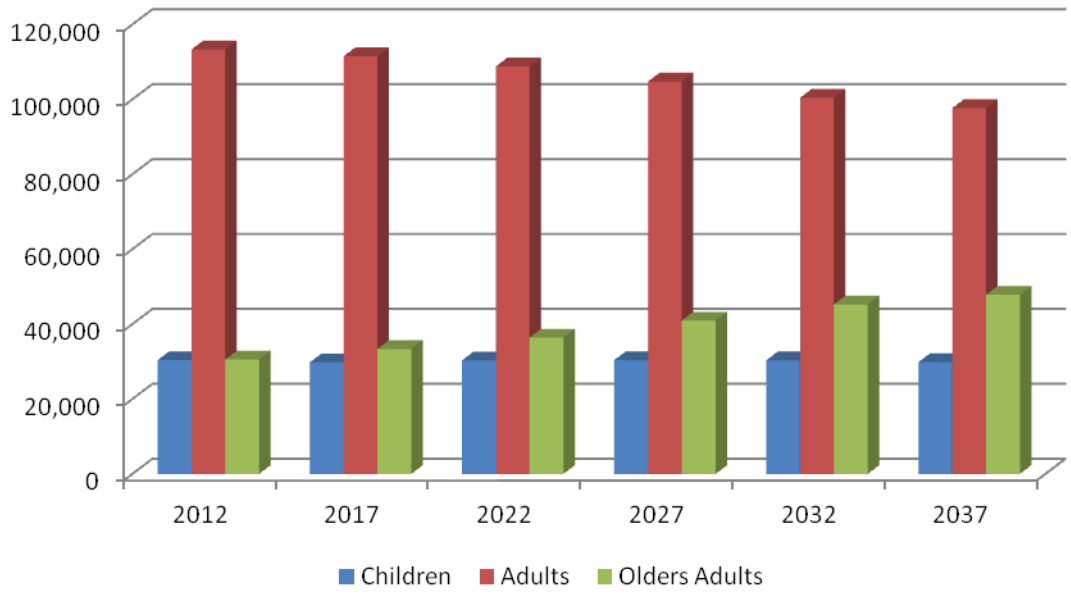
caring for people with palliative and end of life care needs.

4.6 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 housing, 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.

As a consequence of improved healthcare and better standards of living more people are living for longer. This means in Scotland that the number of people with dementia is expected to double between 2011 and 2031. This presents a number of challenges, most directly for the people who develop dementia and their families and carers, but also for the statutory and voluntary sector services that provide care and support. It is estimated that 2,912 people have dementia in Renfrewshire; 1004 male and 1908 female.

The National Dementia Strategy 2013-16 focuses on timely diagnosis of dementia and improving the quality of dementia services. The Renfrewshire Dementia Strategy Group has developed a work plan to localise the commitments of the Dementia Strategy. There was a commitment to provide at least one year's Post Diagnostic Support (PDS) for every person with a new diagnosis of dementia. This was originally attached to a HEAT target and at present there is a 100% rate of contact in Renfrewshire.

Over the next year we will begin developing a Dementia Friendly Community within Renfrewshire. This refers to a local area in which, along with health and social care staff, staff from local businesses and shops are trained in dementia awareness and make changes to their businesses to accommodate people with dementia. Following assessment of the changes, Alzheimer Scotland provides an award for the area to declare it 'dementia friendly'.

4.7 Supporting the Reduction in Delayed Discharges

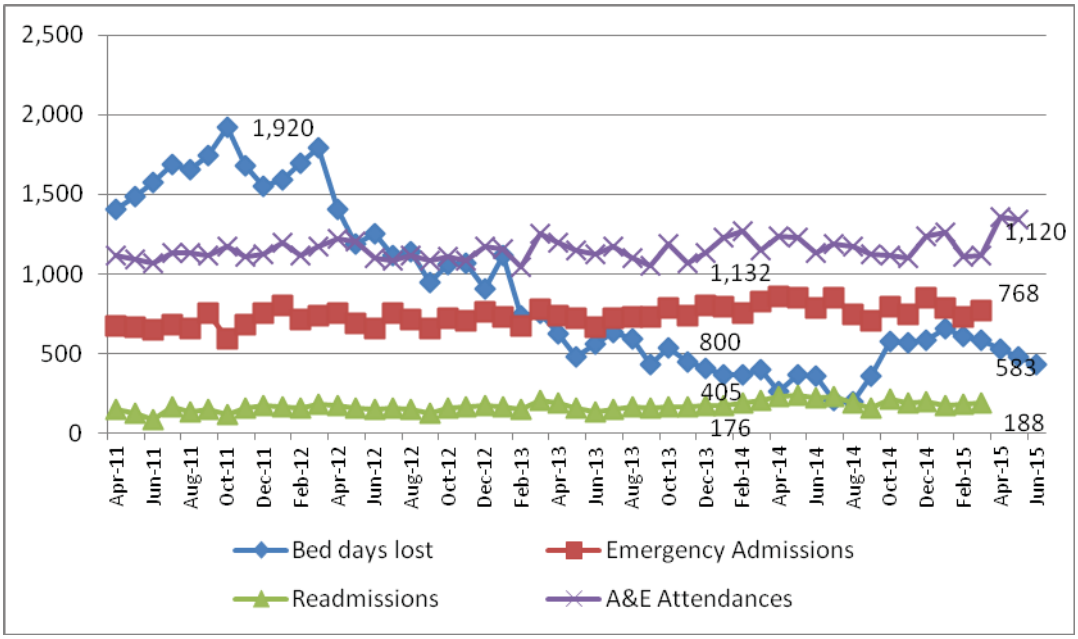
Renfrewshire has made significant progress in reducing hospital bed days lost due to delayed discharges (where a person is medically fit to leave hospital but services, adaptations and supports are not in place to allow a safe discharge).

- 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 important that we work effectively at this interface to promote self care as anticipatory and preventative approaches can reduce demands on services.

Diagram 3

Hospital Activity, April 2011 to June 2015



4.8 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 Social Worker. Renfrewshire Council has invested significantly in additional MHOs to support the increasing demands for AWI reports. The volume of work in this area 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 orders in Renfrewshire since 2010.

In addition to increasing volumes, this area of work is subject to complex and lengthy legal processes which impact on workloads.

4.9 Residential and Nursing Homes

For a number of years, there has been a shift towards supporting more older people to live at home for as long as possible. Increasingly, people moving into residential and nursing homes do so with more complex health and social needs. This meant growing demand for some specialist provision, such as dementia care, but falling demand for residential care. Renfrewshire's 10 Year Plan for Older People dealt with many of the issues that this raised. Towards the end of 2015, this trend began to reverse, and demand for residential and nursing home placements began to rise. Coupled to this, several care homes in

Renfrewshire have closed in the last two years, reducing local bed numbers.

There remains a shortage of specialist placements for very complex needs, including dementia care, care for older adults with a learning disability, care for people with substance misuse related conditions such as Korsakoff's Syndrome and care for younger people with severe physical disabilities requiring intensive support.

4.10 Care at Home

Care at home services are provided by HSCP staff but are also provided through a framework by a number of other providers.

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 remains a challenging issue for Care at Home and other care 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 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.

4.11 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%.

- 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. Those services are valued highly by carers of those with a learning disability. Resources may also be required in the future to support older people with learning disabilities and provide a specialist service.

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

The 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.

There is also a strong link between mental health problems such as depression and over-consumption of alcohol. In 2011, there were 1,626 alcohol-related hospital discharges in Renfrewshire, which is a rate of 958.6 people per 10,000 of population. This is significantly higher than the national rate of 748.6 people.

4.13 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%

4.14 Alcohol and Drugs

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 28% from 2012/13 to 2014/15 in Renfrewshire (1.22 to 1.57 per 100,000 population).

4.15 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. Many children in Renfrewshire provide caring support to parents or other family members.

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 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 has passed the Carers (Scotland) Act 2016 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.

4.16 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. Staff continue to manage these increasing workloads.

The increasing workloads have included a significant rise in the number of adult protection concerns received. In July 2015, 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.

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.

4.17 Self-directed Support

Self- directed support (SDS), alongside many other policies, is intended to support, promote and protect the human rights and independent living of care and support users by enabling individual choice and control and respecting the person's right to participate in society. SDS applies to all people who are eligible for support, allowing people to choose how their support is provided, and giving them as much control as they want of their individual budget. SDS is the support a person purchases or arranges to meet agreed health and social care outcomes.

As SDS is embedded in practice across the partnership, we will continue to:

- develop procedures and systems
- ensure that all staff have access to training to develop the right skills and knowledge to support individuals with their choices and support plans.
- further develop our communications materials, including Easy-Read leaflets and

online content, to raise awareness in both the Council and its partners

- build an online resource directory of local community assets, supports and services.

4.18 Poverty

The fundamental cause of health inequality is the unequal distribution of power, money and resources. While many activities targeted at people's lifestyles are valuable, it is essential that we focus efforts on the underlying causes of health inequalities. Anti-poverty measures such as increasing income are likely to have significant and positive impacts on health outcomes. We will continue to develop clear pathways for health and social work staff to direct patients and clients into financial inclusion and employability services. One of the recommendations of Renfrewshire's Tackling Poverty Commission is to improve levels of physical and mental health of children in low income families. Funding has been made available to implement school counselling into all 11 Renfrewshire secondary schools and to extend a successful peer education model.

4.19 Housing and Homelessness

It is essential that housing services are co-ordinated with health and social care in order to achieve a joined up person centred approach to health and social care integration. The right kind of housing in sustainable attractive places, with appropriate housing related services (e.g. housing support, housing options advice, housing adaptations, Care and Repair services and opportunities for socialisation) are critical to ensuring that people are able to live independently for as long as possible in their own home and community.

The Housing Contribution Statement provides more detail on the housing related issues for various groups, the direct links between the HSCP and the Local Housing Strategy, challenges in the housing system going forward and how these will be addressed.

2,110 people approached the Council's Homelessness Services for assistance in 2014/15. The number of homeless applicants decreased to 825 in 2014/15 – an average of 68 homeless applicants per month in Renfrewshire. Despite this reduction, the challenges of assisting the increasing proportion of applicants with multiple and complex needs are becoming more frequent. Recent research has identified that hospital admissions for homeless people is higher than for the general population living in settled accommodation. Health problems in addition to homelessness have major impacts on people's wellbeing.

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 and 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.
- Day case care in hospitals 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 the 2020 Vision and the 9 national outcomes, we need to recognise and plan based upon a number of demands and drivers.

Increasing Demand

- Many of our services are facing year on year increases in demand.
- Many of the growing demands are characterised by complexity, vulnerability and the aspiration to provide support to people in their own homes and communities for as long as possible.
- 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.

Improving Quality

- 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.
- We will continue to work closely with Community Planning partners, in particular with Renfrewshire Leisure who manage Renfrewshire's sports and cultural facilities and with Third Sector organisations like ROAR, the Carers' Centre, Housing Associations, RAMH and Active Communities who deliver services which support these directly provided by the HSCP.
- 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. In particular, we will work closely with schools to support children and young people's mental health and wellbeing. We will continue to support the Corporate parenting agenda. The recent review of governance arrangements for public protection in Renfrewshire strengthens the role of the HSCP in public protection.
- General Practice is central to highly effective, joined up health and social care. As the new GP contract comes into operation from 1 April 2016, we must review 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.

- 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.

Equally Safe

- Equally Safe is Scotland's strategy to tackle all forms of violence against women and girls. Equally Safe defines gender-based violence as encompassing (but not limited to) domestic abuse, rape and sexual assault, child sexual abuse, commercial sexual exploitation (GBV), sexual harassment and so called 'honour based violence including forced marriage, female genital mutilation (FGM) and dowry related crime'.

- Equally Safe is based on a vision of a strong and flourishing Scotland where all individuals are equally safe and respected, and where women and girls live free from all forms of violence and abuse – and the attitudes that help perpetuate it.

- The overarching aim of the strategy is to work collaboratively with key partners in public, private and third sectors to prevent and eradicate all forms of violence against women and girls. It highlights the need for primary prevention through action to reduce gender inequality and secondary prevention through early interventions to identify and protect victims of abuse and to prevent or disrupt the abuser continuing to perpetrate abuse. It therefore has relevance for health, social care, and criminal justice services.

- At a strategic level, actions which HSCPs and Acute Services take to prevent it and to protect and support those who experience it, fit well with wider strategies and objectives aimed at reducing gender and health inequalities and creating safer communities.

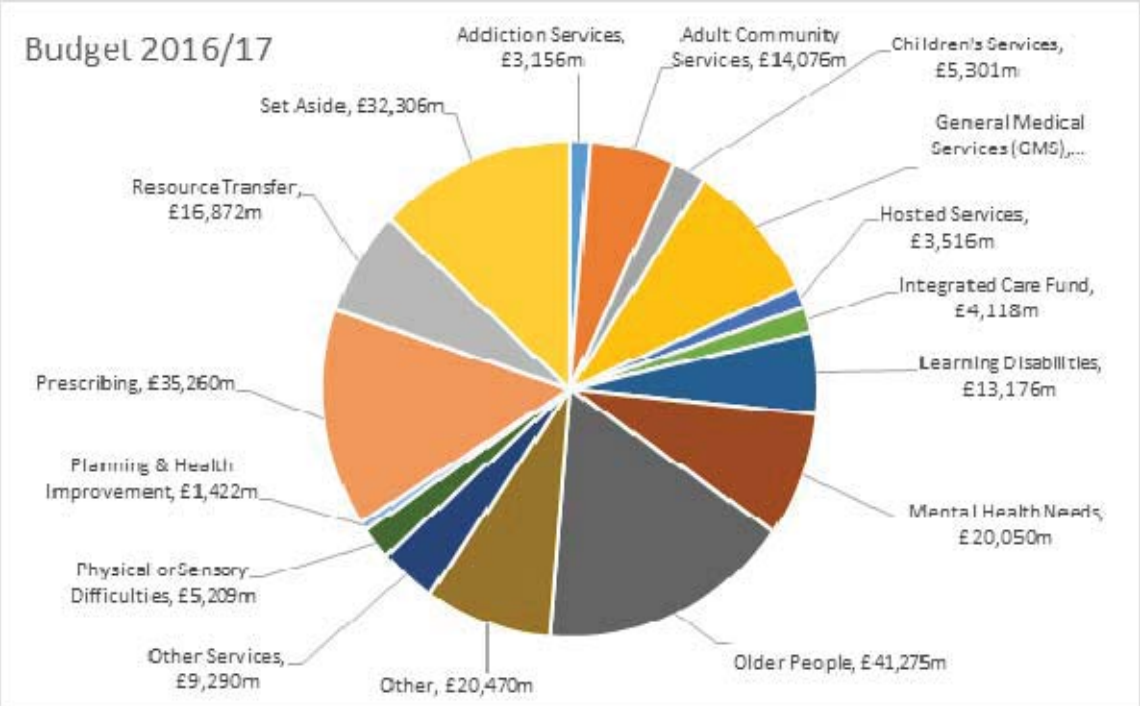
- At a practical level, health and social care staff are uniquely placed to identify and respond to disclosures of abuse and they may provide the one and only chance for an abused person to get the help and support they need.

6. Our Resources

6.1 Context

As set out earlier, this Strategic Plan provides the framework for the development of health and social 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 approved HSCP budget for 2016/17 from Renfrewshire Council and NHS Greater Glasgow and Clyde is £248.269m. The Set Aside budget for unscheduled hospital care is included within the total resources for 2016/17 is £32.3m. The chart below provides a breakdown on where funding is spent.



6.2 Financial Governance

The IJB oversees the budget and spending of the HSCP to ensure funds are spent in ways that deliver the local and national outcomes agreed through statue and within the Plan.

The Chief Finance Officer is required to submit regular financial updates to the IJB, so that the IJB can scrutinise how public money is being used. These reports are also published on the HSCP website, so that anyone who lives in Renfrewshire, or has a vested interest in health and social care in Renfrewshire, can see exactly how we spend the money

delegated to the Partnership.

Renfrewshire IJB is a legal entity in its own right, with delegated responsibility to plan, deliver and resource a range of services and functions on behalf of NHS Greater Glasgow and Clyde and Renfrewshire Council.

The money to fund these services and functions comes to the IJB from the Council and Health Board. Governance arrangements are in place to ensure that the money is sufficient to deliver the Council, Health Board and IJB's priorities. These arrangements also include assurance that the money is being spent in the way that has been agreed and committed to through this Plan.

The IJB complies with the CIPFA Statement on "The Role of the Chief Financial Officer in Local Government 2010". The IJB's Chief Finance Officer has overall responsibility for the Partnership's financial arrangements including the annual budgeting process to ensure financial balance and is professionally qualified and suitably experienced to lead the IJB's finance function and to direct finance staff.

6.3 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 organisations 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.

6.4 **Meeting the Financial Challenges Ahead**

If there are no changes to the way that services are planned and delivered with partners across all sectors, current service provision will not be sufficient to meet the future health and social care needs of the 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 patients.

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. 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.

- Developing community capacity, recognising that some of the best solutions to our challenges come from those at a local level involved in providing care and support.

Service reviews prioritised for the next two years reflect the national policy direction to shift resources and 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 Carers' legislation.

6.5 **Capital Funding**

The IJB does not directly own any property or assets, or receive any capital allocations or grants. The Chief Officer must consult with both the Local Authority and the NHS Board to make the best use of existing resources and develop capital programmes. A Joint Capital Planning Group has been established to have a strategic overview of HSCP property related plans and to develop a rolling programme of work for all HSCP premises.

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 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.
- We will strive to maintain our high immunisation rates in Renfrewshire schools.
- We will review Occupational Therapy services and provision of equipment and adaptations to help promote independent living.
- We will promote the recovery agenda by continuing to monitor the use of the STAR Outcomes tool across drug and alcohol services.

Community Led Activity

- We will enable people to become better connected with each other and encourage co-operation, mutual support and caring within their communities.
- We will support the Renfrewshire Tackling Poverty Programme through a range of specific programmes.
- We will continue to support and signpost patients and service users 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 and to comply with equalities legislation.

Adult and Child 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. This remains a high priority for us.

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 (including pharmacy) through the Renfrewshire Development Programme. This programme, led by NHS Greater Glasgow and Clyde, worked with partners to test new approaches to reduce hospital admissions and promote early discharge.
- 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's services and the Renfrewshire Local Housing Strategy (LHS) highlight the need to respond to the rising demand for smaller properties and for homes which are fully accessible. The LHS also recognises the need to develop appropriate housing solutions to meet the requirements of specific groups. 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 and the Technology Enabled Care Programme (TEC) programme 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.

Support for Carers

- Carers are key partners in contributing to many of the priorities above. We will progress the issues raised by local carers and those in national legislation and guidance: accessing advocacy, providing information and advice and involving them in service planning. In addition, we will specifically work with and support young carers.
- 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 a range 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, working with pilot physiotherapy post. 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, recognising the role of AHPs and other practitioners.	Number of financial inclusion workshops delivered.	4	5

1. Population Health and Wellbeing			
Action	**Indicator**	**16/17 Target**	**National Outcome**
	Number of staff attending 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	48 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.	Number 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 in partnership with Renfrewshire Council's Children's Services.	Procure and oversee implementation of school counselling service. Agree individual models of peer mentoring with all schools.	April 2016 May 2016	5

1. Population Health and Wellbeing			
Action	**Indicator**	**16/17 Target**	**National Outcome**
	Establish target activity levels for both initiatives.	June 2016	
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 Work with Third Sector partners and specialist dietetic services to 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	Increase uptake of the 30 month check and share information appropriately with early years establishments 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
2.2	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
2.3	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
2.4	Continue to support a population based model of parenting programmes.	% of staff trained in Solihull: Number of attendees at Triple P seminars (Level 2). Number of interventions at levels 3 and 4.	90% 40 200	1
2.5	Deliver Autism Spectrum Disorder waiting times target	Referral to assessment time.	18 weeks	3
2.6	Deliver CAMHS referral to treatment waiting times HEAT target.	Referral to treatment time.	18 weeks	3
2.7	Reduce speech and language therapy waiting times in community paediatrics.	Percentage of paediatric Speech & Language Therapy wait times triaged within 8	100%	3

2. Child and Maternal Health			
Action	**Indicator**	**16/17 Target**	**National Outcome**
	weeks Number waiting more than 18 weeks for paediatric Speech & Language Therapy assessment to appointment	 0	 3
2.8 Implement recommendations from multi-disciplinary Inspection Report	Action Plan developed	May 2016	7
2.9 Reduce conceptions in young people under 20 years old.	Teenage pregnancies (15-19) at conception (crude rate/1000).	35 per 1,000	1
2.10 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) Awareness sessions/training in school and other settings.	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. 400 young people reached in school assemblies. 50 young people in community settings reached. Support 2 Freshers'	5

2. Child and Maternal Health			
Action	**Indicator**	**16/17 Target**	**National Outcome**
		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
2.15 Work in partnership with the Carers' Centre and schools to support young carers to have increased confidence, skills and knowledge for managing their caring role.	Training and support to secondary and primary schools. 40 young carers identified and supported.	11 secondary schools 12 primary schools 40 young carers	6

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.	% of care 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 and adult protection case conferences (public protection issues).	GP reports received on time for Case Protection conferences. GPs invited to case conferences	90% 100%	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 for people with long term conditions i.e. COPD, heart failure and diabetes.	Number of people receiving home health monitoring.	350	2
3.10 Increase number of carers on the carers' registers in GP Practices.	Number of carers identified	10% increase	6

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 partnership 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.	By March 2017 50 screenings completed per month completed (local target) By March 2017 50 assessments per month completed (local target) 60	2
4.2 Evidence the provision of 12 months post diagnostic support for people with dementia, and promote the Learnpro module in dementia awareness.	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

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 Re launch Renfrewshire Autism Strategy.	Action plan developed and monitored.	September 2016	4
5.4 In recognition of the growing number of adults with autism, provide Autism Awareness Training to all health and social care staff within RLDS.	Percentage of staff trained	90%	8
5.5 Develop in conjunction with project Search and work placement within RLDS.	The provision of work placements.	1 placement per year to 2018/19	4
5.6 Establish a forum to enable adults with learning disabilities to participate in all aspects of strategic plans, future plans and in the provision of person centred services.	Service User Involvement and Participation Strategy developed and implemented.	March 2017	4
5.7 To ensure all staff have a sound understanding and knowledge of their role in Adult Support and Protection.	Percentage of staff trained in the programmes appropriate to their role.	90% by March 2017	7
5.8 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
5.9 To ensure future work plan is in place to enable the service achieve national performance targets as outlined 'HEAT' Targets	Interventions and Professional national HEAT Targets	90%	1

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 Implement service improvements around rehabilitation services.	Revised Occupational Therapy pathways. Reduced waiting times for people with a physical disability referred to RES – maximum wait times determined by service criteria.	March 2017 Urgent – 3 working days Priority – 5 working days Routine – 9 weeks	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 National Delivery Plan	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% 100%	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 Continue to raise awareness of, and deliver on, Suicide Prevention training in respect of frontline HSCP staff working with adults.	% of staff trained in 'Choose Life' in accordance with their job roles.	90%	7
7.5 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
7.6 Support people in mental health and addictions services to access employment opportunities.	Total referrals: Addiction referrals: Mental health referrals:	310 110 200	5

7. Mental Health			
Action	**Indicator**	**16/17 Target**	**National Outcome**
7.7 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. Alcohol and Drugs			
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 admissions per 100,000 population Drug related hospital stays. Naloxone units issued. Drug related deaths. Alcohol related deaths. Establish baseline and reduce the number of repeat Adult Support and Protection referrals within drug and alcohol services.	8.24 1.35 30% coverage of problem drug users. 13.9 per 100,000 population 27.5 per 100,000 population 10% reduction	7
8.3 Deliver Alcohol Brief Interventions in primary care and in wider settings.	Number of Brief Interventions (primary care) (older people) (young people)	1,116 40 staff trained Establish baseline 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. Alcohol and Drugs			
Action	**Indicator**	**16/17 Target**	**National Outcome**
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 The Torley Unit (Addictions Day Services) Evidence of service change	 60 30 80 One example from each service implemented as part of You Said – We Did.	3
8.6 Promote the recovery agenda by continuing 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
8.8 In the transition to this new organisation, maintain networks and links to partners in Children's Services, Criminal Justice, mental health and child and adult protection.	Regular meetings with Heads of Service	Review by March 2017	4

NB. More detailed actions are described in the Alcohol and Drugs Partnership (ADP) Delivery Plan.

9. Carers			
Action	**Indicator**	**16/17 Target**	**National Outcome**
9.1 Prepare for the implementation of the new Carers' Act.	Carers' Strategy 2017 – 2019 developed	June 2017	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	200	6
9.5 Increase the uptake of Carers' Assessments.	Number of carers' assessments completed for adults (18+)	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 Changes in practice and guidance in relation to adult support and protection procedures are disseminated to appropriate staff.	Guidance produced and operational. Staff are briefed and clear on their role within Adult Support and Protection. % of case files audited by the multi-agency Case File Audit, that evidence effective partnership working	March 2017 100% 90%	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

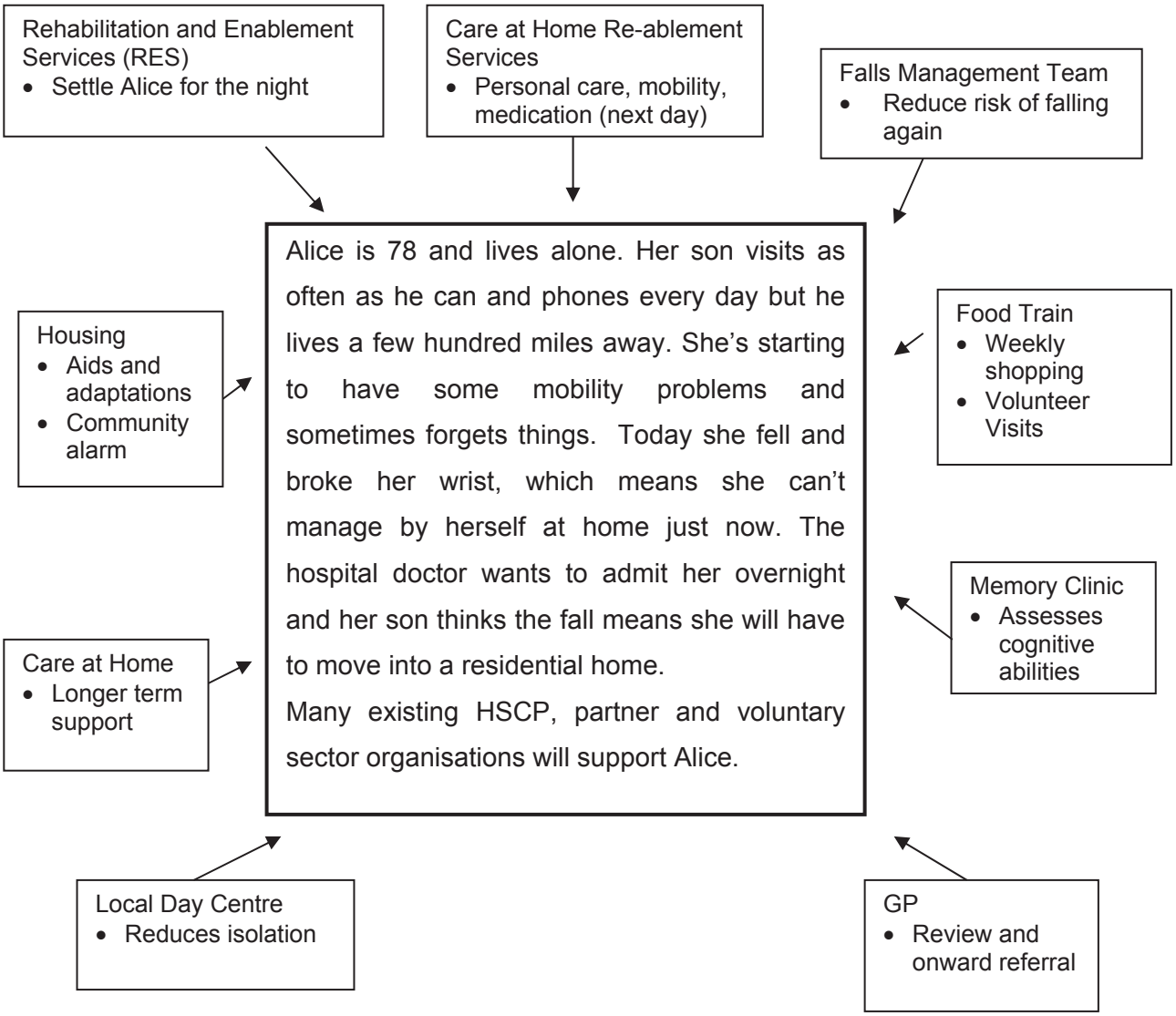
10.6	Embed self-directed support model in locality teams.	Locality managers assume day to day management responsibility for budget monitoring and care planning for service users eligible for SDS.	June 2016	8
10.7	Implement a scheduling system within Care at Home services.	System operational.	March 2017	9
10.8	Develop baseline data on workforce capacity with regard to Gender Based Violence (GBV).	Baseline established	December 2016	5
10.9	Work in partnership with statutory and third sector agencies to improve identification and co-ordinated response to GBV.	Sensitive Routine Enquiry of GBV embedded into practice. % of clients in Health Visiting and Mental Health Services who are asked routinely about GBV (when is it safe to do so). Number of Multi-Agency Risk Assessment Conferences (MARACs) held in Renfrewshire.	March 2017 100% 12	5
10.10	Roll out the Scottish Patient Safety Programme Pharmacy in Primary Care, piloted in the Paisley community pharmacies, to all community pharmacies in Renfrewshire HSCP.	% of community pharmacies providing data collection activities for SPSP PPC	80%	7
10.11	Promote the update 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

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
11.3 Evidence that networks and links between the HSCP and partners are maintained.	Effective governance structure	June 2016	8
11.4 Support community pharmacists to implement and use clinical portal across Renfrewshire for medicines reconciliation and pharmaceutical care purposes.	% of community pharmacies using clinical portal	80%	9

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 from 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

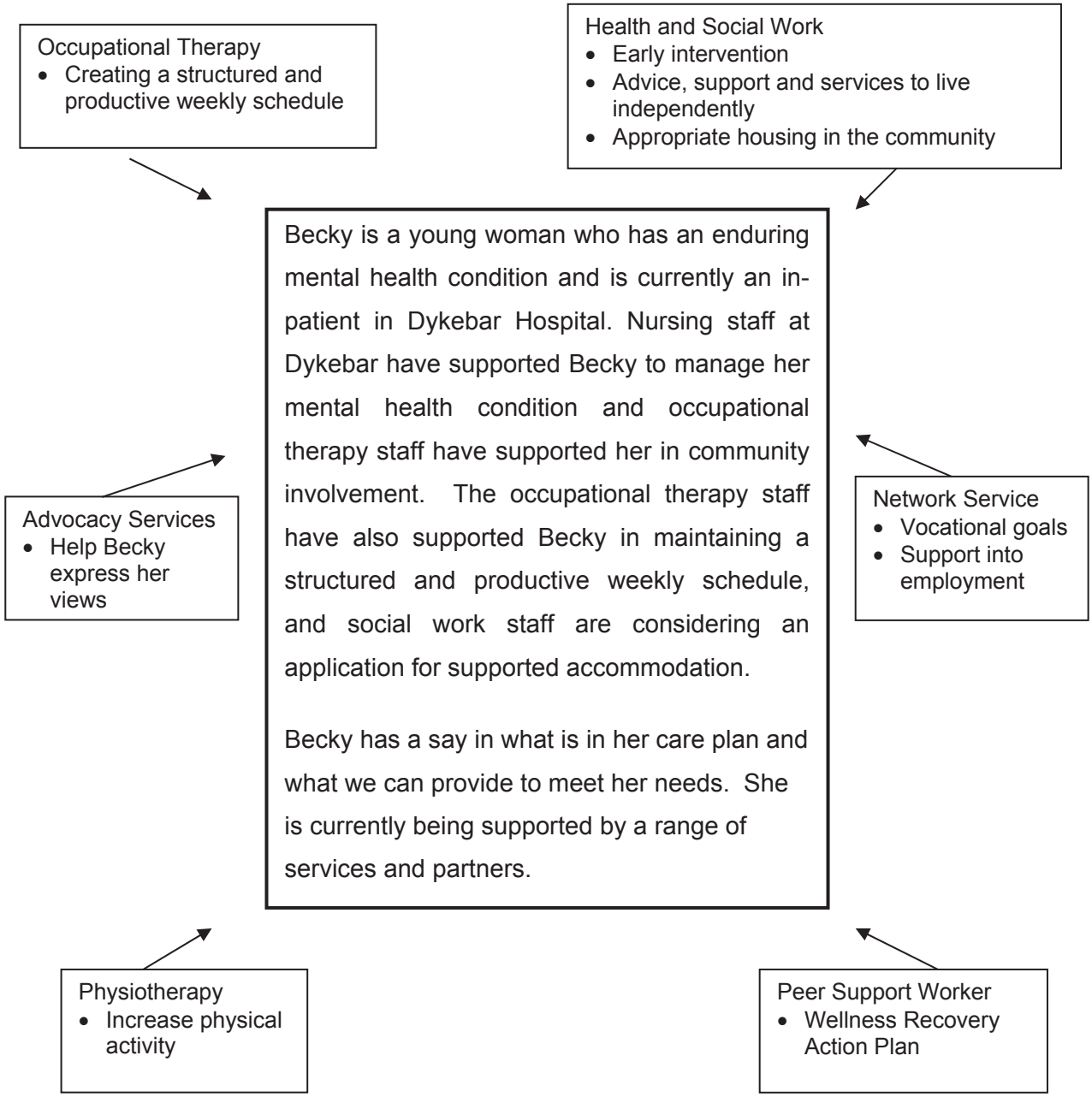
1. Case Studies

What this plan means for Alice and the support available to her



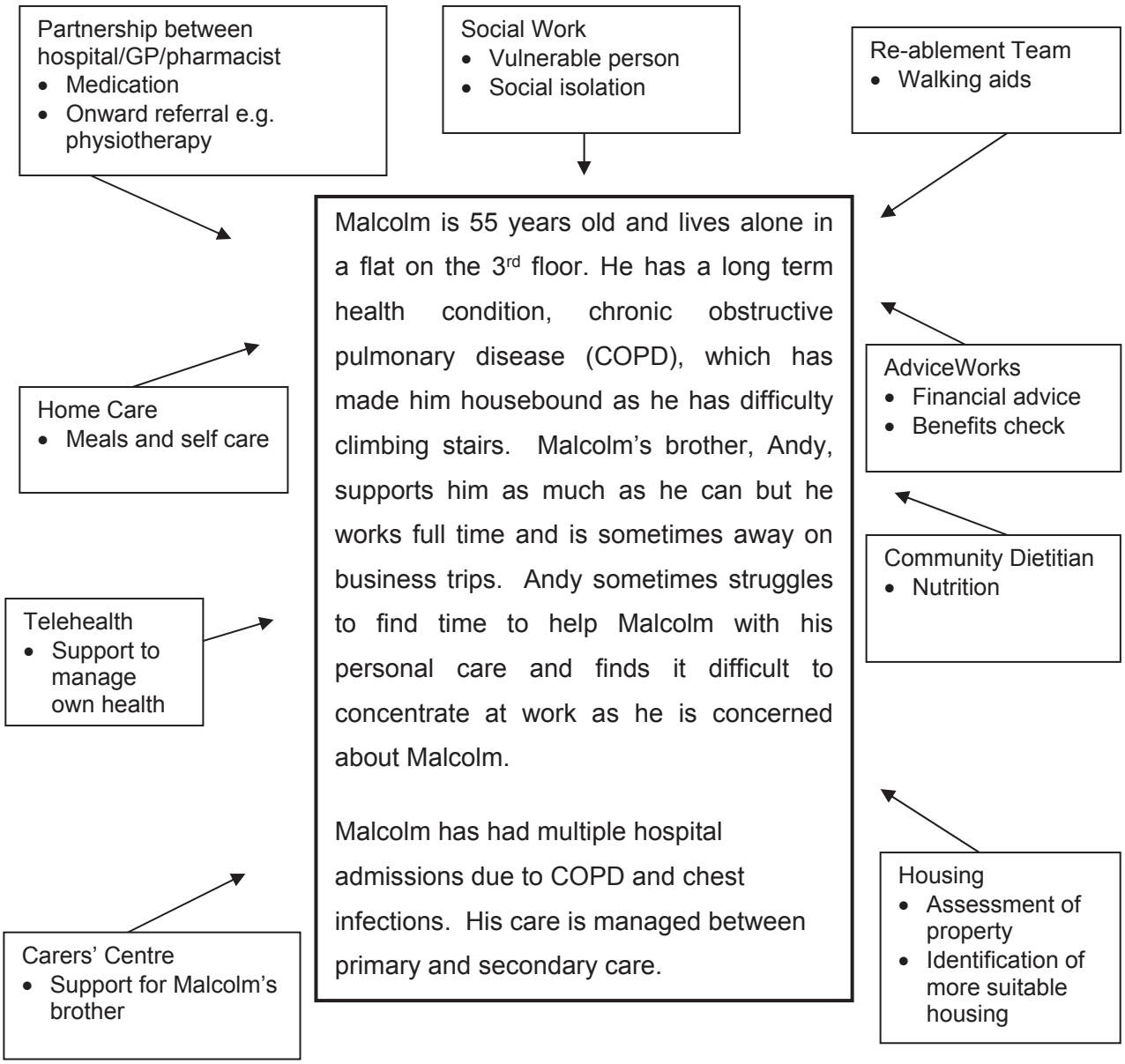
How the Partnership will improve services for Alice in the next 3 years	Action Plan Reference
Work with partners to develop a range of physical activity options to reduce barriers to access and target less active people.	1.3
Increase the number of people benefiting from the Community Falls pathway.	4.1
Reduce the number of falls using the Smartcare online tools in with neighbouring Health and Social Care Partnerships and Health Boards.	4.2
Maintain target levels of lost bed days.	4.4
Implement home health monitoring through the Tec Programme in partnership with East Renfrewshire HSCP.	3.9
Continue to deliver services which support a shift in the balance of care towards community-based services.	10.3
Implement a scheduling system within Care at Home services.	10.7

What this plan means for Becky and the support available to her



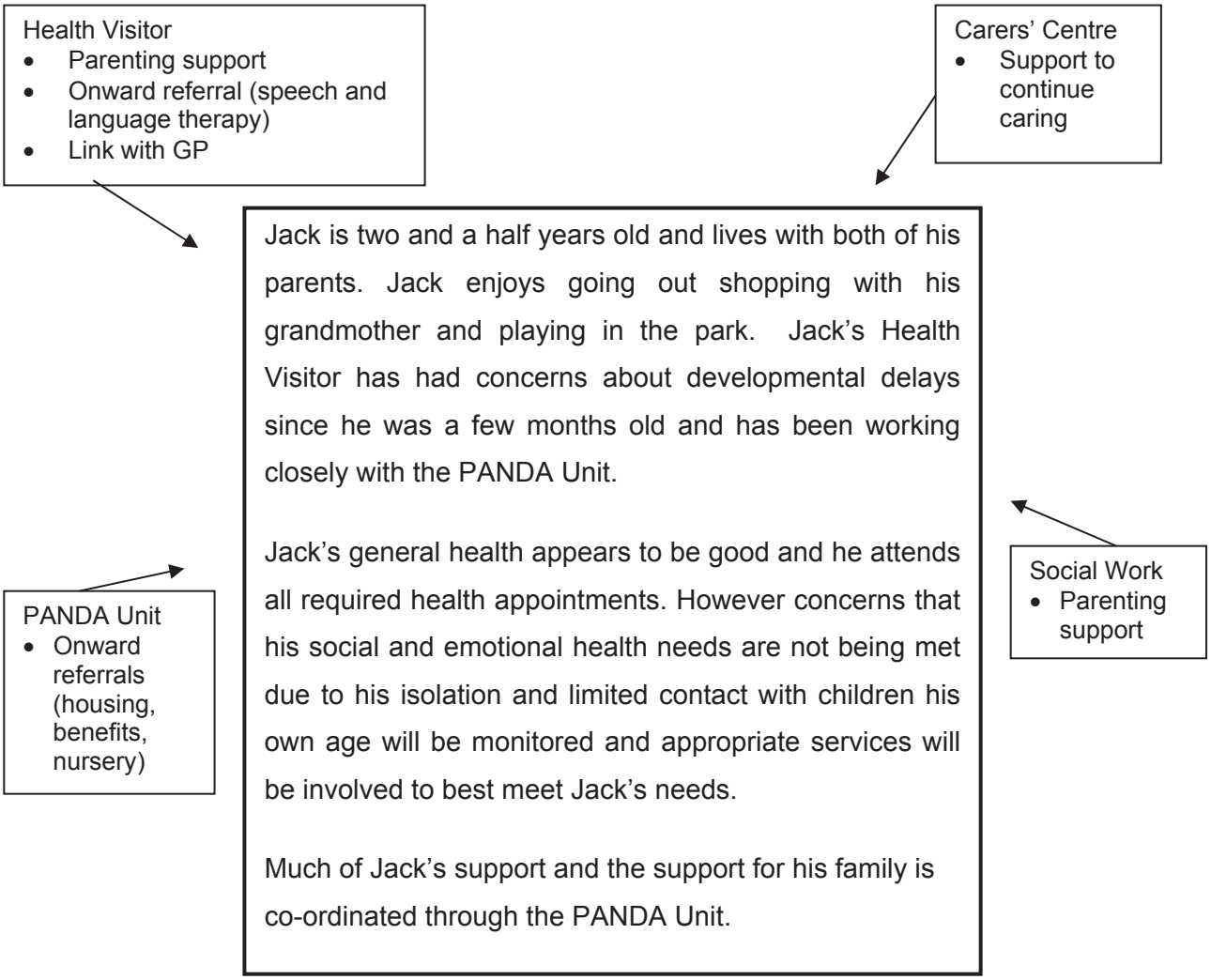
How the Partnership will improve services for Becky in the next 3 years	Action Plan Reference
Work with partners to develop a range of physical activity options to reduce barriers to access and target less active people.	1.3
Raise awareness of mental health issues among the general population.	1.10
Support people in mental health and addictions services to access employment opportunities.	7.5
Demonstrate changed practice in inpatient and community services as a result of listening to patient feedback e.g. Charleston Centre upgrade.	7.6
Embed self-directed support model in locality teams.	10.6

What this plan means for Malcolm and the support available to him



How the Partnership will improve services for Malcolm in the next 3 years	Action Plan Reference
Work with GPs in clusters to pilot improved ways of working with community and social care staff.	3.4
Establish a single route into web based information about long term conditions.	3.6
Support the respiratory early supported discharge initiative.	3.8
Implement home health monitoring through the Tec Programme in partnership with East Renfrewshire HSCP.	3.9
Increase the number of carers identified by GPs and referred to the Carers' Centre.	3.10
Support carers to continue in their caring role.	9.3
Increase the uptake of Carers' Assessments.	9.5
Embed self-directed support model in locality teams.	9.6

What this plan means for Jack and the support available to him



How the Partnership will improve services for Jack in the next 3 years	Action Plan Reference
Increase uptake of the 30 month check and share information appropriately to maximise readiness for schools.	3.4
Continue to support a population based model of parenting programmes.	3.6
Reduce speech and language therapy waiting times in community paediatrics.	3.8
To ensure the establishment of a named person service for pre school children residing in Renfrewshire from August 2016.	3.9
To ensure agreed process for receipt of information related to wellbeing concerns by named person.	3.10
Increase the uptake of Carers' Assessments.	9.3
Support young adult carers in the transition from young carer to young adult carer.	9.5
Improve transition planning for service users moving between services or care groups.	10.6

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**

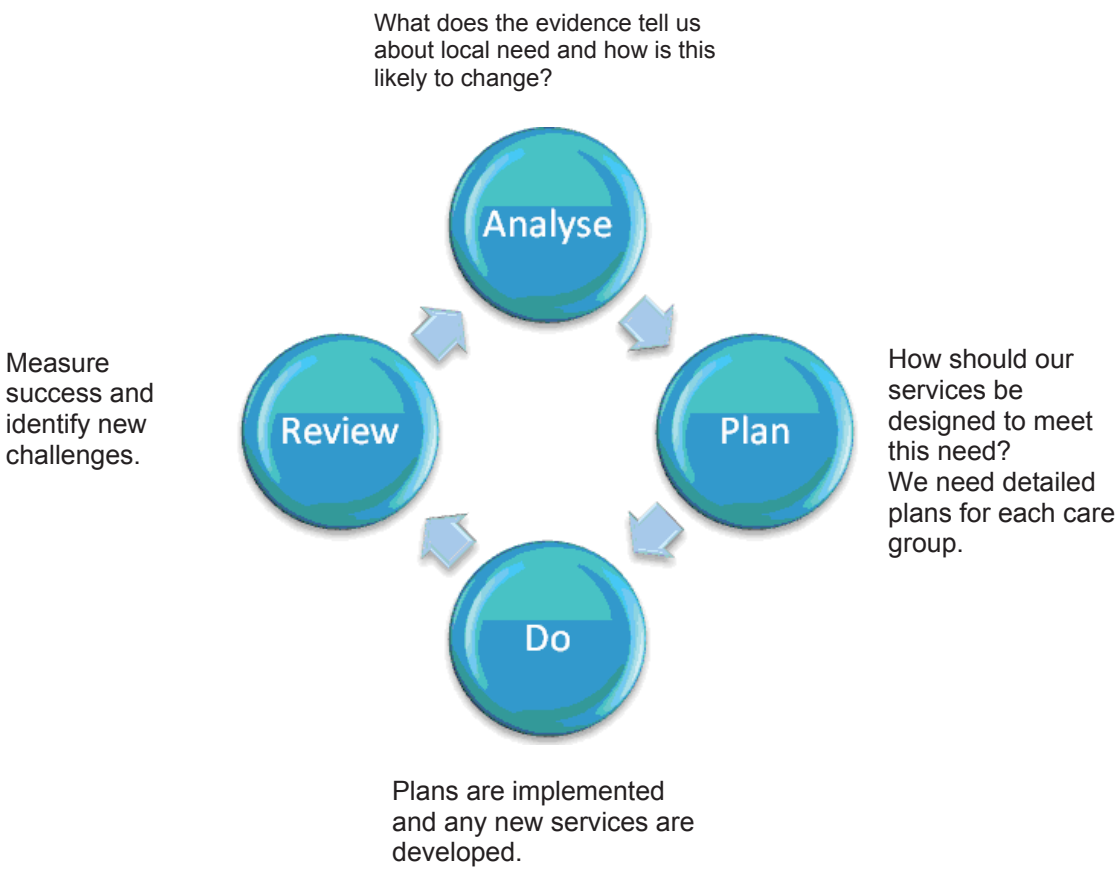
Implementation of the ***Social Care (Self-directed Support) Act 2013*** will affect the delivery of services for people with assessed social care needs as it embeds over time. Where there is an assessed need, individuals can now have an allocated personal budget, which they can choose to take as a direct 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 covered a range of areas relating to supporting carers, such as Adult Carer Support Plans, Young Carers' Statements and Carer Involvement. The Bill proposed 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. It was passed by the Scottish Government in February 2016.

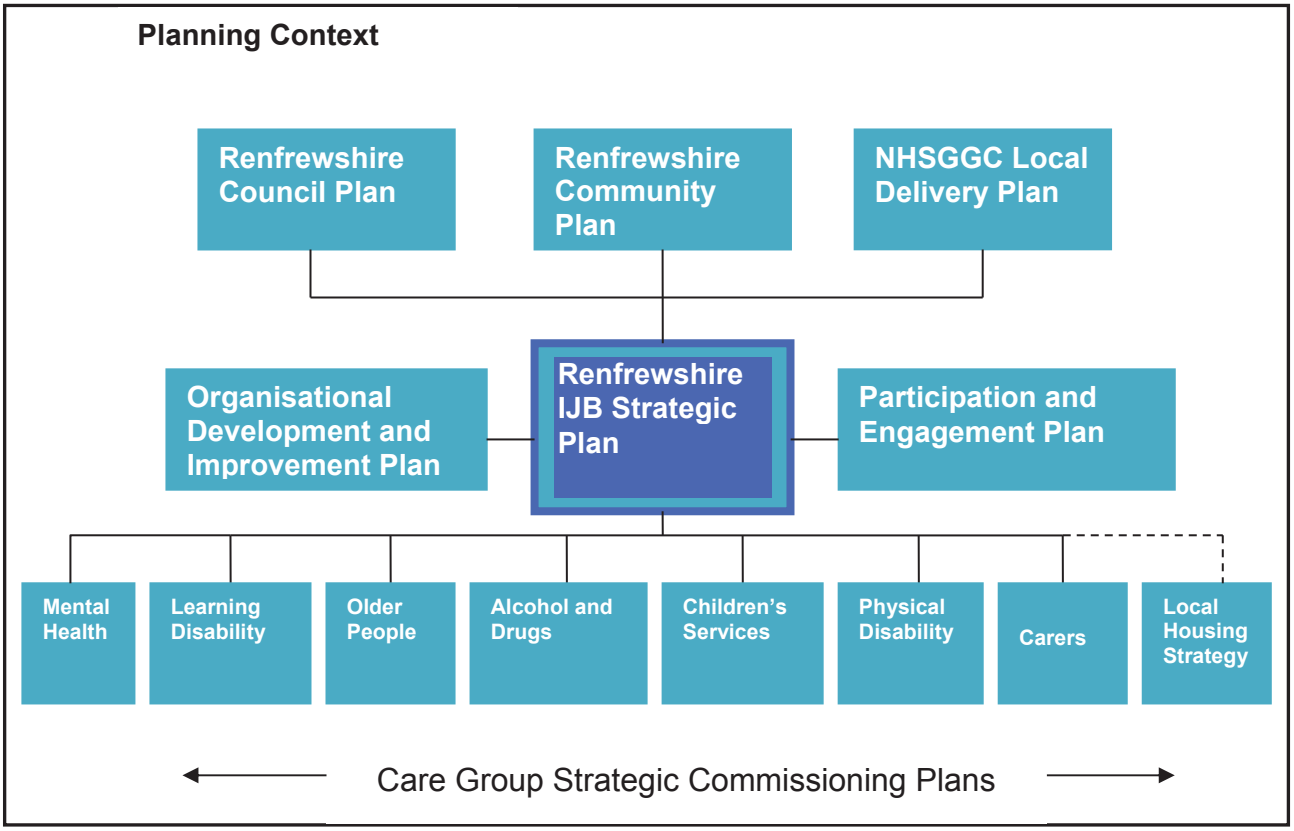
The Community Empowerment (Scotland) Act 2015 received royal assent in July 2015. It aims to empower communities through ownership of land and buildings and by strengthening the community's voice in local decisions. It also supports a quickening of Public Sector Reform by focusing on achieving outcomes 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

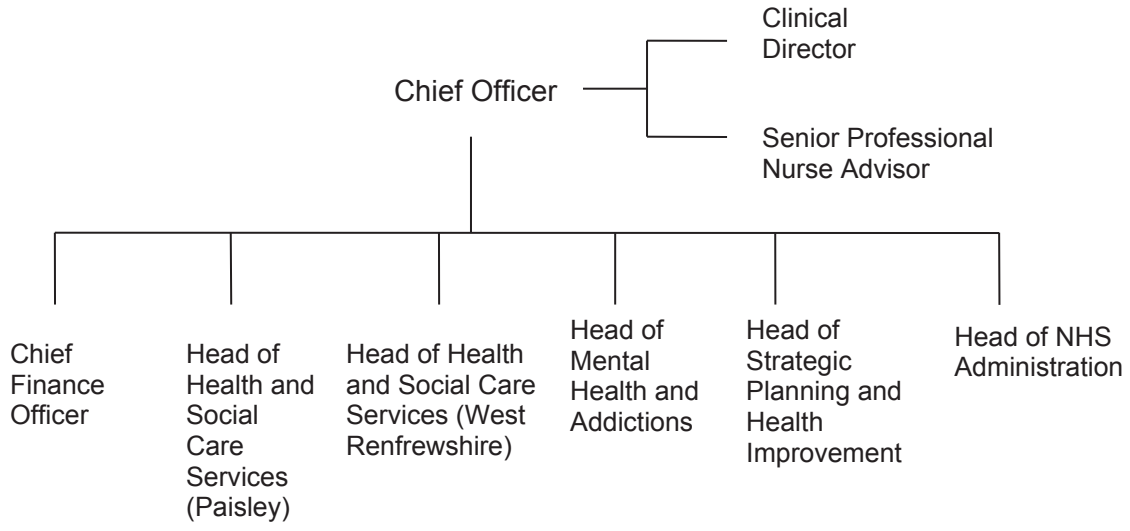
- Accident and Emergency services provided in a hospital
- Inpatient hospital services relating to the following-
  (a) general medicine
  (b) geriatric medicine
  (c) rehabilitation medicine
  (d) respiratory medicine
  (e) psychiatry of learning disability.
- Palliative care services provided in a 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 Strategic 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 or user of social care Carer or 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.

3. Renfrewshire Housing Contribution Statement (Summary)

1.1 Introduction

Housing has a critical role in terms of improving health and social care national health and wellbeing outcomes for people in Renfrewshire. This being the case, Renfrewshire Council's Development and Housing Service as well as local Registered Social Landlords (RSLs) will work closely with Renfrewshire Health and Social Care Partnership (HSCP) to ensure continuity in services as well as improving outcomes. A local authority housing representative and an RSL representative ensures linkage between the different partners and organisations via the HSCP's Strategic Planning Group (SPG). The Housing Contribution Statement is an important part of the HSCP's Strategic Plan.

1.2 Housing need and demand

The Draft Local Housing Strategy (LHS) 2016-2021 identifies housing needs and demands at a local authority level and sets out the various investment programmes which will deliver positive outcomes. The LHS references a number of client groups where a housing contribution would assist in improving health and well being. New homes are not always required; in many instances peoples' needs can be met through existing stock with the provision of physical modifications or provision of appropriate support.

This strategy has informed the development the HSCP Strategic Plan, which provides direction for the actions needed to improve health and social care services and details how the Integrated Joint Board (IJB) sets out to create an integrated approach to delivering health and social care services.

The HSCP has carried out initial scoping work to develop strategic commissioning plans for services associated with learning disabilities, mental health and physical disability/ sensory impairment/ long term conditions. The HSCP, other RSL partners and Development and Housing Services will work closely together following completion of these commissioning plans to determine the best way of addressing housing related need for these client groups and we will use existing housing stock and housing support services where possible to meet needs. Renfrewshire Council Development and Housing Services will take account of any subsequent actions arising from the completion of the commissioning plans in future annual LHS updates. A shared evidence base will be established through our joint working arrangements.

1.3 Client Group Links with Health and Social Care Needs

Listed below are the key client groups with varying complex needs that require or will potentially require at some stage a housing related contribution to improve health and well being:

- People who are homeless or who are at risk of homelessness;

- People with Mental Health conditions;
- People with Learning Disabilities;
- People with Physical Disability, Sensory Impairment and long term conditions;
- People with addictions;
- Older people; and
- Young people (care leavers transitioning from Children's Services to Adult Services).

1.4 Shared outcomes and service priorities

The LHS 2016-2021has 7 key outcomes that the Council and partners seek to achieve in relation to housing and housing related services over the 5 year period of the strategy:

- ***Outcome 1*** *The supply of homes is increased;*
- ***Outcome 2*** *Renfrewshire will have sustainable, attractive and well designed mixed with well functioning town centres;*
- ***Outcome 3*** *People live in high quality, well managed homes ;*
- ***Outcome 4*** *Homes are energy efficient and fuel poverty is minimised;*
- ***Outcome 5*** *Homelessness is prevented whenever possible and advice and support is provided to vulnerable households;*
- ***Outcome 6*** *People are supported to live independently for as long as possible in their own homes and communities; and*
- ***Outcome 7*** *People can access affordable housing that meets their needs at the right time.*

There are a number of key links between these outcomes and the Strategic Plan themes and high level priorities. These are explicitly listed in the full Housing Contribution statement. The consultation processes for the Local Housing Strategy and Strategic Plan provided the opportunity for all relevant partners to realise the areas of shared responsibility in identifying future housing priorities and the necessity of strategic commissioning plans for care groups to develop the right types of services. It also highlighted the necessity for closer and strengthened partnership working.

1.6 Housing related challenges

There are a number of key challenges in terms of delivering positive outcomes and meeting our shared priorities. These include:

- Meeting the increasing demand and need for adaptations given tightening financial constraints;
- The necessity for a holistic approach to the provision of appropriate services and accommodation for the increasing proportion of homeless clients with complex needs such as mental health and addictions issues;
- Preventing homelessness, particularly those 'discharged from prison/hospital care or other institution';
- Improved shared evidence base to identify housing and housing related support requirement for specific groups, and utilise this to commission services that are fit for purpose amongst those with mental health issues, learning disabilities, physical disabilities as well as sensory impairment / long term conditions; and
- Ensuring that there is appropriate housing (whether new or modified) and support to meet particular needs, for example the Reshaping of Care for Older People agenda and more widely the policy shift to support independent living within communities.

1.7 Resources

The Public Bodies (Joint Working) (Scotland) Act 2014 prescribes a number of housing functions that local authorities must delegate to the Health and Social Care Partnership within their area, and number of housing functions that a local authority may chose to delegate in addition. The housing functions that are delegated to the Renfrewshire HSCP are services involving equipment and adaptations and gardening assistance. Renfrewshire Council will make a direct contribution to health and social care through delegated budgets. As well as delegated resources noted, a whole range of different housing and related services funding streams provide a resource to deliver projects and services that help support health and social care integration outcomes. These include:

- Affordable Housing Supply Programme – Scottish Government funding subsidy for local authority and RSL new affordable housing;
- Care and Repair funding ;
- Scottish Government funding and RSLs own resources for adaptations in RSL properties;
- Commissioned housing support;

- Sheltered housing support services;
- Scottish Government and Energy Supplier funding for home insulation and energy efficiency schemes; and
- Tenancy sustainment initiatives including those funded by Shelter Scotland and housing associations.

The full Housing Contribution Statement is available at **www.renfrewshire.gov.uk/integration**

4. Data Sources

- Department of Public Health Biennial Report, 2015-2017
- Renfrewshire Adult Health & Wellbeing Survey 2014
- The Scottish Public Health Observatory: http://www.scotpho.org.uk/
- ScotPHO Health and Wellbeing Profile
- SMR01, NRS Small Area Population Estimates 2009, 2010, 2011, 2012, 2014 (2011 and 2012 based on 2011 Census).
- National Records of Scotland: http://www.nrscotland.gov.uk/
- Carers UK (2012) In Sickness and Health
- People with Learning Disabilities in England 2011 (Emerson et al)
- Psychiatric Morbidity Among Adults Living in Private Households (2001), Singleton N, Bumpstead R, O'Brien M, Lee A, Meltzer H
- Equality Act 2010
- Renfrewshire Tackling Poverty Commissioning Report: http://www.renfrewshire.gov.uk/wps/wcm/connect/b74e4e63-e549-4fbf-987d-9a9d5d981c2e/ce-RenfrewshireTPCReport.pdf?MOD=AJPERES
- Renfrewshire Community Plan: http://www.renfrewshire2023.com/

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 Professional (AHP) is a term used to describe a number of individual professions which support people of all ages with a wide variety of interventions and treatment. AHPs providing services to the HSCP include Physiotherapists, Dietitians, Occupational Therapists and Speech and Language Therapists each bringing their own unique specialist skills to support the population across Renfrewshire.

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, a 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 costs.

GIRFEC – Getting It Right for Every Child

Getting It Right for Every Child (GIRFEC) is the national 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; and believes 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.

Healthier Wealthier Children (HWC)

The Healthier, Wealthier Children (HWC) project's aim is to develop new approaches to providing money/welfare advice and help to pregnant women and families with children at risk of, or experiencing, poverty, across NHS Greater Glasgow and Clyde. A key aim of the project is to establish accessible, sustainable referral pathways between early years' health staff and money/welfare advice services, to maximise income and provide financial advice and support to vulnerable families, with a view to mainstreaming this child poverty response within health and financial inclusion services to alleviate child poverty.

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 Schemes 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).

KARDEX

A Kardex is a medical information system used by nursing staff as a way to communicate important information on their patients. It is a quick summary of individual patient needs that is updated at every shift change.

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.

LearnPro

LearnPro is an easy to use workplace learning online system where NHS staff can manage their own profile and assessments and build up the evidence needed to demonstrate their knowledge and understanding.

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.

PANDA Centre

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.

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.

PIP – Personal Independence Payment

Personal Independence Payment (PIP) helps with some of the extra costs caused by long-term ill-health or a disability if you're aged 16 to 64. The rate depends on how the condition affects the person's health, not the condition itself. An assessment is carried out to work out the level of help given. The rate will be regularly reassessed to make sure the person is getting the right support.

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 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, learning 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. In Renfrewshire, the HSCP manages a TECs service covering Community Alarms and Telecare.

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.