To: **Renfrewshire Integration Joint Board**

On: **23 June 2017**

Report by: **Chief Officer**

Subject: **Annual Performance Report 2016/17**

1. Summary

1.1 The Public Bodies (Joint Working) (Scotland) Act 2014 obliges all Health and Social Care Partnerships (HSCPs) to publish a performance report covering performance over the reporting year no later than four months after the end of the reporting year. The Annual Performance Report 2016/17 is appended to this paper.

1.2 An update on performance is presented at all IJB meetings. The full scorecard updating all performance measures is presented twice yearly. The 2016/17 year end scorecard forms part of the Performance Report appended.

2. Recommendation

It is recommended that the IJB:

- Approves the 2016/17 year end Performance Report for Renfrewshire HSCP, attached at Appendix 1.
- Agrees the publication and dissemination of this report.

3. Annual Performance Report 2016/17

3.1 The Scottish Government guidance accompanying the Public Bodies (Joint Working) (Scotland) Act 2014 gave direction to those producing partnerships' Performance Reports. The guidance notes that the reports are produced for the consideration of partnerships themselves, and it is their responsibility to act on the information and recommendations within them. The report should be published and made available online, ensuring it is accessible to the public.

3.2 The guidance also notes that performance reports will be of interest to the NHS Board and local authorities in monitoring the success of the arrangements that they have put in place for an IJB. No standard layout is given for reports, though the following areas should be covered:

- Performance against national indicators;

- A focus on the experience and quality of services for people using services, carers and their families;
- An assessment of performance against the Strategic Commissioning Plan;
- Evidence of how Partnership decisions have contributed towards improved outcomes.

3.3 Renfrewshire's Annual Performance Report describes performance using different mechanisms. Case studies are used to demonstrate how HSCP decisions and services impact positively on outcomes for individual patients/clients and their families. Progress against planned activities is also shown by care group, allowing readers to review performance in areas such as learning disabilities, older people, mental health etc. This part of the Annual Performance Report can be cross referenced to the Strategic Plan. Finally, quantitative performance is assessed against the 88 performance indicators and the 9 national outcomes, using the red/amber/green system.

3.4 The report is currently presented without formatting and pictures. On approval by the IJB, it will be submitted to graphic designers to develop a version which is widely accessible to members of the public.

4. Performance Indicators

4.1 The scorecard for 2016/17 forms part of the Annual Performance Report.

The scorecard for 2016/17 has 88 indicators:

- 37 data only
- 13 red indicators (target not achieved)
- 11 amber indicators (within 10% of target)
- 27 green indicators (target achieved)

Key movements from the mid-year report are noted below.

4.2 The indicator remains red for the number waiting more than 18 weeks for Paediatric Speech and Language Therapy assessment to appointment, but there has been a reduction in the number of children waiting. The figure has dropped from 199 at November 2016 to 62 at March 2017, showing a 69% improvement.

There were 538 emergency admissions to hospital from care homes in 2016/17 against a target of 480. This is an area identified in our Acute Services Commissioning Intentions, where we want to focus more to support care homes to reduce levels of admission to hospital.

4.3 The percentage of long term care clients receiving intensive home care has moved to amber status at 27% against a target of 30%. Clients are currently being reviewed to ensure that the right level of support is offered.

The percentage of Primary Care Mental Health Team patients offered a first appointment within 4 weeks has risen to 95%. This is a significant improvement from 88% in 2015/16, moving the status from red to amber.

There has been a reduction in the percentage of babies with a low birth weight from 6.8% in 2015/16 to 6.3% in 2016/17. This indicator is now amber as the target is 6%.

4.4 Good progress has been made in reducing the average number of people on the Occupational Therapy (OT) waiting list. This has fallen to 340, below the target of 350.

The uptake rate for the child 30 month assessment has also improved from amber to green. The latest figure for March 2017 shows an uptake rate of 82%, above the 80% target and the 76% uptake rate reported in November 2016.

Induction completion rates for healthcare support workers have risen to 100%, showing another green indicator.

5. Delayed Discharge

5.1 Previously we reported bed days lost to delayed discharge, including Acute and Mental Health beds, for those over 65 only and not all age groups. The indicators included in the Scorecard were as follows:

- The number of delayed discharges over 2 weeks.
- The number of bed days lost to delayed discharges (inc AWI) (patients aged 65 & over on day of admission)
- The number of bed days lost to delayed discharges for Adults with Incapacity (patients aged 65 & over on date of admission)

We reported this way to show the difference the Change Fund made and evidenced a substantial reduction from the 2009/10 baseline of 16,207 for bed days lost and 2,128 for AWIs.

5.2 In July 2016, new national data requirements for Delayed Discharges were introduced. In line with this, new data is available and we can show delayed discharges for all ages and all specialties:

- The total number of patients delayed (at census point)
- Total number of delayed discharge episodes at month end
- Total number of bed days occupied by delayed discharge patients (month end)

This information is now included in the attached Scorecard.

Implications of the Report

1. **Financial –** None
2. **HR & Organisational Development –** None
3. **Community Planning –** None
4. **Legal –** Meets the obligations under clause 4/4 of the Integration Scheme.
5. **Property/Assets –** None
6. **Information Technology –** None
7. **Equality & Human Rights –** The recommendations contained within this report have been assessed in relation to their impact on equalities and human rights. 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 – None.

Author Clare Walker, Planning and Performance Manager

Appendix 1

Renfrewshire
Health & Social Care
Partnership

Annual Performance Report

2016/17

Our Vision

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

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Introduction

Welcome to Renfrewshire Health and Social Care Partnership's first Annual Performance Report

Context

We want to improve the health and wellbeing of the people of Renfrewshire. We will do this by working in partnership to treat the person as well as the condition and to deliver the right service, at the right time and in the right place.

By monitoring our performance, we can improve current services and plan for the future. We do this by measuring our services against a set of National Outcomes and Performance Indicators, and by reporting regularly on our progress.
Our Annual Report summarises what we have achieved in our first year as Renfrewshire Health and Social Care Partnership, from April 2016 to March 2017.
We are working hard to meet our priorities and ensure that the Partnership is delivering the right results for the people of Renfrewshire and their carers.
We will publish an Annual Performance Report every year so we can measure the impact of our efforts and prioritise our areas of work.
Please read on to find out more about the significant progress we are making to improve care and quality outcomes for our service users and carers.

Key Achievements

Some of our key achievements during year one of the Partnership include:

- Developing our Care at Home service to meet service users' ever-changing needs. A large scale recruitment campaign resulted in 68 staff being employed; a new electronic scheduling and monitoring system was developed; a Service Development Team was established; and a new Out of Ours Service created. A recent Customer Satisfaction Survey showed that 90% of service users are satisfied with the Care at Home service with quotes such as: "Every carer I have is fantastic"; "I find them very kind and professional"; "They cheer me up"; and "Thank you to all the carers for their care." This satisfaction is also reflected in the most recent inspection by the Care Inspectorate, where the service has retained 'very good' grades.

- Designing an effective and dynamic approach to 'locality' and 'cluster' based working by encouraging collaboration and joint working between services. By creating multi-disciplinary teams and bringing together GPs, Social Work,

District Nurse Rehabilitation Service, Mental Health and other staff, we can better support the needs of local patients and service users.

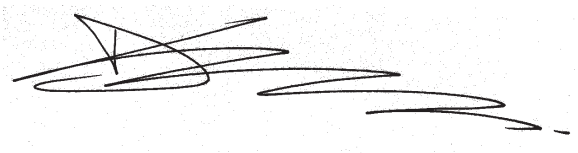
- Establishing a shared framework and work programme for Quality, Care and Professional Governance. The core components of our framework are based on service delivery, care and interventions that are person centred, timely, outcome focused, equitable, safe, efficient, and effective. For example, we have developed mechanisms to obtain feedback from patients, service users and carers so we can learn from them and understand what their priorities are and what works best.

- Continuing our successful evidence based programme of work to reduce delayed discharges has delivered and sustained a reduction of 77.6% in bed days lost due to delayed discharges from the 2009/10 baseline. This is equivalent to 35 beds, and demonstrates how effective our services are in supporting people to live in their own homes.

None of this would be possible without the effort, dedication and professionalism of our staff. Person-centred care is at the very heart of what we do and I would like to extend a sincere thank you to all staff and volunteers.

Finally, the Annual Report is available online on the new Renfrewshire HSCP website at http://www.renfrewshire.hscp.scot/article/4851/Publications--Newsletters

We'd also really appreciate your feedback on our first report, so please take a moment to fill in the form or online questionnaire at https://goo.gl/gcltUS



David Leese,
Chief Officer, Renfrewshire Health and Social Care Partnership

Background

The Public Bodies (Joint Working) (Scotland) Act 2014 was a new law passed by the Scottish Government.

This law says that health and social care services must work together so that people can live better, healthier lives.

On 1 April 2016, a new organisation was formed: Renfrewshire Health and Social Care Partnership, or Renfrewshire HSCP.

We are responsible for Adult Social Work and all Health services within the community, including Health and Community Care, Learning Disability, Mental Health and Addiction, and all health related Children's services.

Our Vision

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

Our Strategic Plan

In order to deliver our vision, our Strategic Plan describes the themes and high level priorities which direct the HSCP over the three year period 2016-19. Our three strategic priorities are:

- **Improving health and wellbeing**
- **The right service, at the right time, in the right place**
- **Working in partnership to treat the person as well as the condition.**

We do this by:

- Bringing services together and improving pathways
- Ensuring services in the community are accessible to all
- Giving people more choice and control
- Helping people to live as independently as possible
- Tackling inequalities and building strong communities
- Focusing on prevention and early intervention
- Providing effective support for carers
- Listening to patients and use service users' feedback to improve services.

Strategic Planning Group

The role of the Strategic Planning Group is to give its views during the development, implementation and review of strategic plans. As the main group within the strategic planning process, it represents the interests of local stakeholders, carers, members of the public and the 3rd sector. We also have a number of smaller working groups which enable members to have a voice in influencing and improving health and social care service delivery.

National Outcomes

The Public Bodies (Joint Working) (National Health and Wellbeing Outcomes) (Scotland) Regulations 2014 requires Partnerships to assess their performance in relation to the 9 National Health and Wellbeing Outcomes. These outcomes provide a strategic framework for the planning and delivery of health and social care services. They focus on the experiences and quality of services for people using those services, carers and their families.

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 terms 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 reducing 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.

Our performance is assessed in the context of the arrangements set out in our Strategic Plan 2016-19 and Financial Statement.

We continuously build on our commitment to community engagement and participation, creative learning, equalities, diversity and inclusion.

The Scorecard at appendix 4 shows our progress against a range of performance indicators which demonstrates how we are improving outcomes for Renfrewshire residents. This is further demonstrated in the following case studies, which show how we have impacted on local people and families.

We have also included at appendix 2, key indicators from Renfrewshire's Health and Wellbeing Profile, compiled by the Scottish Public Health Observatory (ScotPHO).

Report Framework

This report describes our performance in a number of different ways, recognising that information is used and understood differently by different audiences.

Case Studies (p8 – 14): for those who want to see how the Partnership makes a difference in the lives of individuals and families.

Care Groups (p22 – 42): for those who are interested in particular services including addictions, learning disabilities, carers, and mental health.

National/Local Outcomes (p65 – 77): for those who want to see quantitative data and assurance that national and local outcomes are being progressed.

Financial information is part of our performance management framework. 2016-17 has been a financially challenging year and we have detailed our financial position and how we have delivered best value whilst having to respond to difficult budget decisions.

Renfrewshire HSCP has lead Partnership responsibility for Podiatry and Primary Care Support across NHS Greater Glasgow and Clyde. This report features some of the excellent work and a few of the challenges of leading these services for the largest NHS Board in Scotland.

In this first year of integration, bringing the services and cultures of two organisations has been both challenging and rewarding. Our aim is to highlight the significant benefits of joint working and show that our services provide high quality, effective care and support to the people of Renfrewshire.

Case Studies

CARE AT HOME

Mr M lives in Elderslie, Renfrewshire. He is an 89 year old widower who has lived in his own home for the last 60 years. Until recently he had been supported to live independently at home, with minimal support via a community alarm.

Mr M experienced a fall that resulted in his admission to the Royal Alexandra Hospital, where he was treated for a hip fracture. Following an operation, Mr M was assessed by Social Work staff in the hospital to identify what assistance he required to enable him to return home quickly, safely and with the appropriate care and support.

The assessment identified that Mr M was at risk of falls and required support with personal care, meal preparation, assistance with medication and continence care. Services were arranged as part of our sector leading pathway for avoiding hospital discharge delays. Care at Home Services were in place to facilitate Mr M's discharge the following day.

The Care at Home Reablement Team worked closely with Mr M over a six-week period to support him to regain confidence and to maximise his independence. Mr M and his family were given further reassurance that appropriate support was on hand via the Technology Enabled Care Service with a fall detector and bed monitor installed, enabling the service to respond in the event of a fall.

A Reablement Occupational Therapist assessed Mr M at home and identified that he would benefit from a Community Meals service. This was arranged quickly and Mr M now benefits from his meals being delivered to his home at lunch and teatime every day of the year.

Mr M continues to live independently in his own home with the appropriate support to meet his needs and maximise his quality of life. This highlights the benefits of our integrated and co-ordinated approach to enabling service users to return home following a hospital stay.

Outcomes: 2, 8 and 9

CARERS

The Adult Support Worker from the Carers' Centre arranged an initial meeting with a carer requesting support from the Centre. The family had recently moved to the area and were living in a privately rented property. Through discussion, the following areas of concerns were identified: financial concerns - specifically around whether the family were in receipt of appropriate benefits; housing - their current property did not meet their needs; Social Work - the family were waiting on an allocated Social Worker after transferring from another Local Authority area; and a lack of community involvement - the carer felt socially isolated having just moved into a new area.

Outcomes from interventions:

- The carer attended Advice Works' appointments and all benefits are now in place
- The carer attends training sessions held in the Carers' Centre
- The carer attends the monthly Parents' Support Group held in the Carers' Centre
- The Adult Support Worker carried out a joint home visit with the newly allocated Social Worker. Social Housing applications were completed and an application was successful to the Community Care Panel. The family will move to a new home
- The Adult Support Worker successfully applied to the Carers' Trust for funding for the carer to have driving lessons
- The Adult Support Worker continues to keep in touch with the carer. A funding application has been submitted for a caravan holiday for the family this summer.

Outcomes: 5 and 6

FAMILIES FIRST

Lucy (7), her younger brother Paul (1) and her mum Debbie (27) were referred to the Families First team by Lucy's school who advised that an integrated assessment had been opened due to Lucy's poor attendance. Lucy's attendance was 80% and she had a total of 36 late arrivals at school in one term. The school hoped that having support from Families First would improve Lucy's attendance and reduce late comings.

Lucy, Paul and Debbie were allocated a Families First Key Worker who identified that building a trusting relationship with Debbie was crucial to the success of the support as Debbie felt distrusting towards other professionals. Debbie had been resistant to the support she was offered by her Health Visitor who had concerns for her mental health.

Debbie identified that mornings were a difficult time for the family therefore the Families First Key Worker visited the home during this time. This allowed the Key Worker to 'walk with' the family to see how their previous routine went and then support Debbie to make changes. During these early visits the worker observed that all three family members were sleeping in one bed. This was making bedtime and morning routines difficult.

The key worker supported Debbie at an appointment with the core team's Money Advisor who was able to get the family a grant to purchase a buggy, a cot bed, a single bed, mattress and carpets (a total financial gain of £620). It was also discovered that Debbie was not claiming for Tax Credits which the Money Advisor was able to get reinstated. This resulted in the family being £112 a week better off. In turn this helped reduce family stress and allowed Debbie to think about her and her children's future.

Lucy now has her own bed and when the school started back in August 2016 the Family Key Worker visited in the mornings to help the family establish a new routine. Debbie accepted ongoing morning support as she wanted to get Lucy to school on time. Lucy is now attending the breakfast club before school and free swimming lessons offered by Renfrewshire Leisure through the Tackling Poverty Fund.

Debbie is now more motivated to take part in activities with her children. She has brought both children along to Families First community activities during the October school holidays. They took part in a baking class and a family fun day. This was a real achievement for Debbie who had felt isolated and previously kept the children with her in the house during holidays.

Lucy's attendance at school has improved from 80% to 90%, and the late coming has reduced from 36 mornings to 6 in one term. Due to the improvements made by Debbie, Social Services have now closed the case and following a final assessment by the family Health Visitor the Integrated Assessment has also come to a close. Families First will continue to support Debbie with her goals and will only begin to withdraw when Debbie feels she can manage the family's routine independently. The changes made to date will have a positive impact on Lucy's learning as she is now in school on time and ready to learn with her peers.

Outcomes: 3, 4 and 5

HEALTHIER WEALTHIER CHILDREN

Renfrewshire HSCP supports the delivery of the Healthier Wealthier Children programme across Renfrewshire. The programme has been funded by Renfrewshire Council Tackling Poverty Programme and aims to contribute to reducing child poverty by helping families with money worries. The programme is delivered by a specialist advisor from Renfrewshire Council Advice Works Programme. The staff have supported 435 families across Renfrewshire in 2016/17 resulting in over £1 million of income being generated for these families. The advisor works closely with Health Visitors to ensure the most vulnerable families receive support to manage their finances.

Case Study

A Health Visitor asked Healthier Wealthier Children staff to accompany them on a home visit to a vulnerable family in Renfrewshire. The family had struggled to engage with services previously, and their tenancy in their overcrowded home was in jeopardy due to significant rent arrears. The specialist skills of Healthier Wealthier Children staff resulted in increased income for the family and the housing arrears being settled. In addressing the overcrowding issue, the family were re-housed in more suitable accommodation.

Outcomes: 4 and 5

LIVE ACTIVE PROGRAMME

When Vanessa first met Carol from the Live Active programme in March, 2016 she could barely drive the 15 minutes to the On-X sports centre due to excruciating nerve and back pain. She was in tears with the pain from driving and getting in and out the car; her legs were giving way and she was also falling. She was unable to find the cause of her pain which was having a significant impact on her life.

The day Vanessa met Carol for her assessment, she recounts being at her wits' end, feeling hopeless and desperate. However, Carol took the time to really listen to what she was saying, and also to see the effect her symptoms were having on her and all aspects of her life; including family and work. She was given a structured pathway to start building up her activity levels; in small steps at first and then through a more general range of classes.

One year on, Vanessa has progressed from not being able to walk without pain from the car park to the reception to doing an hour-long gym session each week and running for almost 15 minutes on the treadmill - pain free! She is now adding extra exercises and repetitions to her workouts and knows that she will soon be back outside, running on the cycle track.

What is more remarkable is she is no longer in pain, has finished her PhD and returned to work. Vanessa has her life back again.

She is grateful to the Live Active initiative as she genuinely believes without the support and guidance of the staff she would not have had the mental and physical strength to make this remarkable recovery.

Outcomes: 1, 4, 7 and 9

OCCUPATIONAL THERAPY/REHABILITATION & ENABLEMENT SERVICES

Mrs J is 78 years old and lives in Lochwinnoch, Renfrewshire. She lives alone in a privately owned ground floor flat and has a brother who lives nearby and can provide support. Mrs J was admitted to the RAH in Paisley following a stroke and has now been discharged back to her home.

Occupational therapy and physiotherapy as part of the Rehabilitation and Enablement Service (RES) have been a key part of making a success of her discharge. She is currently receiving ongoing rehabilitation with the physiotherapist from RES who is practising mobility with her using a quad stick. This is a slow process and it is unlikely that she will regain functional mobility around the house. The RES team is supporting her to be able to mobilise a few metres indoors. Mrs J and the RES team are happy with how she has progressed since her stroke, however further adaptations are needed.

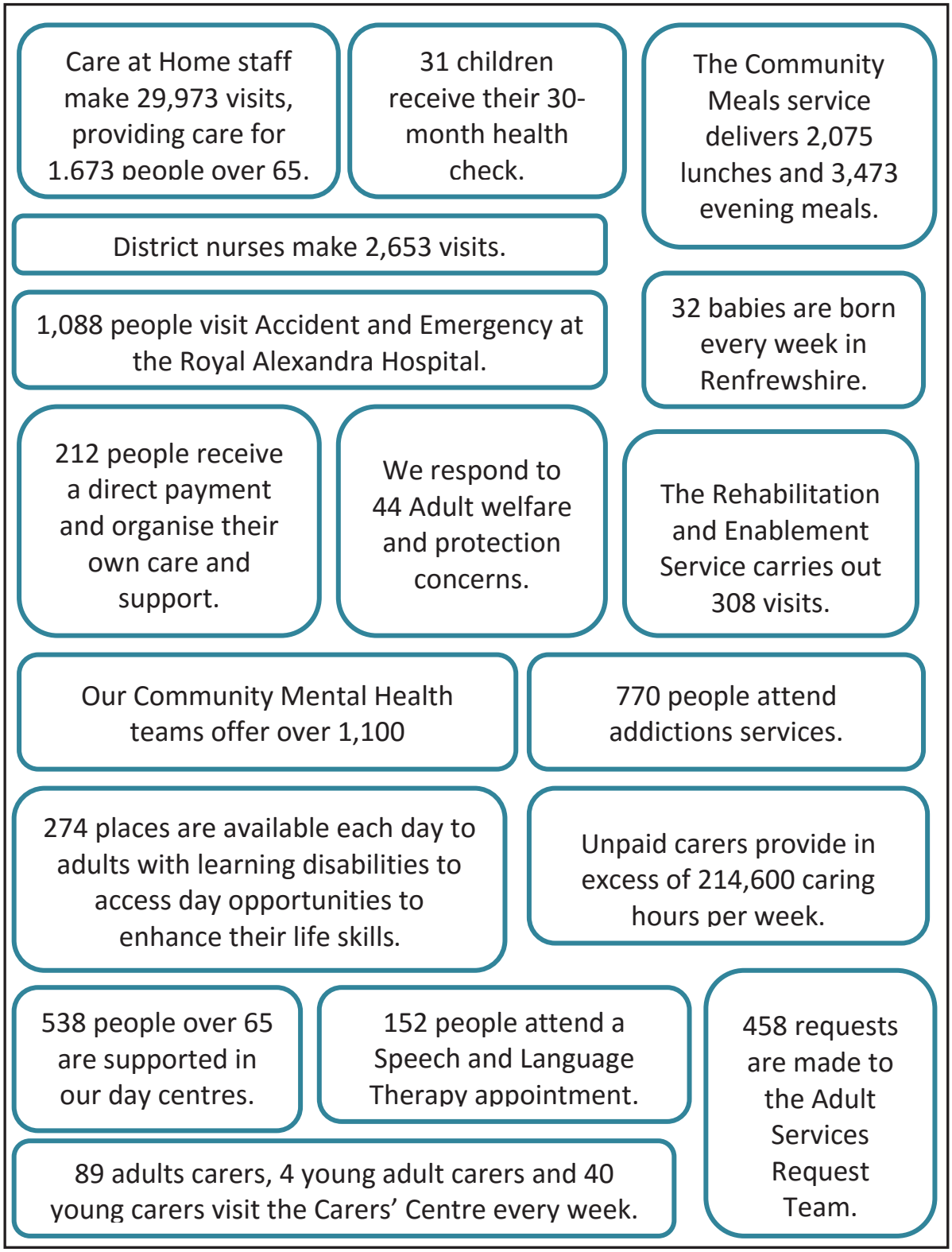
Due to stroke and weakness in right limbs, she requires assistance with personal care. She now has carers in the morning and evening; and for lunch, tea and for toileting. The Occupational Therapist in the RES team has provided a temporary ramp, but she needs help from a friend to use this and she is keen to be able to leave the house herself.

Community occupational Therapy Services are now involved with Mrs J and have completed an assessment for an external ramp and a wet floor. She is also being assessed for accessing an appropriate self directed support option.

Outcomes: 2, 4 and 9

A Week in the Life of Renfrewshire HSCP

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



Reducing Health Inequalities

Our work to reduce health inequalities has focused on primary care, the local community and our own staff.

Primary Care

In primary care, we are testing a Social Prescribing model in three GP practices, in Linwood and Bishopton.

Link workers, employed by the third sector (RAMH) can spend time with patients explaining some of the underlying social needs which patients may have, and signposting them to local support available.

The Link Worker works in partnership with housing colleagues (Linstone Housing Association) and a local voluntary organisation (Active Communities) to support local engagement and address housing issues.

The aim is to offer support for social issues by utilising community and third sector supports, freeing up time for GPs to focus on medical issues.

Wider Community

Our wider community activity has included:

- Embedding Sensitive Routine Enquiry into practice for community based NHS staff; health visiting and the community mental health team

- Providing mental health awareness training for Department of Work and Pensions Renfrewshire's work coaches. The aim is to increase their knowledge and skills to support those customers with mental health issues look for employment.

- Providing financial inclusion/benefits advice programme for families with young children (Healthier Wealthier Children)

- Commissioning a counselling service for secondary school pupils on the school premises

- Piloting an enhanced Smoking Cessation service with pharmacy and community Smoke Free services providing a joint service from three pharmacy premises

- Providing a peer mentoring programme for every secondary school, supported by Renfrewshire Poverty Commission.

Staff

We equip our staff with the skills, knowledge and confidence to signpost patients and clients to appropriate services. It is also necessary to assess the impact of service changes on particular equality groups. The following are examples of our investment in staff training:

- Delivering multi-agency, monthly Gender Based Violence training for staff including those working with, and for, young people in Renfrewshire including: Youth Services, Education (including Homelink and Pupil Support Co-ordinators), Barnardo's, residential, third and voluntary sectors, and the University of the West of Scotland

- Providing equalities training such as Equality Impact Assessment (EQIA) training and Lesbian, Gay, Bisexual and Transgender (LGBT) awareness sessions for staff. In 2016-17 the Partnership completed six EQIAs

- Delivering financial inclusion and employability awareness workshops.

Future Focus

In the next year we will progress and expand work already planned, including:

- Setting up an Integration Network with the support of local Black, Minority, Ethnic (BME)-led community groups and the Diversity and Equality Alliance in Renfrewshire (DEAR) group. This will help us ensure partner agencies work together to reduce inequalities for BME communities and will promote equitable access to services and opportunities.

- Improving the experience for visually impaired patients using local health services by supporting Renfrewshire Visually Impaired Forum to produce an educational DVD for staff.

- Developing information portal, Well in Renfrewshire (WiRe), in conjunction with the Health and Social Care Alliance 'A Local Information Service for Scotland' (ALISS) project. The aim is to make local community assets such as clubs, groups and third sector organisations easier to find by making best use of technology and social media.

Quality, Care and Professional Governance

Over the last year, Renfrewshire HSCP has established its supporting governance arrangements to ensure that the health & social care systems are working to a shared understanding and definition for Quality, Care & Professional Governance.

Example of incident management/investigation/reporting improvements:

- In November 2016, 30 service managers/team leaders were trained in Root Cause Analysis (RCA) methodology to support Significant Clinical Incident Reviews. RCA investigations help identify how and why incidents happen and analysis is used to identify areas for change and to develop recommendations which deliver safer care.
- Renfrewshire HSCP Social Work services have now adopted the "Rapid Alert" template used within health for serious incidents to ensure consistency in approach within the HSCP.
- A process is in place to share learning across all HSCP Governance Groups using a status report template.

Patient/Service User/Client and Carer Feedback

Renfrewshire HSCP listens to the views of patients, service users and carers. Various mechanisms have been used to capture experience of people who have been using/receiving our service(s) so that we can learn from them.

Here are a few examples:

Specialist Children Services (SCS) Engagement Event offered a forum for families, service users and other agencies to comment on Specialist Children services and voice their thoughts on what could be improved. This encouraged staff from across SCS team to look at service user involvement. Small tests of change are being planned to look at the local voice of our service users and plan service accordingly where practical.

- Patient conversations continue in ward areas in mental health. Dates are planned for the year in advance and patients and their carers are invited to an informal discussion about their experiences in the ward. After each meeting, feedback is provided on a poster which describes the positive comments and any concerns raised by patients and their carers and what was done in response. These visits are carried out by the Service Manager, Professional Nurse Advisor and a representative from the service user organisation - Mental Health Network.
- The Community Mental Health Team undertakes annual feedback surveys.

- "Just to say" cards are in every outpatient area.
- The Podiatry Service has a suggestion box in every clinic to give service users the opportunity to provide feedback. Patient led feedback sessions have been held in Renfrew and Foxbar.
- Multi-Disciplinary Team meetings to discuss patients with palliative care needs are being tested. The Primary Care Team and representatives from locality teams meet to discuss care plans.

Example of Patient Experience Initiative which has led to improvements in services based on feedback from patients/carers:

- A number of services are working with a local volunteer to have conversations with people they care for and their carers about their experience, treatment, involvement and care. Conversations were based on the 5 'Must Do with Me' areas being promoted and supported through the Person-Centred Health & Care Collaborative. Link: www.healthcareimprovementscotland.org/our_work/person-centred_care/person-centred_programme.aspx. Each service area has received direct feedback following this initiative and supporting action plans are in place based on areas identified for improvement.

Quotes:

Rehabilitation & Enablement Service (RES)

"The management of RES would like to formally acknowledge the valuable contribution that this work has made to revealing insights into service provision, allowing for positive changes to be made within RES. We praise the volunteer for their highly insightful, caring, empathetic and professional manner in which this work was carried out, at all times ensuring that people's views were heard and acted upon".

Podiatry Service

"Working with the volunteer gave us in Podiatry the objectivity missing from the majority of patient experience work. The feedback was both confirming and challenging. We want to adopt this approach on a wider scale. It is truly innovative".

District Nursing Service

"The hard work and dedication from the volunteer within the carers' experience project allowed for truly insightful conversations to take place, which not only highlighted areas of good work but allowed for exploration and identification of service improvements. This work is innovative in its approach and provided a reflection opportunity for the service which we have never had before. This has allowed the service to develop an improvement plan to address the issues and concerns raised by carers."

Unscheduled Care

Unscheduled care is the unplanned treatment and care of a patient usually as a result of an emergency or urgent event. Most of the focus on unscheduled care is on accident and emergency attendances, and emergency admissions to hospital. The Scottish Government has made unscheduled care an important area of focus for the health service in Scotland, with reducing waiting times in A&E and reducing the number of emergency admissions key targets. In Renfrewshire, most emergency admissions (86%) are to the RAH, with 8% going to the Queen Elizabeth University Hospital (QEUH).

The Integration Joint Board's budget includes a 'set aside' budget for the commissioning of acute hospital services within scope. For 2016/17, the set aside budget for unscheduled acute services in Renfrewshire was £32.3m.

The Acute Services Transformation paper was approved by the NHS Board in February 2017 (available at: http://www.nhsggc.org.uk/media/241076/nhsggc_board_paper_17-10.pdf). This paper sets out the need to transform the delivery of acute services in NHS Greater Glasgow and Clyde to continue to deliver the highest quality of care to patients over the short, medium and longer term. The approach described in the paper is in line with the National Clinical Strategy and the National Delivery Plan launched in December (available at http://www.gov.scot/Resource/0051/00511950.pdf). NHS Greater Glasgow and Clyde's Unscheduled Care Report, November 2016, puts forward four improvement programme recommendations:

- Improve discharge rates in Assessment Units (AUs) – scheduling of GP referral activity and alternatives to admission.
- Spread 'Exemplar' wards – improve earlier in the day discharge, reduce boarding and generate specialty capacity to facilitate movement in receiving units.
- Implement the full suite of ambulatory care pathways across all sites – stream patients away from AU unless there is deemed to be value added activity.
- Reduce Low Acuity Demand – work with Primary Care to explore alternatives to admission.

Renfrewshire HSCP has developed a set of Strategic Commissioning intentions with the other HSCPs in the Greater Glasgow and Clyde area and with Acute Services.

For Renfrewshire HSCP, these proposed strategic commissioning intentions should be read in the context of our Strategic Plan 2016/19, available on our website at http://www.renfrewshire.hscp.scot/article/4851/Publications--Newsletters.

For 2017/18, we have focused our commissioning intentions on three priority areas:

- A&E performance
- Unplanned admissions
- Delayed discharges

We also plan to work closely with acute services on the following three areas:

- Occupied bed days for unscheduled care
- End of life care, and
- The balance of spend across institutional and community services.

During 2017/18 we will develop a set of agreed metrics to reduce our reliance on acute services and release resource to invest in strengthening community services. Early work has focused on reducing emergency admission to hospital from care homes, reducing frequent users of A&E services, and supporting people to receive end of life care at home.

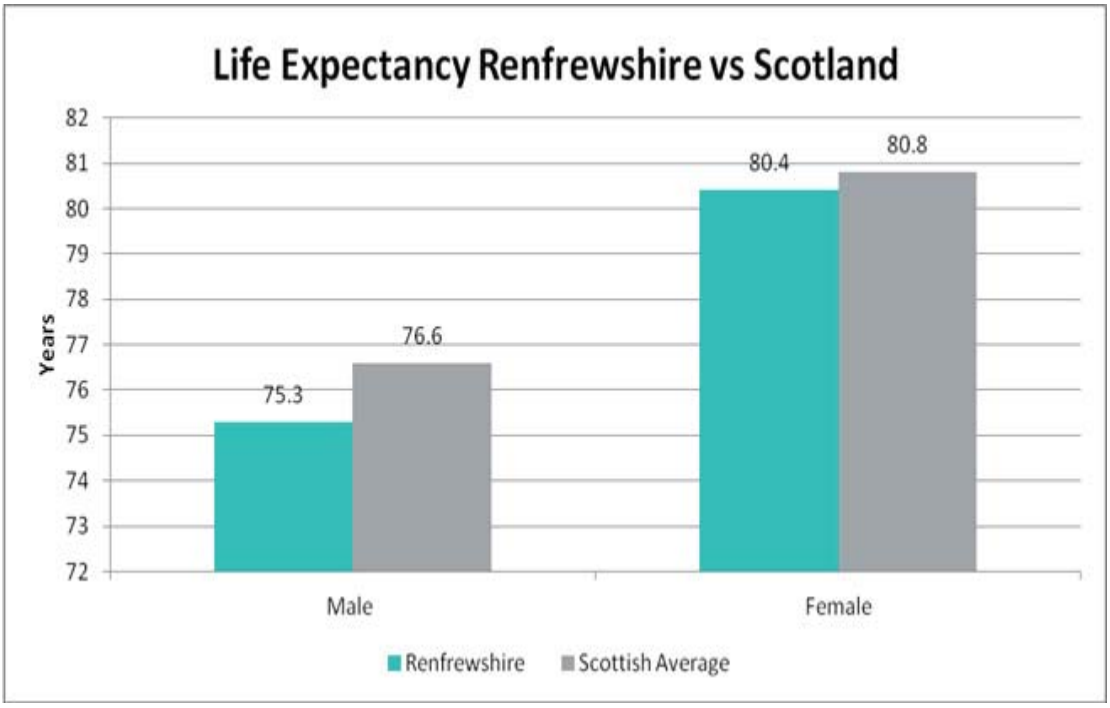
Our Performance by Care Group

Our Performance in relation to National Health and Wellbeing Outcomes by Care Group

Population Health & Wellbeing

Just under 176,000 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.

Life expectancy in Renfrewshire is lower than the Scottish average.



Source: ScotPHO, 2011

There are significant variations within Renfrewshire, with male life expectancy in some areas being 18 years lower than in other more affluent areas.

We continue to promote health and wellbeing, self-care, prevention and early intervention to enable Renfrewshire's population to live healthy and good quality lives. We have targeted our interventions and resources to narrow inequalities and build strong, resilient communities.

One of our priorities to address health inequalities in 2016/17 included a Homelessness Service User Consultation. During the consultation, the Health, Homelessness and Housing Lead supported clients to register with a GP and access

Primary Care Services and arranged appointments at the Royal Alexandra Hospital Dental Facility. All actions resulting from the consultation have been completed.

Targeted group work within educational establishments and key partner agencies has allowed in depth inputs with identified vulnerable young people.

Tackling Poverty Projects included school counselling and peer education being available in all secondary schools in Renfrewshire.

Child & Maternal Health

Family Nurse Partnership

Family Nurse Partnership (FNP) is a preventive, intensive home visiting programme offered to first time young mothers aged 19 years and under and their families. Young women are offered the programme in early pregnancy and are visited by a specially trained Family Nurse until the baby is two years old. The programme delivers an attachment based therapeutic relationship in order to improve pregnancy outcomes, child health and development and future educational readiness and achievement. The programme effectively diverts young, vulnerable parents away from statutory services. There are 108 young mothers receiving support through Family Nurse Partnership in Renfrewshire with an average age of 18. Areas of improvement include engagement of dads and subsequent positive outcomes for wider family members; a 43% reduction in clients smoking by the end of their pregnancy and 32% of clients initiated breastfeeding which is higher than the national and local average for the same age group.

Families First

More than 1,000 families with children aged 0-8 years across Renfrewshire have received support from our multi-agency Families First Support Teams in Linwood, Johnstone, Ferguslie, Foxbar and Gallowhill. The impact on individual families has been recorded through a series of case studies and independently evaluated by Glasgow University.

By 2019, Renfrewshire Health and Social Care Partnership will benefit from 22 additional health visitors from the Government's Universal Pathways Programme. We will monitor the roll-out of the Pathway and measure its impact upon children's wellbeing.

30-32 Month Assessment

Our Children's Services commenced delivery of the 30-32 month development assessments in 2015. The current uptake of assessments is 82% of eligible families at March 2017. Within this group, 79% of infants have achieved their developmental milestones. For children where difficulties are identified, there is an intervention pathway in place to support behavioural and communication needs.

EMIS Web

A new clinical information system, EMIS Web, was implemented in June 2016. The system shares the electronic record for all children aged 0-18 years and all health staff within community based Children's Services are using the single shared record. This includes Children and Families teams; Speech and Language Therapy teams; Child and Adolescent Mental Health teams; Community Paediatric teams and the Child Protection Unit. The new approach improves co-ordination and communication between care professionals and enables services to provide the right help to children and families at the right time.

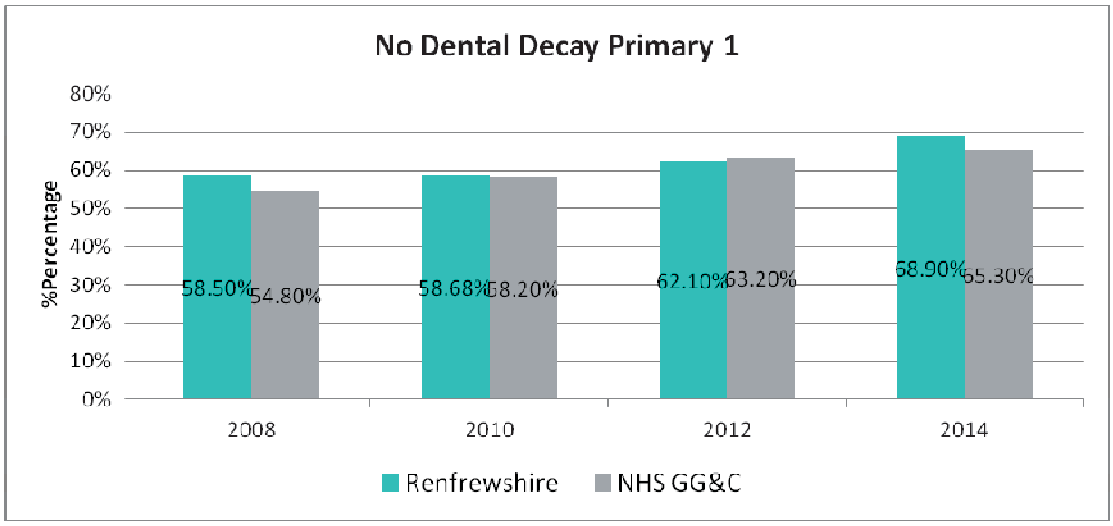
Childsmile Programme

In 2016/17, the Childsmile programme was delivered in all 74 local authority, partnership and private nurseries and 55 primary schools in Renfrewshire. 21 nurseries and 15 primary schools also took part in the fluoride varnishing programme, with children receiving two applications per year. To further support local nurseries in the delivery of the Childsmile programme, oral health sessions were provided to Primaries 1, 2 and 7 as well as at P1 induction events and parents' nights.

We have seen a steady improvement in dental registrations in the 0-2 year olds from 44.3% in 2011 to 51.3% in 2016, above the GG&C average of 50.9%.

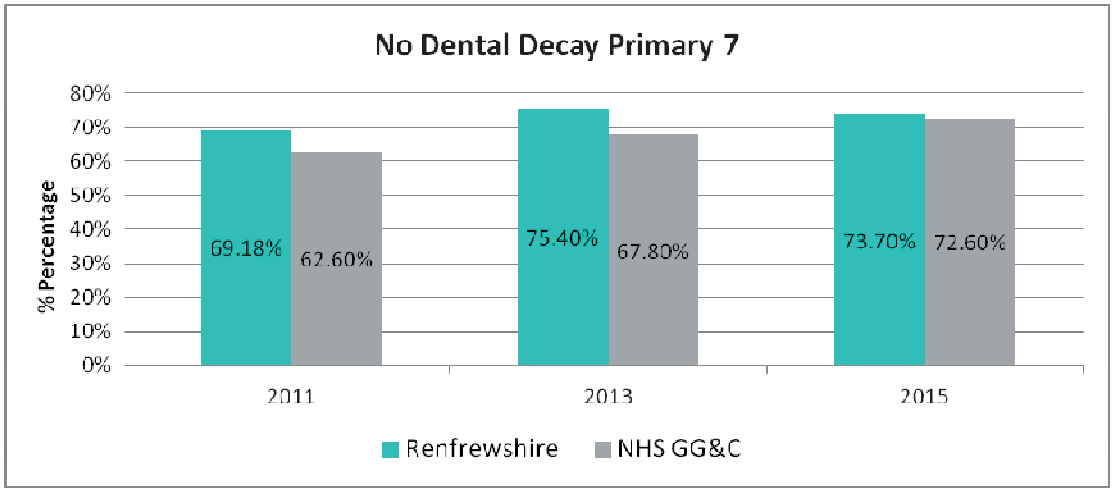
There has also been an improvement in dental registrations in 3-5 year olds from 84.7% in 2011 to 92.7% in 2016, slightly below the GG&C average of 94.3%.

Primary 1 children showing no signs of dental decay has increased from 58.5% in Renfrewshire in 2008 to 68.9% in 2014. We hope to see a further improvement when the 2016 data is released later in 2017.



Source: NHS GGC SharePoint

Primary 7 children showing no sign of dental decay has increased from 69.18% in Renfrewshire in 2011 to 73.7% in 2015 although this is a slight drop on the 2013 rate of 75.4%.

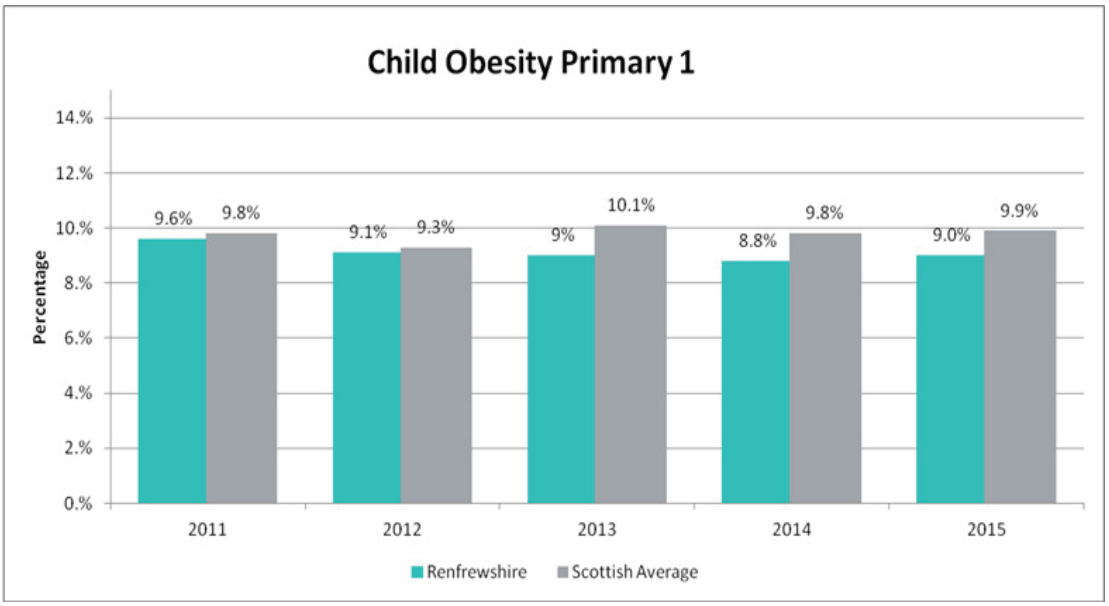


Source: NHS GGC SharePoint

Weigh to Go

Weigh to Go is an adolescent weight management service delivered by Greater Glasgow and Clyde's Youth Health Service, in partnership with commercial weight management and is available to young people aged 12-18 with a BMI>25. The weight management programme is 12-24 weeks in duration and provides young people with free access to a local commercial weight management service with wrap around support for young people with complex issues/needs or long term conditions. The service was launched on 23 March 2017. Performance will be monitored by a Board-wide Operational Group that meets quarterly.

The rate of child obesity in Primary 1 in Renfrewshire is below the Scottish average of 9.9% at 9% in 2015. Although this rate has reduced from 9.6% in 2011, it is a small increase from 8.8% in 2014. We hope to see a reduction in this rate when the 2016 data is released. Reducing rates of childhood obesity is a priority in Renfrewshire for the HSCP and wider Community Planning Partners.



Source: ScotPHO, 2015

Between November 2016 and January 2017, more than 10,000 children and young people between P5 and S5 completed an on-line survey during class-time about their wellbeing. The survey used the ChildrenCount tool developed by the Dartington Social Research Unit and asked participants a range of questions about their experience of growing up in Renfrewshire. We look forward to the results later in 2017.

41 young people across Renfrewshire participated in mental health first aid training.

Specialist Children's Services

The Specialist Children's Services' Disability Team has implemented the new disability pathway which improves the 'team around the child' communication and model of service delivery.

This has improved access into services and allows better response times to meet the needs of more complex children. It also ensures the care provided to the child and family is coordinated and communicated effectively between team members to improve outcomes and reduce duplication of care.

In 2016/17, the Child and Adolescent Health Service (CAMHS) welcomed Speech and Language Therapists and Occupational Therapists to the team for the first time. Work is ongoing to maximise the benefits of these additional posts for the service.

Waiting times for Occupational Therapy and Speech and Language Therapy have proved challenging in 2016/17. Although we had reduced the waiting time for both services over the 4 month period November 2016 to March 2017, work is ongoing to further reduce waiting times in both service areas.

	From	No. of weeks wait	To	No. of weeks wait
SLT	November 2016	47 weeks	March 2017	25 weeks
Occupational Therapy	November 2016	24 weeks	March 2017	15 weeks

Source: Renfrewshire HSCP

Primary Care and Long Term Conditions

Screening Programmes

Cancer screening remains a priority for the HSCP. We promote and raise awareness via social media to underline the importance of the uptake of screening.

Our uptake of screening in Renfrewshire is above the Greater Glasgow and Clyde average for all three programmes: bowel, breast and cervical. Most recent performance data is below target for bowel screening: 56.3% against a 60% target; above target for breast screening: 71.2% against a 70% target; and below target for cervical screening: 77% against an 80% target.

Screening	Renfrewshire	GG&C	Target
Bowel (2015)	**56.3%**	**53.3%**	**60.0%**
Breast (2013)	**71.2%**	**69.7%**	**70.0%**
Cervical (2015)	**77.0%**	**72.3%**	**80.0%**

Anticipatory Care Planning

Work has continued with supporting Anticipatory Care Planning (ACP) across Renfrewshire. An Anticipatory Care Plan is a record that is developed over time through conversations and shared decision making between the person, those close to them and the practitioner.

Within the care homes the Care Home Liaison Nurses continue to support the care home to develop ACP. The Palliative Care Team together with Accord Hospice continue to provide palliative care training sessions to all registered nursing staff within Renfrewshire Health and Social Care Partnership. The Renfrewshire MacMillan Service has successfully completed a project which challenged them to redesign delivery of Palliative Care Services through integration of supportive and palliative care approaches into mainstream Primary and Community Care Service provision. 1,847 new ACPs have been carried out in the period April 2016 to March 2017 against a target of 440.

Flu Vaccine

Uptake rates of seasonal flu vaccine in Renfrewshire are similar to the NHSGGC and Scottish average.

Seasonal Flu Vaccine Uptake Averages - As at Week 8, 2017					
HSCP	Over 65s	Under 65s in at risk groups	Pregnant (not in clinical risk group)	Pregnant (in clinical at risk group)	Pre school 2-5 yrs old
Ren	73.0%	45.6%	55.7%	59.1%	55.1%
NHSGGC	**72.8%**	**46.1%**	**54.2%**	**62.9%**	**55.6%**
SCOTLAND	**72.7%**	**44.6%**	**47.3%**	**57.2%**	**58.0%**

To increase flu uptake rates in our 'at risk' housebound population, flu vaccinations will be centrally managed. Patient information will be collated from each practice, inclusive of allergies, and the operational management of immunising these patients will be managed centrally outwith surgeries. This approach will be tested in autumn

2017 and will see the most vulnerable patients vaccinated promptly, reducing the risk of them developing flu and avoiding a likely hospital admission.

Diabetes

Our Diabetes Interface Group identified diabetes and health inequalities as a priority, and in particular taking diabetes awareness and education out into the community. The Diabetes Specialist Nurse provided specialist input to the Disability Resource Centre staff and service users.

As at December 2016, 1,048 patients within Renfrewshire GP practices have signed up to My Diabetes, My Way.

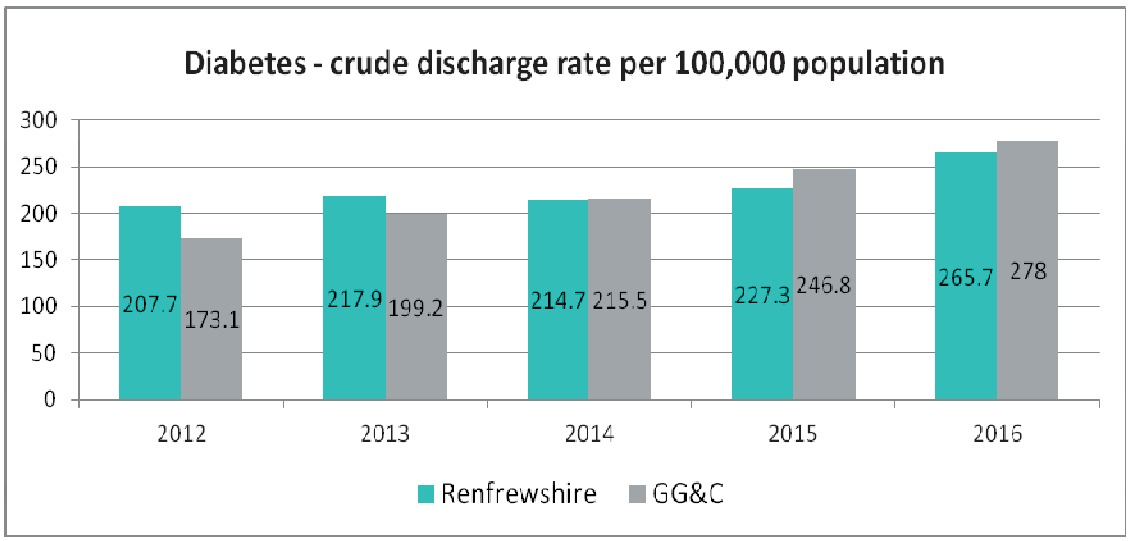
There is now a single point of access to the Integrated Diabetes Service, including conversational maps, with referrals made via Scottish Care Information Gateway (SCI) to the RAH.

From January – December 2016, 85 patients were invited to attend Conversation Maps, a patient-centered, innovative tool for diabetes education.

Eat Better Feel Better 6 week nutritional programme tailored for type 2 Diabetes has been offered and delivered in Renfrewshire. 6 courses and 29 participants attended from January – August 2016.

To raise awareness of diabetes and how to prevent the disease within vulnerable populations, health improvement has organised specialist input from the Renfrewshire Diabetes Team at the RAH to the Renfrewshire Disability Resource Centre and is also linked to the Carers' Centre.

The diabetes crude discharge rate per 100,000 population in Renfrewshire has increased by 28% from 2012 to 2016. Greater Glasgow and Clyde shows a 60.5% increase for the same period.



Source: SMR01, NHS SharePoint

One of our priorities continuing into 2017/18 is providing Diabetes specialist input in the Housing Advice and Homeless Centre; the Carers' Centre; and the West of Scotland Regional Equality Council.

All Long Term Conditions

Long term conditions include asthma, COPD (chronic obstructive pulmonary disease), CHD (coronary heart disease, heart failure & hypertension) and diabetes. The crude discharge rate per 100,000 population is monitored in Renfrewshire and across NHS Greater Glasgow and Clyde. From 2012 to 2016, we have seen substantial increases in all long term condition discharge rates in Renfrewshire from a 27% increase in asthma to a 60% increase in COPD. Similar increases are evident in the NHSGGC rates: 45% increase in all long term conditions; 38% in asthma and 56% in COPD.

Crude Discharge Rate Per 100,000 Population	Jan 12 – Dec 12	Jan 13 – Dec 13	Jan 14 – Dec 14	Jan 15 – Dec 15	Jan 16 – Dec 16	Renfrewshire % Increase 2012 – 2016
All LTCs	2343.0	2280.6	2704.5	2931.8	Renf: 3253.7 GGC: 3449.6	39%
Asthma	172.7	182.3	176.2	218.1	Renf: 219.8 GGC: 259.0	27%
COPD*	561.1	581.9	707.7	773.7	Renf: 901.7 GGC: 1253.5	60%
CHD**	1,401.5	1,298.4	1,605.9	1,712.7	Renf: 1,866.5 GGC: 1659.2	33%
Diabetes	207.7	217.9	214.7	227.3	Renf: 265.7 GGC: 278.0	28%

***COPD – Chronic obstructive pulmonary disease & bronchiectasis**
**** CHD – Coronary Heart Disease, Heart Failure & Hypertensive Disease**
SMR01, NHS SharePoint

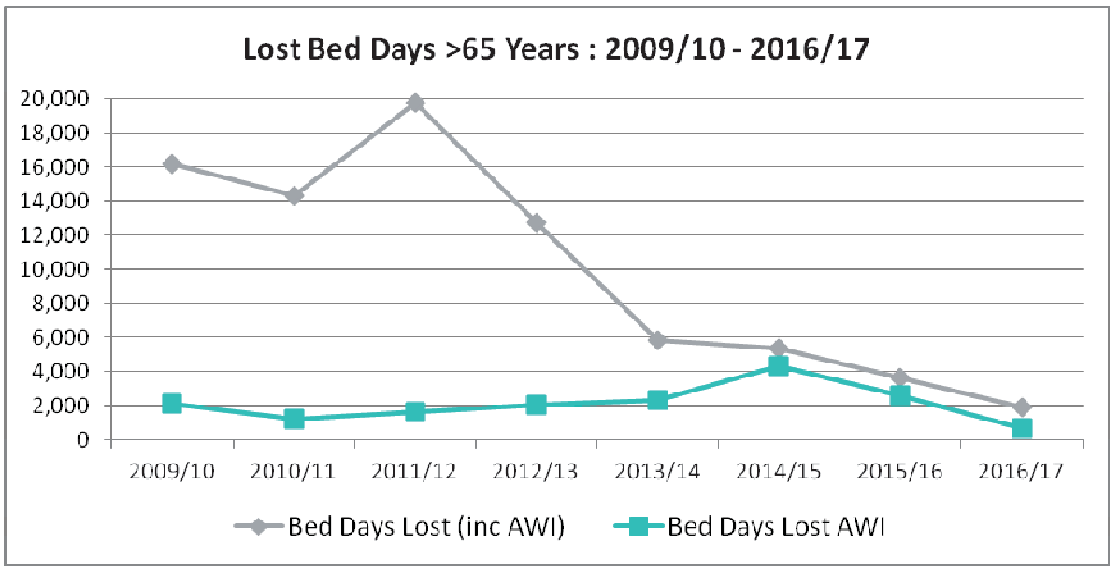
Older People

Delayed Discharges

A delayed discharge occurs when a patient who is ready to leave hospital, cannot do so because the other necessary care, support or accommodation for them is not in place and/or funding is not available, for example to purchase a care home place.

The partnership has continued to deliver a high level of performance around delayed discharges and ensure effective support to individuals and families where there is an Adult with Incapacity. In 2016, there were 1,595 new Power of Attorneys granted in Renfrewshire. A Power of Attorney is a legal document that lets a person appoint one or more people (known as 'attorneys') to help them make decisions or to make

decisions on their behalf. We continue to promote the uptake of Power of Attorney to ensure that adults and families are planning for their future care needs.



Source: NHS GGC Older People's Monitoring Report, March 2017

Good progress continues to be made with the number of acute bed days lost to delayed discharges (including Adults with Incapacity), aged 65 years and over. The cumulative total for 2016/17 was 1,910; an 88.2% decrease on the 2009/10 baseline figure of 16,207.

Similarly, the number of acute bed days lost to delayed discharges for Adults with Incapacity, aged 65 years and over reduced by 68.8% from 2,128 in 2009/10 to 664 in 2016/17.

The partnership has progressed with its programme to address unscheduled care. Two key strands of this are falls prevention and support to care homes to prevent avoidable admissions to hospital. Our Falls Strategy and Pathway are now being implemented and additional resources have been allocated to support Care Homes, specifically with residents with mental health issues. The new Older People's Mental Health (OPMH) Liaison Service provides advice and support on the care and treatment of people in Care Homes to prevent avoidable admissions to hospital.

55% of nursing home beds are supported through the Care Home Local Enhanced Service which accounts for 593 beds and 7 nursing homes. Four Care Home Liaison Nurses work with the Care Homes providing support and clinical guidance.

The Care at Home Service launched a substantial recruitment programme in 2016/17 to address workforce challenges, with 68 new Care at Home staff recruited this year, an increase of 59 on 2015/16. Service improvement programmes are underway to support the service meeting increasing demand.

Falls Prevention

Falls prevention is a key priority for community health and care services to address. In 2014/15, 84% of emergency admissions for an unintentional injury in those aged 65 and over resulted from a fall. In 2015, 2% of those aged 65 and over were discharged following a fall-related admission.

The impact of a fall for older people is well-documented, including loss of function, independence, confidence, and social isolation.

Given the demographic changes that are anticipated, it is expected that without changes in practice, the impact of falls will become more apparent over the next few years. However, there is evidence that suggests that early identification and access to appropriate interventions can reduce the risk of falls by up to 30%.

The Falls Prevention Strategy in Renfrewshire aims to set a clear direction for action to reduce falls and fractures, and to contribute to maintaining independence and social inclusion for our residents. This strategy focuses on joint working across the Health and Care Partnership across a range of agencies, including Acute services, third and independent sector staff and volunteers.

In 2015, 2% of those aged 65 and over in Renfrewshire were discharged following a fall-related admission.

Dementia

850,000 people in the UK live with dementia. This figure includes 93,000 in Scotland, with approximately 2,750 of those living in Renfrewshire. It is anticipated that this will increase to around 4,400 people by 2030; an increase of 60%.

The Renfrewshire Dementia Strategy Group has developed a work plan to ensure the required actions and outcomes of the national strategy are achieved. This aims to ensure that in-patient and community services, across statutory, independent and third sector agencies, develop person centred services that assist people with dementia, to live as independently as possible and that they are treated with dignity and respect.

Recent developments include:

- A change in the way assessment and diagnostic service are provided, leading to an increase in weekly appointments from 9 to 16 and a reduction in the waiting time for an appointment from 17 weeks to 4 weeks.

- The introduction of Post Diagnostic Support, which ensures that all people that receive a new diagnosis of dementia will receive at least 1 years' support from a named link worker.
- A review of existing information relating to services to ensure that this is dementia friendly.
- The training of around 500 Renfrewshire HSCP staff using Promoting Excellence, a staff development tool based on the care of people with dementia.
- Review of existing approaches to assessment, and use of complementary assessment tools to focus on enabling people with dementia to live safely at home for as long as possible, facilitate effective care at times of transition, including use of advance statements and life story work.
- Fast track mental health assessment with the aim of preventing hospital admission and facilitating appropriate care at home.
- The development of an Older People's Mental Health Liaison service, which will provide advice and support to acute hospitals and care homes on the appropriate care and treatment for people with a diagnosis of dementia.
- Developments within acute hospitals and care home settings to enable appropriate training and development of staff to provide support and care to people with a diagnosis of dementia.

The service is currently undertaking preparatory work for a bid to apply for funding to build a Dementia Friendly Community within Renfrewshire. The bid is likely to be submitted in autumn 2017.

Learning Disabilities

All day and respite services received a positive inspection from the Care Inspectorate with average grades of 4-6.

National Involvement Network (NiN) – Renfrewshire is the first Partnership to sign up to the Charter of Involvement which sets out 12 standards that care providers should meet to ensure that service users are supported and encouraged to take control over things that affect their lives. The NiN Charter was launched at a successful event held in March 2017, attended by 55 service users and 15 staff.

Five young men from Gateway were supported by members of the team to achieve their bronze Duke of Edinburgh Award.

Community Network Outdoor Work Space – grant funding was secured to create an outdoor work area at Spinners Gate. The new Learning Pod has just been erected and work will begin at the end of May to kit out the space and begin a series of horticultural sessions to ensure the continued development of horticultural training for service users.

Our Autism Strategy Working Group has developed a work plan to drive forward effective care and support for people with autism and their families. Two public events were held in 2016/17 to first launch the Renfrewshire Autism Strategy and then consult with carers and professionals on developing resources for people with autism living in Renfrewshire.

Autism Connections have received over 70 referrals for support and advice in their first year of operation

The transition process for children in Learning Disabilities continues to prove challenging. Earlier transfer of cases from children to adult services is required along with appropriate information and assessments. Self Directed Support assessments also need to be completed at an earlier stage to support the services starting their transition programme. We will work to improve this further in 2017/18.

Physical Disabilities

Physical Disability Day Services

Physical Disability Day Services at the Disability Resource Centre currently has 110 customers with long term health conditions accessing the service. Many of our customers have acquired a disability or impairment and now feel they are no longer able to work in their previous employment. Customers generally have physical and mobility impairments.

Sensory and communication impairments can become barriers towards retaining independence. Reducing the risk of falling and reducing hospital admissions are also areas we will develop further with our partners.

Health & Wellbeing and self-management of long term conditions

Health improvement is an important part of our work. Social inclusion, being involved and participating in community activities enables our customers to continue to maintain their independence in the community and reduce hospital admissions.

Approximately 50% of our customers now have a Self Directed Support budget and access the service twice a week. We recognise that 37% of our customers accessing the service may receive additional support because of low mood. Peer support and group work in the community assists people to promote more positive mental health.

Our staff team facilitates over 40 groups each week, including physical activity groups such as Tai Chi, swimming and gentle exercise, memory groups and digital projects.

The Care Inspectorate carried out an unannounced Inspection of the service on 29 September 2016, with the following encouraging results:

Graded service
Quality of care and support: 6 – Excellent
Quality of staffing: 6 – Excellent

Customer quotes:
"Feel you have a place in society."
"Great for help and support."
"There is a big social aspect."
"Give you a sense of achievement."

Mental Health

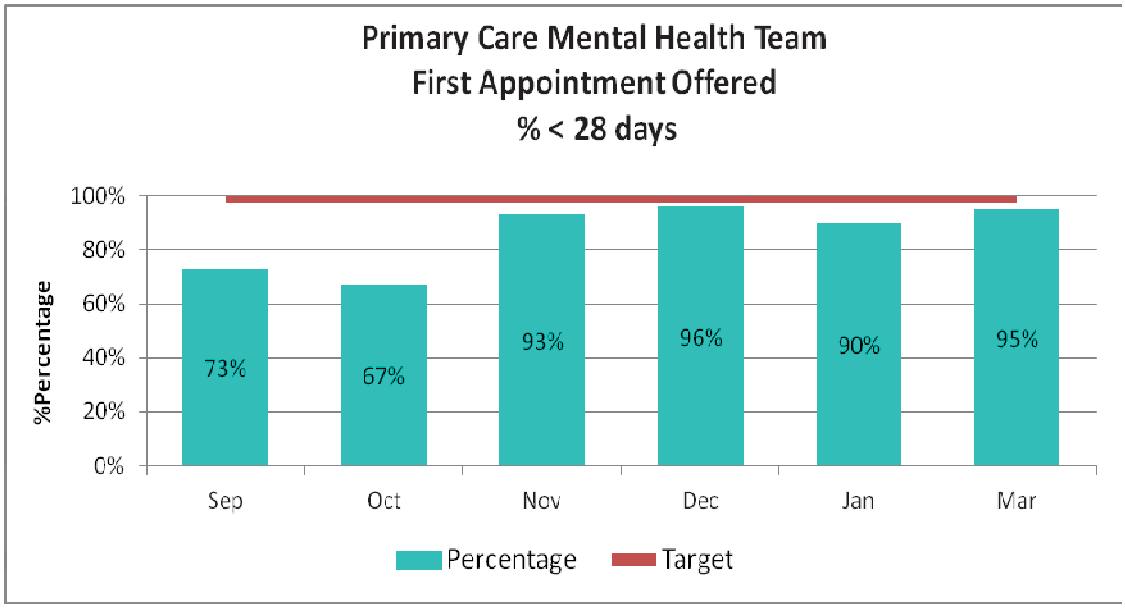
NHS Greater Glasgow & Clyde's Community Mental Health Team Operational Framework and associated standard operating procedures has been implemented to ensure timeous access to the most appropriate practitioners across our community mental health teams.

The Older Peoples' Mental Health Liaison Service was developed in 2016/17, and provides advice and support to the Royal Alexandra Hospital wards and Renfrewshire Care Homes. The liaison staff work in collaboration with health and social care professionals from multiple disciplines and care settings to meet the complex needs of older people. Since its introduction in September 2016, the service has received 159 referrals.

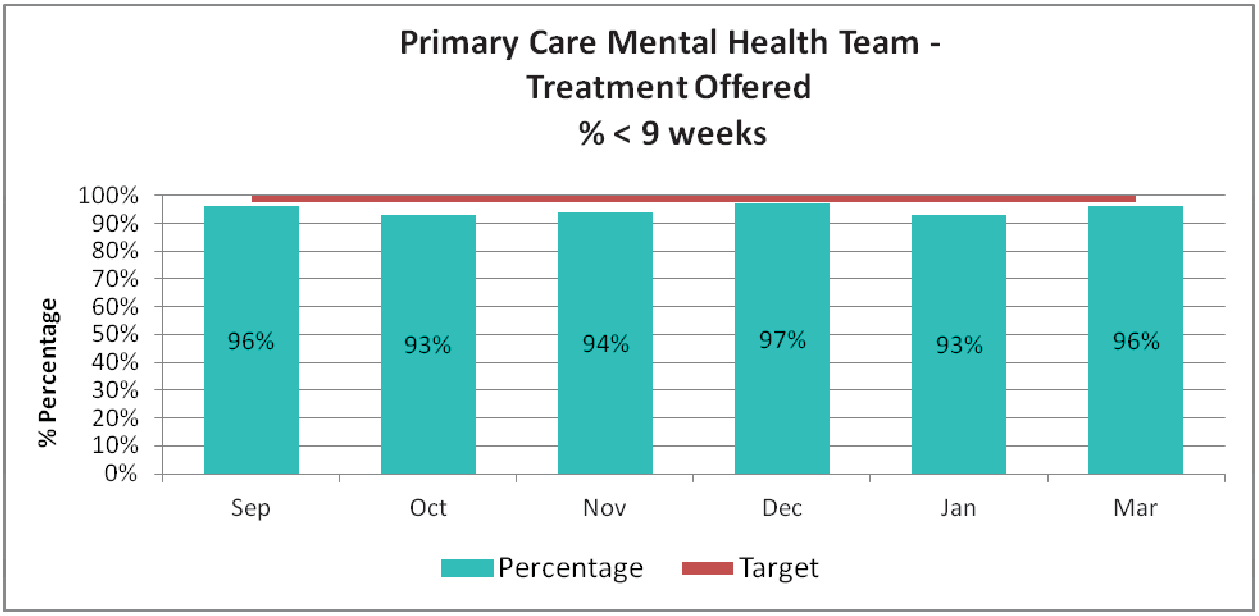
In addition, the refurbishment of Ward 39 at the Royal Alexandra Hospital takes into account the recommendation from the Mental Welfare Commission to increase the therapeutic space within the ward. The refurbishment work was completed in April 2017. The work included improvements to shower rooms in the patient dormitories which made them more easily accessible, as well as the development of a multi-purpose therapeutic room from space previously used as an office. This room increases the overall living space for patients within Ward 39 and will allow AHP and nursing staff to deliver a number of therapeutic activities. Gym equipment and physiotherapy and occupational therapy assessment equipment have also been installed, and a calendar of activities has been developed to ensure patients receive maximum benefit from the new space.

The Psychiatric Assessment Room in the A&E Department of the RAH has also been developed, providing a safer environment for staff and vulnerable clients presenting with mental health issues.

Achieving the targets set for the Primary Care Mental Health Team has proved challenging due to levels of staff absence. Patients should be offered a first appointment within 28 days of referral, and treatment should be offered in less than 9 weeks.



Source: PIMS MH Microstrategy – NB: February 2017 data unavailable due to migration to EMIS system



Source: PIMS MH Microstrategy – NB: February 2017 data unavailable due to migration to EMIS system

Alcohol and Drugs

Renfrewshire Alcohol and Drugs Partnership has continually exceeded the local improvement target (91.5%) to ensure all individuals wait no longer than three weeks from referral to receiving treatment. Current performance is 97.8% (as at December 2016).

Drugs such as heroin and methadone are called opioid drugs. Naloxone is a medicine which can temporarily reverse the effects of opioids if an individual overdoses. In Scotland, Naloxone is distributed to drug users in a single issue kit containing a pre-filled syringe. Recent changes in legislation have allowed the provision of Naloxone to family, carers or friends of someone who might be at risk of an opioid overdose. The provision of Naloxone is offered to all individuals who attend for assessment in Renfrewshire and local campaigns have taken place to target individuals who may have been offered Naloxone in the past. Current performance has reached the target of achieving 30% coverage of problem drug users.

Around 50-60 individuals attend the award-winning Sunshine Recovery Café each week. Managed by a group of volunteers the Café offers a safe, drug and alcohol free space where individuals in recovery can connect with their peers who share similar experiences. The Café provides peer led support to access training and employment opportunities. The Café has been involved in a number of arts and culture projects including RecoverFest, the Scottish Mental Health Arts and Film Festival and other local events. Recently the volunteers won the Renfrewshire Health and Social Care Partnership Staff Award and the NHSGGC Facing the Future Award for Renfrewshire. Since November 2016, there have been 770,000 days of recovery counted by participants who attend the Café.

The Alcohol and Drugs Partnership has developed a Quality Improvement Action Plan which ensures all services are compliant with the National Quality Standards. Service users are consulted bi-annually to evidence progress

Brighter Renfrewshire Alcohol Awareness Week (BRAW) was funded for a second year in 2016/17. During 2016, 15 groups received funding, ranging from small community groups, Scottish Fire and Rescue and Police Scotland, to the private sector. The funding was used to develop local projects which aimed to increase awareness and reduce the harm caused by alcohol.

We have developed a recovery peer support project, to help focus on recovery. This initiative supports individuals to gain access to training and employment opportunities, and has resulted in seven people gaining places on the University of the West of Scotland Professional Development Award and five people starting 6 month paid work placements in the NHS as Peer Support Worker trainees.

Carers

Carers' Information Strategy funding has enabled the continuation of a number of posts at the Carers' Centre covering training, group work support, mental health, identifying hidden carers, and support for young carers and young adult carers.

46 training courses delivered to 233 carers from April 2016 to March 2017, against an annual target of 35 and 195 respectively.

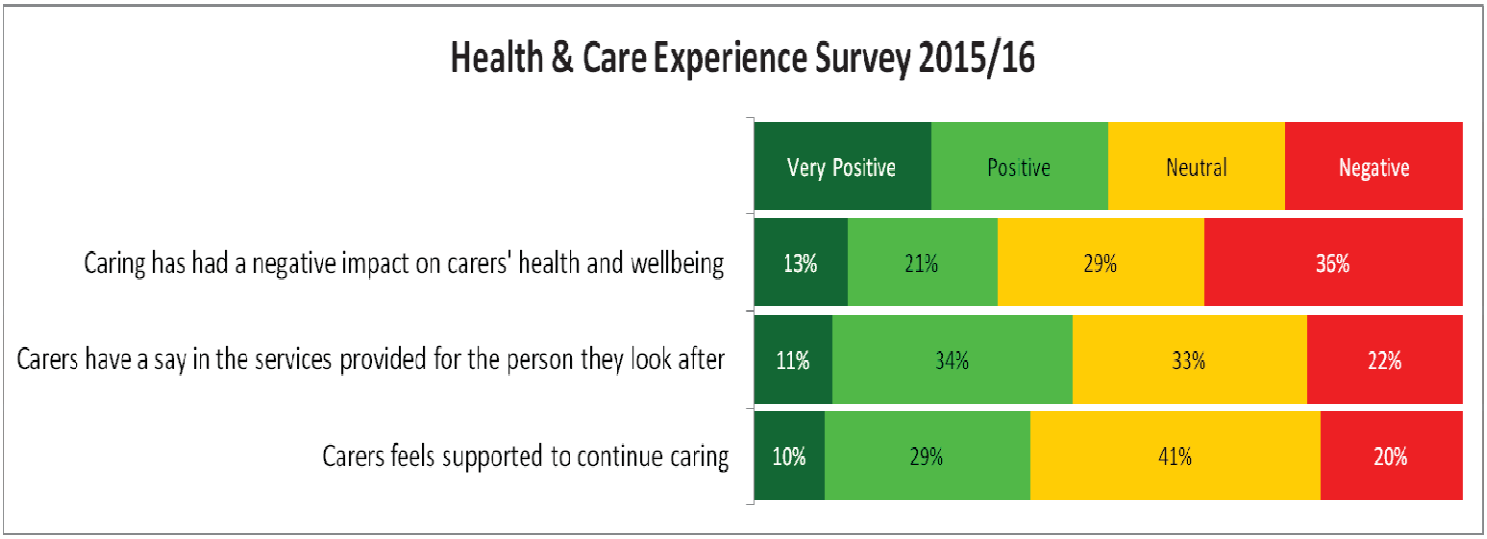
84 of those attending carers' training at the Carers' Centre were 'new carers'. The courses evaluated well and improved carers' skills and knowledge to enable them to feel more comfortable and confident in their caring role. Specific courses to provide tools for looking after the carer's own health and wellbeing were also well attended.

The Carers' Centre launched a new logo and website, which is updated weekly. The Centre is also using Facebook and Twitter to reach new and existing carers. This approach assists engagement with young carers and young adult carers.

Renfrewshire Carers' Centre held their 20th Anniversary Party in August 2016 at Paisley Town Hall. The event was well attended by carers, volunteers and staff who enjoyed celebrating 20 years of supporting carers in Renfrewshire.

Fifty carers attended a consultation event to increase awareness of the Carers' Act and its implications in March 2017. Carers had the opportunity to feedback on what was important to them to continue in their caring role. The feedback will be used to inform the local Carers' Strategy and prepare for the implementation of the Carers' Act in April 2018.

The results on the caring questions in the Health and Care Experience Survey showed that 36% of carers felt that caring had a negative effect on their health and wellbeing. Only 39% of carers felt supported to continue caring. We will continue to work with practitioners and the Carers' Centre to improve the experience of carers.



Health and Care Experience Survey, 2015/16

Carers are key partners in contributing to many of our priorities. We progress the issues raised by local carers and those in national legislation and guidance including accessing advocacy; providing information and advice and involving them in service planning through representation on our Strategic Planning Group. Work is progressing for implementation of the Carers' Act on 1 April 2018.

We work with Community Planning partners and other service providers to identify all young carers in Renfrewshire. The Renfrewshire wellbeing survey tells us that we have more than 220 children and young people aged 9 – 16 years who provide daily care, such as helping with washing and dressing, cooking and cleaning, for a parent or relative who lives in their home.

While many families with young carers are in contact with services and receive support, we know that too few young carers receive specific support in relation to their role. We are also aware that there are others who, for a variety of reasons, are not known to us. We aim to identify these 'hidden' young carers and assess their wellbeing needs.

The Carers' Centre currently provides information, advice and support through the Young Adult Carers' service. Consultation events took place in 2016/17 with young carers and we will use their feedback to develop a pathway to support them in the transition from young carer to young adult carer.

Effective Organisation

iMatter

iMatter is a team based, employee engagement questionnaire which was introduced by the Scottish Government in January 2015 with a three year roll out plan.

Renfrewshire HSCP implemented iMatter as part of our Organisational Development and Service Improvement Strategy and our staff undertook the survey in January 2017.

The Benefits

- Gives staff the chance to feed back on specifics and to influence change and improvement in the workplace

- Helps managers understand the team's perspective on what it means to be in the team and service area

- Provides an opportunity for local partnership groups to incorporate actions to their Directorate Staff Governance action plan

- Improves outcomes for patients, families and other users of health and social care services as a result of teams taking action in respect of their experience at work

- Identifies themes that may require addressing across the organisation.

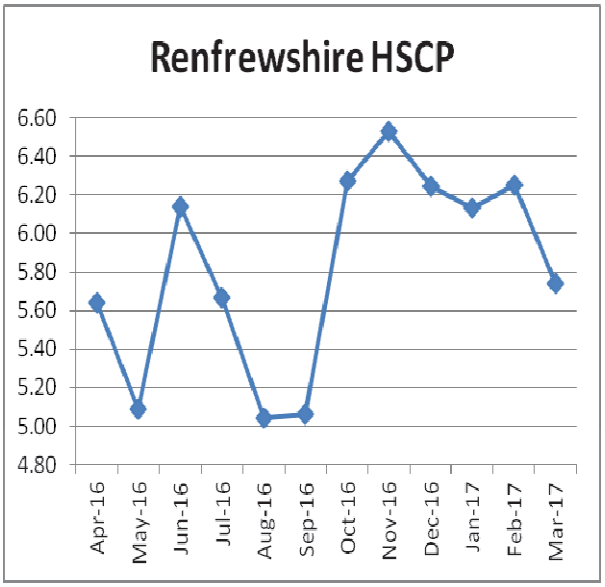
Results

Renfrewshire Health and Social Care Partnership had the joint highest completion and engagement rate in Scotland with 1,511 respondents, equating to 65% of the Partnership's workforce.

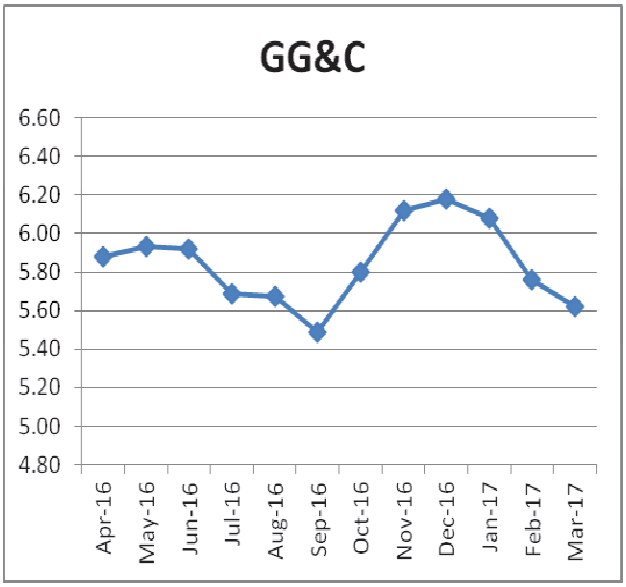
Team Action Plans are now being put in place and further monitoring and evaluation will continue throughout 2017.

Sickness Absence

The health sickness absence level at the end of March 2017 in Renfrewshire is 5.67%, similar to the April 2016 figure of 5.64%. The highest rate in 2016/17 was 6.53% at November 2016, dropping to 5.04% in August 2016.



* Health staff only



* Health staff only

Sickness Absence	Renfrewshire	Partnerships	NHS GG&C
March 2017	5.67%	6.15%	5.59%

Within Renfrewshire HSCP the long-term absence level has increased to 3.05% from 2.72%. However the short-term absence level has decreased by almost 1% to **2.62%** from 3.53%**.**

In terms of benchmarking the overall absence rate, NHS GG&C has decreased to 5.59% (from 5.76%), while the Partnership rate has increased to 6.15% (from 6.13%).

There is now increased overview and analysis of long term and short term absence levels within NHS GGC and Renfrewshire HSCP. People and Change Managers are now actively reviewing and reporting the management interventions and progress of all long term absences. There is also heightened focus on absence trigger points and scrutiny of excessive absence incidence, which is being monitored and challenged through relevant and appropriate NHS GGC policies.

Adult Social Work records their sickness absence in a different way to health. Absence is expressed as a number of work days lost per full time equivalent (FTE) employee. At March 2017, the rate was 3.65 days per person against a target of 2.69 days.

Absence Rate (Work Days Lost)	**Jun 2016**	**Sep 2016**	**Dec 2016**	**Mar 2017**
Adult Social Work	4.29	3.95	5.03	3.65

Similar to the NHS GGC approach, Renfrewshire Council is also actively reviewing absence cases. Action taken to date is being monitored along with proposed next steps, to ensure managers intervene early in absence cases and keep in regular contact with absent employees. Discussion is facilitated around the employee's progress, any support that may be required and allows flexible return to work options to be explored.

Workforce Planning

In the first full year of Renfrewshire Health and Social Care Partnership, work has begun on the delivery of the Organisational Development and Service Improvement Strategy (Workforce Plan) approved by the IJB on 18 March 2016.

This Strategy focuses on three key objectives that support the workforce to be committed, capable and engaged in person centred, safe and effective service delivery:

- Development of a healthy organisational culture;
- Delivering a clear approach to organisational development and service improvement; and
- Delivering a Workforce Plan for tomorrow's workforce.

Work in this first year has focused on establishing the supporting governance arrangements to ensure that the health and social care systems are working to a shared understanding and definition for Workforce and Professional Governance. Supporting governance structures have now been fully established and embedded.

Reporting mechanisms include: quarterly reports to the HSCP Senior Management Team; Annual Report to the Integration Joint Board; and a joint SPF Annual Report.

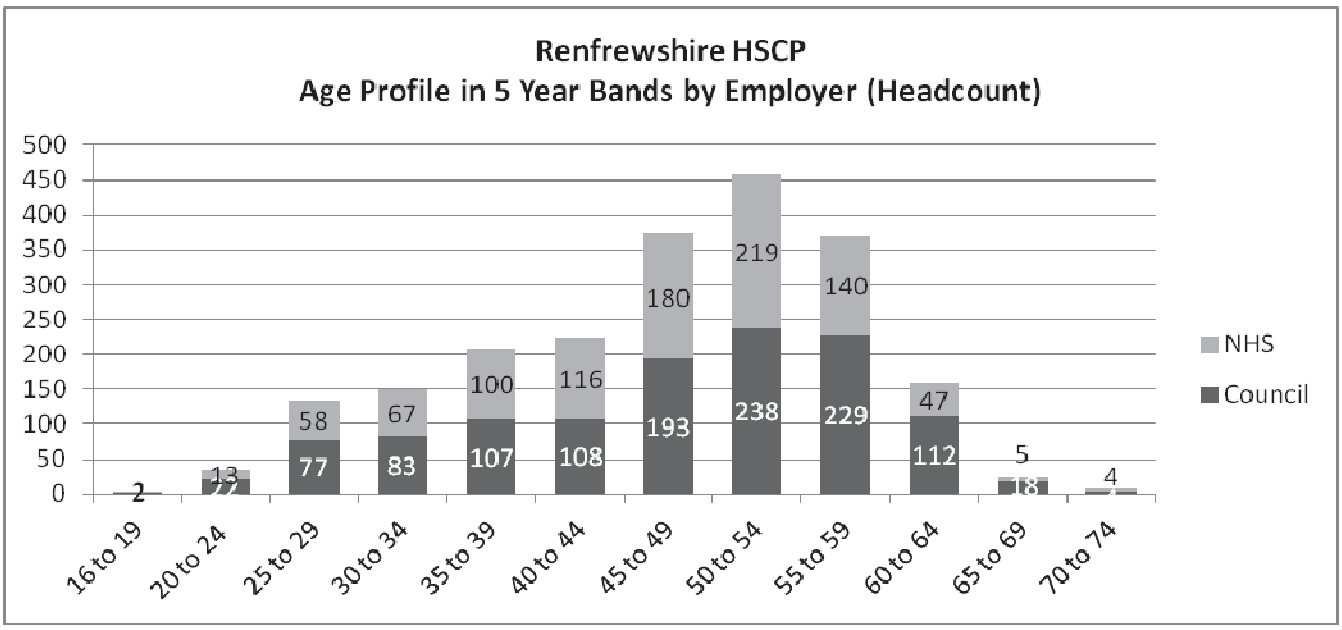
Links are also in place to operational and professional structures and networks, in particular:

- Participation, Engagement and Communication Group
- Quality, Care and Professional Governance Groups

An annual update on implementation of the Strategy and our first Workforce Plan 2017-2020 are in final draft.

Age Profiles

The chart below shows the HSCP headcount workforce age profile in 5 year bandings.



The profile displays a number of workforce characteristics which are important in relation to our workforce planning processes:

- **47.3%** of the combined HSCP workforce is over 50 years old
- **50%** of the Council workforce are over 50 years old with the NHS figure at **43%**
- The largest age band falls between 50 and 54 years of age with significant numbers also falling in the 55 to 59 year old grouping.
- **8.7%** of the workforce is over 60 years old.
- Only **1.78%** of HSCP staff are under 24 years old and there are only 3 staff members under 20 years old.

When the age profile is further broken down into the different employing authorities it suggests that there is a greater tendency among council staff to work into their sixties and beyond.

Change Programme: Our Approach to Change

To support the delivery of Renfrewshire IJB's Strategic and Financial Plans, the Chief Officer established an ambitious Change and Improvement Programme, to tackle our challenging budget position whilst delivering safe, sustainable and integrated services in line with the priorities set out in the draft Strategic Plan. This programme was split into two key workstreams:

- unlocking the benefits of integration
- delivering social care savings

The first, to establish a health and social care service which is managed and delivered through a single organisational model, unlocking the benefits which can be derived from integration. These projects have brought together GPs, Social Work, District Nursing, Rehabilitation and Mental Health teams and other staff to consider how they can further improve joint working to better support the needs of local patients and service users.

Over the last year, a number of change projects have been progressed to help inform how the HSCP can best design an effective and dynamic approach to 'locality' and 'cluster' based working and to build collaboration and joint working between services.

Localities

A locality is defined as a smaller area within the borders of the HSCP to provide a mechanism of local leadership for service planning and to support greater clinical integration between primary and seconday care.

In Renfrewshire we have established two locality areas: Paisley and West Renfrewshire. Within our locality structures we have carried out a number of service review and redesign workstrands to maximise effective use of resources and improve the patient journey across Renfrewshire. Some examples of the work undertaken includes:

- Work within Mental Health and Addictions services to maximise effective use of resources and improve the patient journey, ensuring systems for access to services are clear, open and responsive.
- Introducing a Single Point of Access (SPoA) for District Nursing services. This will simplify both the referral and access process for those referring patients to the service and those who are being referred. The implementation of this will also

create capacity for increased patient-facing time as well as a more flexible service.

During 2016/17 there has been a focus on building a structured approach to involving and engaging with General Practitioners (GPs).

GP Clusters

In line with Scottish Government guidance, we have established six GP clusters in Renfrewshire. GP clusters are small groups of geographically connected practices that work collaboratively to improve outcomes, pathways and services for patients. In addition, as required in the 2016/17 GP Contract, Practice Quality Leads (PQLs) and Cluster Quality Leads (CQLs) have been identified, to support these emerging integrated models of working. One named GP within each practice will undertake the role of the PQL. The Cluster Quality Lead role will have dual accountability. It will be accountable to 'the cluster' for developing effective joint working, and for developing and delivering the cluster quality improvement programme (CQIP). The CQL will also be accountable to the HSCP for these functions and through these will bring advice and real influence within the partnership that connects the CQIP to the wider partnership plans and responsibilities.

Some examples of joint work that the HSCP has progressed with our GPs include:

- Realignment of the HSCP's Prescribing Support Pharmacists in order to release GP capacity, which is a recognised pressure amongst this area of the workforce.

- Shared caseloads between GP practices and HSCP services in order to improve how we support patients/service users and provide a more seamless service experience. For example, identifying current patients within Mental Health services who are registered with GP practices and those clinicians the patient receives input from; and sharing the list of children on the child protection register with GP practices.

- Regular update of Anticipatory Care Plans to ensure a dynamic patient record that details the preferred actions, interventions and responses care providers should make following a clinical deterioration or crisis in the person's care.

- Direct access to a range of self-referral services thereby reducing the need for GP referrals to these services.

The HSCP cannot transform health and social care services in isolation. As part of this work we have worked actively with key stakeholders, our parent organisations, community planning partners, NHSGGC Acute Services, the third sector and providers to take forward a number of service improvement initiatives including:

- NHSGGC system-wide initiatives, such as the District Nursing review, Mental Health In-patient Services redesign, Community Mental Health Framework, and the Learning Disability redesign.

- Contributing to the review of Community Planning arrangements in Renfrewshire. The new structure (approved by Renfrewshire Council on 15 December 2016) recognises the Strategic Planning Group (SPG) as the main planning group for health and social care.

We have worked closely with the third sector to develop our Community Connectors' Initiative. This three components:

- Housing and health information hubs have been established to provide easy access to a range of housing and health information for local people;
- A GP Social Prescribing service ('Community Links') works with GP practices to refer people into social and wellbeing supports in their own communities, reducing demand on GPs for non-medical support;
- Community Health Champions project recruits and supports local residents in designing and delivering health and wellbeing activities in local communities.

The second workstream framed the HSCP's delivery of social care savings, legislative requirements and service improvement work to assist the IJB mitigate a number of the key demographic and financial pressures identified within adult social care. Some examples of this work includes:

Care at Home: a three year transformation programme for our Care at Home services is underway which seeks to modernise and redesign the service to enable it to respond to increasing need both efficiently and effectively. The service has been pivotal to our success in minimising hospital delays and in shifting the balance of care from long-term settings. As the older population increases, the service is expected to continue to experience growing demand, resulting in financial and operational pressures. The transformation will be wide ranging and will focus on attracting new staff through sustained recruitment campaigns; creating and implementing a learning and development strategy to ensure staff are suitably equipped to meet the changing needs of service users; and developing a range of tools and processes that will improve the supervision and support that staff receive. The programme will also see the procurement and implementation of an electronic scheduling and monitoring system.

Care & Repair: the service has experienced a higher level of demand than initially set in the original contract. Additional non-recurring resources from Renfrewshire Council in 2016/17 enabled an historic issue in relation to a growing waiting list to be cleared. As at May 2017 there was no waiting list for (Care and Repair). This figure is a substantial improvement from July 2016 figures, when 126 people were on the waiting list with the longest wait being from February 2015. The Council's Procurement Service is currently preparing the tender for a new Care and Repair contract, to begin in November 2017, in partnership with East Renfrewshire HSCP.

Self Directed Support: new streamlined and controlled Self Directed Support (SDS) business processes have been introduced to promote equity and to quickly enable frontline staff to deliver the agreed support plan within the agreed finance rules. The new processes have reduced the time required to agree an indicative budget for the service user's support plan from 16 days in 2014 to 4 days in 2016

Negotiations have been successfully concluded to bring all contracted providers currently delivering services in Renfrewshire in line with the Living Wage from 1 October 2016.

These prioritised areas reflect the national policy direction to shift the balance of care, promote independent living and ensure person centred care. Service reviews challenge our current models of service delivery to ensure our resources are focused on greatest need and to deliver the best outcomes for our service users.

Renfrewshire IJB's Strategy and Business Model

It is recognised that the IJBs Strategic Plan must be dynamic in nature, to ensure it continues to reflect national and local priorities, the impact to changing external drivers and aligns with the IJB's financial plan.

The HSCP is undertaking a review of the IJB's performance in its first year in operation, in line with the objectives and actions set out in its Strategic Plan. This review is taking a collaborative approach, working in consultation with our key stakeholders including staff, the HSCP Leadership Network, the Strategic Planning Group and parent organisations to identify:

- Key achievements in delivering the 2016/17 action plan which contribute to the IJB's longer term objectives

- Challenges, both financial and operational, which have had an impact on service delivery over the last year

- Our priorities for 2017/18, taking into account the outcome of this review, financial pressures and any other external drivers e.g. national policy, legislation, workforce.

In light of the challenging financial position the HSCP now faces, a dedicated HSCP finance and planning forum has been established, jointly led by the Chief Finance Officer and Head of Strategic Planning, to ensure the Strategic Plan, and supporting action plans, aligns with budget planning. This planning will be carried out in consultation with the HSCP's Operational Heads of Service and Professional Leads to assess any impact reduced resource may have on service delivery and performance, and the aspirations set out in the current Strategic Plan.

The HSCP is committed to proactively transforming our health and social care services, realising the opportunities integrated working offers, with service redesign informed by a strategic commissioning approach. This in turn will support the long term financial sustainability of the Partnership and deliver the savings required to address the IJB's medium term budget deficit.

In 2017/18 a comprehensive action plan will be developed to support the HSCP's service developments and improvements for year two of the Strategic Plan. In addition to operational continuous improvement activity, this action plan will include transformational projects and proposals to deliver financial savings. Similar to 2016/17, these larger projects will be progressed as part of the Partnership's wider Change and Improvement Programme, and will be subject to IJB approval.

Reporting on Lead Partnership Responsibility

Renfrewshire HSCP is the lead Partnership for **Podiatry** and **Primary Care Support** for NHS Greater Glasgow and Clyde. This means we are responsible for the strategic planning and operational budget of all issues relating to Podiatry across six Health and Social Care Partnerships. We also support primary care contractors within the Board area.

Podiatry

Podiatrists are health care specialists in treating problems affecting the feet and lower limb. They also play a key role in keeping people mobile and active, relieving chronic pain and treating acute infections.

NHS Greater Glasgow and Clyde employs approximately 200 podiatrists in around 60 clinical locations spread across the six Health and Social Care Partnerships. The Podiatry service is managed in four geographical quadrants (West, East, South and Clyde), and is currently providing care to around 40,000 patients across the NHSGG&C Board area, representing 3.4% of the population.

Since April 2012, the podiatry service has been undergoing whole system redesign. The ongoing impact of this on service improvement is significant:

- Waiting times are now consistently less than four weeks for over 90% of referrals

- 95% of diabetic foot ulcers are treated within 48 working hours. This has been evidenced to improve amputation rates and life expectancy for individuals with diabetes

- The service has made a total of £735k in direct savings (recurrent) – or around 11% over 5 years.

- We have also reduced sickness absence within the service from an annual average of 5.8% to 2.8%. This equates to around £180k per year more resource at work.

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Primary Care Support

Primary Care Support (PCS) is hosted by Renfrewshire HSCP. The team works across the whole of the NHS Greater Glasgow and Clyde area to support primary care contractors. This includes managing Contracts and payments; working with Health and Social Care Partnerships on future planning and any changes to practices; GP appraisal; Practice Nursing Support; and Screening and Immunisation services. The team works with 238 GP practices, and 184 Optometry premises.

INFOGRAPHIC: 238 GP Practices & 184 Optometry premises

Supporting practices into new contracting arrangements, testing new ways of working (17c and Inverclyde).

The PCS team has supported the continuation of new contracting arrangements through the Inverclyde New Ways programme, including administering the necessary contract changes and supporting service developments with clusters and practices. The team continues to support the 47 17c practices through annual visits and payment arrangements. Transitional Quality Arrangements as part of the transition to a new contract have been introduced and supported by the team.

Developing the role of practice nurses to support people to live longer at home.

The practice nurse support and development team continues to offer a comprehensive range of support and advice to practice nurses directly, and to practices on the development of practice nursing roles. This includes training events, individual support where required and the development of 'learning tables' which provide detailed training resources and contacts on key areas of chronic disease management; these are being extended to cover a wider range of topics. The team is also supporting the extension of roles including nurse practitioners, prescribing and Advanced Nurse Practitioners, providing advice and linking to wider developments in these areas.

Improving resilience planning

Primary Care Support has raised the profile of sustainability and resilience issues for practices, supporting local conversations with HSCPs on resilience particularly associated with recruitment and premises. This includes providing direct support to practices and capturing learning from crisis situations.

Inspection of Services

Renfrewshire Health and Social Care Partnership directly provide and commission a number of externally provided care services. A high quality of care is vital across all services to ensure positive outcomes for our service users. Monitoring and evaluation play a key part in ensuring these services meet contractual standards and obligations as well as delivering planned commissioning outcomes on the ground.

External Services

The HSCP has an internal Contract Performance Management Team, which monitors externally provided services. A rolling programme of contract monitoring visits cover:

- 13 Supported Living providers;
- 21 Care Home Services;
- 3 Care Homes for people with Learning/Physical Disabilities;
- 7 Care at Home companies
- 9 block funded services covering mental health, carers' services, domestic violence, advocacy and older people.

Through a proactive approach, our Contract Performance Management Team ensures externally contracted organisations are person centred, safe, effective and sustainable. Services are visited and any performance issues are addressed through jointly negotiated service improvement action plans and follow-up visits.

The team also adopts a reactive practice and keeps a 'watchful eye' on services as the main point of contact for managing significant events, Adult Protection referrals, managing complaints and investigations, and through regular liaison with:

- The Providers on an individual basis or through organising provider forums; and
- The Care Inspectorate through joint working and regular information sharing.

Internal Services

Renfrewshire Health and Social Care Partnership directly provide a number of services subject to a rolling programme of inspection from the Care Inspectorate. Inspection assures people that services are working well and highlights areas for improvement. This is carried out by independent inspectors who look at the overall quality of care and support, the staffing, the management and leadership, and the

environment in which the care is provided. Inspections are designed to evidence the impact that care has on people's individual experiences.

As at May 2017, our directly provided services attained the following grades for care as detailed below:

Establishment / Care Inspectorate No.	Inspection Date	Quality Theme	Care Grades
Hunterhill Care Home	28/11/2016	Care & Support	6 - Excellent
		Management & Leadership	6 - Excellent
Montrose Care Home	27/05/2016	Environment	6 - Excellent
		Staffing	5 - Very Good
		Management & Leadership	6 - Excellent
		Care & Support	6 - Excellent
Renfrew Care Home	20/07/2016	Care & Support	4 - Good
		Management & Leadership	4 - Good
Falcon Day Centre	17/04/2014	Care & Support	5 – Very Good
		Environment	5 – Very Good
		Staffing	5 – Very Good
		Management & Leadership	5 – Very Good
Johnstone Day Centre	23/05/2014	Care & Support	6 – Excellent
		Environment	6 – Excellent
		Staffing	5 – Very Good
		Management & Leadership	5 – Very Good
Montrose Day Centre	12/08/2016	Care & Support	6 – Excellent
		Management & Leadership	5 – Very Good
Ralston Day Centre	11/04/2014	Care & Support	5 – Very Good
		Environment	5 – Very Good
		Staffing	5 – Very Good
		Management & Leadership	5 – Very Good
Renfrew Day Centre	08/02/2017	Care & Support	5 – Very Good
		Management & Leadership	5 – Very Good

The Mirin Day Opportunities	28/11/2016	Care & Support	4 - Good
		Environment	4 - Good
		Staffing	4 - Good
		Management & Leadership	4 - Good
Milldale Day Opportunities	15/06/2016	Care & Support	4 - Good
		Management & Leadership	4 - Good
The Anchor Day Service	21/12/2016	Care & Support	4 - Good
		Environment	3 - Adequate
		Staffing	4 - Good
		Management & Leadership	3 - Adequate
Weavers Linn	11/11/2016	Care & Support	5 – Very Good
		Staffing	6 - Excellent
Gateway (ISS)	14/01/2015	Care & Support	5 – Very Good
		Environment	5 – Very Good
		Staffing	5 – Very Good
		Management & Leadership	5 – Very Good
Community Networks	16/05/2016	Care & Support	5 – Very Good
		Staffing	5 – Very Good
		Management & Leadership	5 – Very Good
Disability Resource Centre	29/11/2016	Care & Support	6 - Excellent
		Staffing	6 - Excellent
Care at Home Service		Management & leadership	5 – Very Good
		Staffing	5 – Very Good
		Care and Support	5 – Very Good

Financial Performance and Best Value

Renfrewshire HSCP Net Revenue Position 2016/17

Throughout 2016/17 a number of services experienced a significant increase in demand, particularly: Care at Home services; Adult Placements, and Special Observations within Mental Health. The overall revenue position for Renfrewshire HSCP at 31 March 2017 was a breakeven position after the movement of planned underspends to create reserves for use in 2017/18.

Early in 2016/17, the Chief Finance Officer, considering the climate of ongoing financial austerity and increasing demand, made the decision to hold back on the application of the use of a proportion of the Social Care Fund allocated by the Scottish Government in 2016/17 for driving forward service redesign to shift the balance of care. This prudent approach enabled the increasing demand and associated cost pressures within the Care at Home service and Adult Supported Placements to be funded in 2016/17, leaving a balance of £1.519m to be transferred to reserves for use in 2017/18 to meet ongoing pressures within the adult social care service budget.

In addition, given the significant budget gap to be met for 2017/18, with regards to the Health budget allocation, the Chief Officer and Chief Finance officer worked with the senior management team on a number of cost containment programmes through the final quarter of 2016/17 to enable reserves to be created to assist in covering this gap.

Table 1 below details the performance by service for 2016/17, with summary notes on the main variances included overleaf.

Table 1: Financial Performance for 2016/17

Client Group	Budget	Year to Date Budget	Actual	Variance			Notes
	£000's	£000's	£000's	£000's	%		
Older People	39,671	39,671	39,248	423	1.1%	underspend	1
Physical or Sensory Difficulties	6,265	6,265	6,779	(514)	-8.2%	overspend	2
Learning Disabilities	12,544	12,544	12,494	50	0.4%	underspend	
Mental Health Needs	988	988	982	6	0.6%	underspend	
Addiction Services	706	706	671	35	5.0%	underspend	
Integrated Care Fund	650	650	650	-	0.0%	breakeven	
Total Adult Social Care	**60,824**	**60,824**	**60,824**	**-**	**0.00%**	**breakeven**	
Addiction Services	2,501	2,501	2,501	-	0.0%	breakeven	
Adult Community Services	13,220	13,220	13,023	197	1.5%	underspend	
Children's Services	5,408	5,408	5,013	395	7.3%	underspend	3
Learning Disabilities	1,129	1,129	1,044	85	7.5%	underspend	
Mental Health	18,922	18,922	19,576	(654)	-3.5%	overspend	4
Hosted Services	5,173	5,173	4,950	223	4.3%	underspend	
Prescribing	35,007	35,007	35,007	-	0.0%	breakeven	
GMS	22,842	22,842	22,842	-	0.0%	breakeven	
Other	20,864	20,864	20,864	-	0.0%	breakeven	
Planning and Health Improvement	1,122	1,122	1,083	39	3.5%	underspend	
Other Services	2,353	2,353	2,638	(285)	-12.1%	overspend	
Resource Transfer	25,646	25,646	25,646	-	0.0%	breakeven	
Integrated Care Fund	3,490	3,490	3,490	-	0.0%	breakeven	
Total Health	**157,677**	**157,677**	**157,677**	**-**	**0.00%**	**breakeven**	
Garden Assistance Scheme	296	296	369	(73)	-24.7%	overspend	
Housing Adaptations	770	770	770	-	0.0%	breakeven	
Women's Aid	81	81	81	-	0.0%	breakeven	
Total Other Council Delegated Services	**1,147**	**1,147**	**1,220**	**(73)**	**-6.36%**	**overspend**	
TOTAL NET EXPENDITURE	**219,648**	**219,648**	**219,721**	**(73)**	**-0.03%**	**overspend**	

Note: The above figures reflect the delegated budget managed by the IJB during 2016/17, excluding the large hospital set aside budget for 2016/17

1. **Older People**: Net underspend of £423k

The overall position within Older People's services was a net underspend. The Care at Home service budget was under significant pressure throughout 2016/17, with a final position at the year-end of a £3.3m overspend. In order to bring the overall position of adult social care back into a breakeven position, Social Care Integration monies (allocated as part of the Scottish Government 2016 Financial Settlement) were used to fund the overspend within the Care at Home service.

2. **Physical Disabilities:** Net overspend of £514k

The overspend within Physical Disabilities was in relation to pressures within the Adult Placement Budget reflecting both the impact of increasing demand and Self Directed Support (SDS).

3. **Children's Services:** Net underspend of £395k

The overall underspend in Children's Services was due to underspends within CAMHS from lower than anticipated payroll costs, reflecting the position staff are placed on the pay scale along with staff turnover. In addition, there were a number of vacancies within the School Nursing and Childsmile teams throughout the year due to service redesign, retirals, and an increase in the number of nurses leaving to undertake the health visiting course.

4. **Mental Health:** Net overspend of £654k

This overspend was due to a number of contributing factors within both adult and in-patient services. The main overspends were in relation to significant costs (overtime, agency and bank costs) associated with patients requiring enhanced levels of observation across all ward areas. In addition, there were pressures in relation to maintaining the recommended safe staffing and skill mix for registered nurse to bed ratios.

Financial Outlook, Risks and Plans for the Future

Although no figures are available beyond 2017/18, it is anticipated that the public sector in Scotland will continue to face a challenging medium term financial outlook. This will potentially have significant implications for Renfrewshire IJB's parent organisations and therefore the delegated Heath and Adult Social Care budgets.

From 2017/18 and beyond, it is important to be clear that within the current models of working, the reducing budgets available will require further recurring savings to be made; this will mean the IJB needs to consider what can safely be delivered.

There are number of key strategic risks and uncertainties for the IJB:

The impact of Brexit on the HSCP is not currently known, possible areas of risk include:

- Impact of European funding, regarding how this will be replaced if at all;
- Whether staff born outwith the UK will be able to continue working for the HSCP.
- Potential increased overheads of associated new legislation/regulations.
- The Scottish Government response to Brexit and the possibility of a second independence referendum creates further uncertainty.
- Complexity of the IJB governance arrangements has been highlighted by Audit Scotland as an ongoing concern, including lack of clarity around decision-making.
- Risk to the effectiveness of the IJB's governance caused by turnover in Board members
- The IJB governance model promotes decision making by consensus, therefore complex and difficult issues being faced by the IJB may prove difficult to get to a position where consensus is possible
- IJB Voting Members may feel challenged by their competing roles, as members of the IJB and their constituent bodies.

A shortage of key professionals including General Practitioners, District Nurses, Mental Health Officers, Psychologists and Care at Home Staff are a current recruitment and retention challenge for Renfrewshire HSCP.

The most significant financial risks facing the IJB are set out below:

- **2016/17 savings proposals** have not been approved
- **The IJB has not agreed its 2017/18 delegated health budget allocation**
- The alignment of our three year financial plan with the Strategic Plan has been delayed due to the lack of an approved delegated health budget
- **The set aside budget for 2017/18 has not been confirmed by NHSGGC for 2017/18; in addition, there are a number of risks associated with the set aside budget which may mean the IJB will not be able to deliver the Scottish Government's expectations in relation to the commissioning of set aside services.**
- **From** 2017/18, the current risk sharing arrangement with NHS GGC for prescribing will change
- The Carers (Scotland) Act will commence on 1 April 2018. This new legislation will create new demands on our adult care services through the requirement to produce Adult Carer Support Plans and Young Carer Statements.

In light of the challenging financial position the HSCP faces, a dedicated HSCP finance and planning forum has been established, jointly led by the Chief Finance Officer and Head of Strategic Planning, to ensure the Strategic Plan, and supporting action plans, align with budget planning. This will be carried out in consultation with the HSCP's Operational Heads of Service and Professional Leads to assess any impact reduced resource may have on service delivery and performance, and the aspirations set out in the current Strategic Plan.

In 2017/18, our year two Strategic Plan action plan will be developed to support the HSCP's service developments and improvements for year 2 of the Strategic Plan. This action plan will include transformational projects and proposals to deliver financial savings which will be progressed as part of the Partnership's wider Change and Improvement Programme, subject to IJB approval.

Reporting on the Integrated Care Fund 2016/17

Renfrewshire HSCP has noted and acted upon lessons learned from the processes involved in implementing and monitoring the delivery of complex programmes of change, through the experience of delivering the Reshaping Care for Older People (RCOP) Programme. The Integrated Care Fund (£3.490m) has been used to build on the progress and lessons learned through the four-year RCOP Change Programme. Key approaches have been to develop and change working practices in:

- Person-centred health and care service provision and patients' and carers' pathways
- Capacity building at key pathways and interfaces between Acute, Community Health and Social Care services
- Multi-agency work, particularly in relation to planning and developing preventative services and to area-based planning with community-based partners.

In the statutory sector the ICF is targeted on further developing the reablement and technology-enabled models of health and social care and in building on joint and integrated working between services. Examples include rapid response services within community health and social care services, preventing unnecessary admissions to hospital; and the further development of dementia and palliative care in people's homes or in homely settings within the community.

Initiated in 2015/2016, four new health and social care projects were piloted (as part of the Community Connectors' Initiative) in some areas of Renfrewshire with support from the Integrated Care Fund. Their impact on health and care outcomes will be evaluated and the findings will contribute to the future planning and delivery of health and care services.

What do you think?

Please take a few minutes to tell us what you think about this Annual Report by completing this short questionnaire. This can be found online at https://goo.gl/gcItUS

1. How do you rate the design and layout of the Annual Report?

☐ Very good ☐ Fairly good ☐ Average ☐ Poor

2. How easy is it to read and understand?

☐ Very easy ☐ Fairly easy ☐ Not very easy ☐ Not at all easy

3. How useful is it in informing you about the work of your Health and Social Care Partnership?

☐ Very Useful ☐ Fairly useful ☐ Not very useful ☐ Not at all useful

4. Which sections did you find particularly useful?

5. What other information would you like to see in a future Annual Report?

6. Other comments

Thank you for your feedback

Alternatively you can print and complete the questions on this page and return to Planning & Health Improvement, Renfrewshire Health and Social Care Partnership, Renfrewshire House, Cotton Street, Paisley PA1 1AL.
Or contact Tel: 0141 618 7629, Email: Renfrewshire.HSCP@ggc.scot.nhs.uk
We will use your feedback to improve future publications.

Renfrewshire Health & Social Care Partnership

Health and Care Experience Survey 2015-2016

Renfrewshire Health and Social Care Partnership
The survey was sent to 23,285 people registered with GP practices in the area.

The survey asks about people's experiences of accessing and using primary care services and was widened in 2013/14 to include aspects of care, support and caring to support the principles underpinning the integration of health and care in Scotland outlined in the Public Bodies (Joint Working)(Scotland) Act 2014.

A copy of the survey is available at:
www.gov.scot/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey/HACE2015-16

3,357 patients of Renfrewshire Health and Social Care Partnership sent in feedback on their experiences at the practice. Of the patients that answered questions about themselves:

- 41% were male and 59% were female;
- 9% were aged 17-34, 15% were aged 35-49, 33% were aged 50-64 and 42% were 65 and over;
- 63% did not have any limiting illness or disability.

The survey was commissioned by the Scottish Government as part of the Scottish Care Experience Survey Programme, which aims to use the public's experiences of health and care services to improve those services. The survey was managed by the Scottish Government in partnership with Information Services Division (ISD) of NHS National Services Scotland.

The results of the survey will be used by GP practices, Health Boards, Health and Social Care Partnerships and the Scottish Government to improve the quality of health and care services in Scotland.

National results for this survey and further details on the methods used to generate the reports are available at:
www.gov.scot/Topics/Statistics/Browse/Health/GPPatientExperienceSurvey/HACE2015-16

Summary of Results

This section provides the results for those questions which align to the Health and Social Care Indicators.

The difference between the percent positive score for the H&SCP and the Scottish average is shown in the final column. Differences which are statistically significant are marked with an S. Where a comparison has not been tested due to small numbers, this is marked with an NT.

I am able to look after my own health	93%	-1*
Service users are supported to live as independently as possible	81%	-3
Service users have a say in how their help, care or support is provided	81%	+2
Service users' health and care services seem to be well coordinated	77%	+1
Rating overall help, care or support services	79%	-2
Rating of overall care provided by GP practice	88%	+2 S
The help, care or support improves service users' quality of life	80%	-4
Carers feels supported to continue caring	39%	-2
Service users feel safe	84%	-0

*Please note that measure "I am able to look after my own health" has not been subject to significant testing.

Renfrewshire Health & Wellbeing Profile

Domain		Indicator	Period	Number	Measure	Type	National Average
Life Expectancy & Mortality	1	Life expectancy (Males)[18]	2011	n/a	75.3	yrs	76.6
	2	Life Expectancy (Females)[18]	2011	n/a	80.4	yrs	80.8
	3	All-cause mortality among the 15-44 year olds. [12]	2014	70	116.5	sr4	98.2
Behaviours	4	Estimated smoking attributable deaths [3, 13, 16]	2014	347	377.8	sr4	366.8
	5	Smoking prevalence (adults 16+) [3,14]	2014	50	20.1	%	20.2
	6	Alcohol-related hospital stays [15]	2015	1,618	945.3	sr4	664.5
	7	Alcohol-related mortality [17]	2013	46	27.0	sr4	22.1
Mental Health	8	Population prescribed drugs for anxiety/depression/psychosis	2015	33,807	19.4	%	18.0
	9	Deaths from suicide [17]	2012	26	15.3	sr4	14.2
Social Care & Housing	10	Children looked after by local authority[3]	2014	681	18.9	cr2	14.0
Economy	11	Population income deprived	2015	23,450	13.4	%	12.3
	12	Working age population employment deprived	2015	13,725	12.2	%	10.6
	13	Children Living in Poverty	2012	6,090	15.7	%	15.3
Crime	14	Domestic Abuse [3]	2015	2,151	123.2	cr9	108.1
Women's & Children's Health	15	Teenage pregnancies[12]	2013	171	34.8	cr2	37.7
	16	Women smoking during pregnancy [12]	2014	273	16.6	%	17.3
	17	Child dental health in primary 1	2015	1,181	67.9	%	69.9
	18	Child dental health in primary 7	2015	1,079	66.2	%	67.9
	19	Child obesity in primary 1	2015	156	9.0	%	9.9

Key	
%	Percent
cr2	Crude rate per 1,000 population
cr9	Crude rate per 10,000 population
sr4	Age-sex standardised rate per 100,000 populations to ESP2013.
Yrs	Years
Notes	
3. Data available down to council (local authority) area only.	
12. Three-year average number and 3-year average annual measure.	
13. Indicator based on HB boundaries prior to April 2014.	
14. Two-year combined number, and 2-year average annual measure.	
15. All 6 diagnosis codes used in the analysis.	
16. Two-year average number and 2-year average annual measure.	
17. Five-year average number and 5-year average annual measure.	
18. Three year average for health boards, local authorities and Scotland. Five year average intermediate geographies.	

DASHBOARD

Summary of Red, Amber and Green Measures as at March 2017

The summary chart shows 37 measures for information only; there are no specific targets for these measures.
Of the **51** measures that have performance targets, 51% show green (on or above target); 22% show amber (within 10% variance of target); and 27% show red (more than 10% variance of target).

National outcome	Red	Amber	Green	Data Only	Total	Movement
National Outcome 1. People are able to look after and improve their own health and wellbeing and live in good health for longer	0	2	5	1	8	One ▲ to ✓
National Outcome 2. People are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community	1	2	5	11	19	One ✓ to ▲ Two ● to ✓
National Outcome 3. People who use health and social care services have positive experiences of those services, and have their dignity respected	0	3	4	5	12	One ● to ▲
National Outcome 4. Health and social care services are centred on helping to maintain or improve the quality of life of service users	5	3	6	2	16	One ✓ to ● One ● to ▲ One ▲ to ✓
National Outcome 5. Health and social care services contribute to reducing health inequalities	3	0	1	4	8	One ✓ to ●
National Outcome 6. People who provide unpaid care are supported to reduce the potential impact of their caring role on their own health and well-being	1	0	0	3	4	No change
National Outcome 7. People who use health and social care services are safe from harm	0	0	2	2	4	No change
National Outcome 8. People who work in health and social care services are supported to continuously improve the information, support, care and treatment they provide and feel engaged with the work they do	3	1	2	3	9	One ● to ✓
National Outcome 9. Resources are used effectively in the provision of health and social care services, without waste	1	0	1	6	8	No change
Total:	**14**	**11**	**26**	**37**	**88**	
Percentage %:	**27%**	**22%**	**51%**	**-**	**100%**	

Renfrewshire Integration Joint Board Scorecard 2016-2017

PI Status	
	Alert
	Warning
	OK
	Unknown
	Data Only

Direction of Travel	
	Improvement
	Deterioration
	Same as previous reporting period

National Outcome 1. People are able to look after and improve their own health and wellbeing and live in good health for longer						
PI code & name	2014/15 Value	2015/16 Value	Latest 2016/17 Value	Target	Direction of Travel	Status
National Indicators						
HSCP/CI/HCES/01 Percentage of adults able to look after their health very well or quite well	94%	-	Survey. Next data expected in 2018	-	-	
Local Indicators						
HSCP/HI/AD/02 Reduce smoking in pregnancy	13.6%	15.5%	15.2%	20%		
HSCP/HI/ANT/01 Breastfeeding exclusive for 6-8 weeks	21.8%	20.8 %	Sep 16: 22.6%	21.4%		
HSCP/HI/LS/01 Increase in the number of people who assessed their health as good or very good	77%	-	Survey. Next data expected in 2018	80%		
HSCP/HI/LS/02 Increase the percentage of people participating in 30 mins of moderate physical activity 5 or more times a week	53%	-	Survey. Next data expected in 2018	32%		
HSCP/HI/LS/03 Reduce the percentage of adults who smoke	19%	-	Survey. Next data expected in 2018	23%		

Renfrewshire Integration Joint Board Scorecard 2016-2017

PI code & name	2014/15	2015/16	Latest 2016/17	Target	Direction of Travel	Status
	Value	Value	Value			
HSCP/HI/LS/04 Reduce the percentage of adults that are overweight or obese	49%	-	Survey. Next data expected in 2018	55%		
HSCP/HI/MH/01 Increase the average score on the short version of the Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS)	53.4	-	Survey. ext data expected in 2018	57		

Renfrewshire Integration Joint Board Scorecard 2016-2017

National Outcome 2. People are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.						
PI code & name	2014/15 Value	2015/16 Value	Latest 2016/17 Value	Target	Direction of Travel	Status
National Indicators						
HSCP/CI/HCES/02 Percentage of adults supported at home who agree that they are supported to live as independently as possible	80%	-	Survey. Next data expected in 2018	-	-	
HSCP/CI/HCES/19 Number of days people spend in hospital when they are ready to be discharged, per 1,000 population	-	-	-	-	-	
Local Indicators						
The total number of patients delayed (at census point) (Acute and Mental Health)	-	-	**Total:** 5 **Acute:** 5 (1<72hrs; 4>72hrs) **MH**: 0	-		
The total number of delayed discharge episodes at month end (Acute and Mental Health)	-	-	**Total:** 38 **Acute:** 37 **MH**: 1	-		
The total number of bed days occupied by delayed discharge patients (month end) (Acute and Mental Health)	-	-	**Total:** 313 **Acute:** 282 **MH**: 31	-		
HPBS14b1 Number of PSHG awarded to disabled tenants to adapt private homes	109	108	2017 data will be available early 2018	-	-	
HPCHARTER22 Percentage of approved applications for medical adaptations completed during the year	87.8%	96%	96%	99%		
HPCHARTER23 The average time (in days) to complete medical adaptation applications	64	44	40	-	-	
HSCP/AS/ACP/02 Number of adults with an Anticipatory Care Plan	649	977	1,847	440		
HSCP/AS/DEM/01 Number of patients registered with dementia	-	1,431	1,431	1,384		

Renfrewshire Integration Joint Board Scorecard 2016-2017

PI code & name	2014/15	2015/16	Latest 2016/17	Target	Direction of Travel	Status
	Value	Value	Value			
HSCP/AS/DEM/02 People newly diagnosed with dementia will have a minimum of 1 year's post-diagnostic support (female & male)	-	100%	100%	100%	-	
HSCP/AS/HC/01.1 Percentage of clients accessing out of hours home care services (65+)	86%	87%	89%	85%		
HSCP/AS/HC/02 Percentage of long term care clients receiving intensive home care (National Target: 30%)	28%	31%	27%	30%		
HSCP/AS/HC/07 Total number of homecare hours provided as a rate per 1,000 population aged 65+	499	501	460	-	-	
HSCP/AS/HC/09 Percentage of homecare clients aged 65+ receiving personal care	99%	98%	99%	-	-	
HSCP/AS/HC/11 Percentage of homecare clients aged 65+ receiving a service during evening/overnight	59%	64%	66%	-	-	
HSCP/AS/HC/16 Total number of clients receiving telecare (75+) per 1,000 population	21.37	20.71	29.13	-	-	
HSCP/AS/OT/01 Percentage of clients on the OT waiting list allocated a worker within 4 weeks (Social Work Service)	13%	20%	15%	70%		
HSCP/AS/OT/04 The average number of clients on the Occupational Therapy waiting list	387	297	340	350		

Renfrewshire Integration Joint Board Scorecard 2016-2017

National Outcome 3. People who use health and social care services have positive experiences of those services, and have their dignity respected.						
PI code & name	2014/15	2015/16	Latest 2016/17	Target	Direction of Travel	Status
	Value	Value	Value			
National Indicators						
HSCP/CI/HCES/04 Percentage of adults supported at home who agree that their health and care services seemed to be well co-ordinated	75%	-	Survey information. Next data expected in 2018	-	-	
HSCP/CI/HCES/05 Percentage of adults receiving any care or support who rate it as excellent or good	83%	-	Survey information Next data expected in 2018	-	-	
Local Indicators						
HSCP/AS/AE/01 A&E waits less than 4 hours	91.9%	88.6%	89.5%	95%	-	
HSCP/AS/MORT/01 Percentage of deaths in acute hospitals (65+).	46%	42.8%	41.3%	48.2%	↑	
HSCP/AS/MORT/02a Percentage of deaths in acute hospitals (75+) SIMD 1	44.6%	43.0%	40.4%	45%	↑	
HSCP/CS/MH/01 Child and Adolescents Mental Health (CAMHS) - % of patients seen within 18 weeks	100%	100%	100%	100%	-	
HSCP/EQ/EDT/02 Number of staff trained in Equality and Diversity Training	-	161	117	-	-	
HSCP/HI/SI/01 Number of routine sensitive inquiries carried out	88% of Audit of 70	-	71% of an audit of 319 (August and February audits combined.)	-	-	
HSCP/HI/SI/02 Number of referrals made as a result of the routine sensitive inquiry being carried out	1	13	16	-	-	

Renfrewshire Integration Joint Board Scorecard 2016-2017

PI code & name	2014/15	2015/16	Latest 2016/17	Target	Direction of Travel	Status
	Value	Value	Value			
HSCP/MH/PCMHT/03 Percentage of Primary Care Mental Health Team patients referred to first appointment offered within 4 weeks	-	88%	95%	100%		
HSCP/MH/PCMHT/04 Percentage of patients referred to first treatment appointment offered within 9 weeks	-	98%	96%	100%		
HSCP/MH/PT/01 Percentage of patients who started treatment within 18 weeks of referral to Psychological Therapies	99.4%	99.8%	100%	90%		

Renfrewshire Integration Joint Board Scorecard 2016-2017

National Outcome 4. Health and social care services are centred on helping to maintain or improve the quality of life of service users						
PI code & name	2014/15 Value	2015/16 Value	Latest 2016/17 Value	Target	Direction of Travel	Status
National Indicators						
HSCP/CI/HCES/07 Percentage of adults supported at home who agree that their services and support had an impact in improving or maintaining their quality of life.	82%	-	Survey. Next data available 2018	-	-	
Local Indicators						
HSCP/AS/ANT/04 At least 80% of pregnant women in each SIMD quintile will have booked for antenatal care by the 12th week of gestation	89.2%	88.3%	Dec 16: 84.75%	80%		
HSCP/AS/HA/03 Emergency admissions from care homes	508	477	538	480		
HSCP/AS/HA/04 Emergency bed days rate 65+	305	302	297	-	-	
HSCP/HI/ADS/01 Alcohol brief interventions	1,067	1,036	761	1,116		
HSCP/HI/ADS/06 Reduce the estimated prevalence of problem drug use amongst 15-64 year olds (percentage of total population age 15-64)	2.41%	-	Data expected in 2018.	1.86		
HSCP/HI/ADS/07 Drug related hospital discharge rate per 100,000	153.4	153.5	Data available July 2017	130		
HSCP/HI/ADS/08 Alcohol and Drugs waiting times for referral to treatment. % seen within 3 weeks	98.5%	99.6%	Dec 16: 97.8%	91.5%		
HSCP/HI/ANT/03 Reduce the rate of pregnancies for those under 16 years of age (rate per 1,000 population)	4.5	3.9	3.9	5%		
SOA13CHP.04 Reduction in the rate of alcohol related hospital admissions per 1,000 population	10.1	9.5	9.2	8.9		
SOA13CHP.11 Reduce the percentage of babies with a low birth weight (<2500g	6.7%	6.8%	Dec 16: 6.3%	6%		

Renfrewshire Integration Joint Board Scorecard 2016-2017

PI code & name	2014/15	2015/16	Latest 2016/17	Target	Direction of Travel	Status
	Value	Value	Value			
HSCP/CS/AX/01 Uptake rate of 30-month assessment	87.7%	83%	82%	80%	-	
HSCP/CS/SPL/01 Percentage of paediatric Speech & Language Therapy wait times triaged within 8 weeks	100%	100%	100%	100%	-	
HSCP/CS/SPL/02 Number waiting more than 18 weeks for paediatric Speech & Language Therapy assessment to appointment	12	82	62	0		
HSCP/HI/GP/01 Number of patients accessing GP services within 48 hours/advance booking	94%	-	-	95%	-	
HSCP/HI/GP/01 Percentage of patients able to book an appointment with a GP in advance	90.3%	-	-	90%	-	

Renfrewshire Integration Joint Board Scorecard 2016-2017

National Outcome 5. Health and social care services contribute to reducing health inequalities.						
PI code & name	2014/15	2015/16	Latest 2016/17	Target	Direction of Travel	Status
	Value	Value	Value			
National Indicators						
HSCP/CI/HCES/11 Premature mortality rate.	449.0	463.1	Annual data. Available autumn 2017	-	-	
Local Indicators						
HSCP/HI/AD/01 Smoking cessation - non smokers at the 3 month follow up in the 40% most deprived areas	170	254	Feb 17: 187	228		
HSCP/HI/AD/03 Smoking in pregnancy (SIMD)	24.9%	23.9%	23.9%	20%		
HSCP/HI/ANT/04 Breastfeeding at 6-8 weeks in most deprived areas	14.6%	12.0%	15.4%	19.9%		
HSCP/HI/EQ/FI/04 Number of referrals to Financial Inclusion and Employability Services	-	1,997	935	-	-	
HSCP/HI/EQIA/03 Number of quality assured EQIAs carried out	-	1	6	-	-	
HSCP/HI/GBV/01 Number of staff trained in Gender Based Violence ** emailed LJack	-	63	38	-	-	
HSCP/HI/LE/01 Reduce the gap between minimum and maximum life expectancy (years) in the communities of Renfrewshire (Bishopton and Ferguslie).	14.8	14.8	14.8	15.3		

Renfrewshire Integration Joint Board Scorecard 2016-2017

National Outcome 6. People who provide unpaid care are supported to reduce the potential impact of their caring role on their own health and well-being.						
PI code & name	2014/15 Value	2015/16 Value	Latest 2016/17 Value	Target	Direction of Travel	Status
National Indicators						
HSCP/CI/HCES/08 Percentage of carers who feel supported to continue in their caring role (National Survey)	-	39%	Survey. Next data available 2018	-	-	
Local Indicators						
HSCP/AS/AS/19 Number of carers' assessments completed for adults (18+)	147	80	64	185		
HSCP/AS/AS/20 Number of carers' self assessments received for adults (18+)	81	56	29	-	-	
HSCP/AS/CO/01 Number of carers reporting that they feel supported in their caring role (Local Survey)	83.0%	79.0%	89.7%	-	-	

Renfrewshire Integration Joint Board Scorecard 2016-2017

National Outcome 7. People who use health and social care services are safe from harm.						
PI code & name	2014/15	2015/16	Latest 2016/17	Target	Direction of Travel	Status
	Value	Value	Value			
National Indicators						
HSCP/CI/HCES/09 Percentage of adults supported at home who agree they felt safe.	80%	-	Information available late 2017	-	-	
HSCP/CI/SR/24 Suicide rate	24	21	Information available late 2017	-	-	
Local Indicators						
SOA13SW.06 Reduction in the proportion of adults referred to Social Work with three or more incidents of harm in each year	11.4%	6.4%	Information available June 2017	12%		
SOA13SW.08 Reduction in the proportion of children subject to 2 or more periods of child protection registration in a 2 year period	2.7%	2%	Information available June 2017	6%		

Renfrewshire Integration Joint Board Scorecard 2016-2017

National Outcome 8. People who work in health and social care services are supported to continuously improve the information, support, care and treatment they provide and feel engaged with the work they do.						
PI code & name	2014/15 Value	2015/16 Value	Latest 2016/17 Value	Target	Direction of Travel	Status
National Indicators						
HSCP/CI/HCES/10 Percentage of staff who say they would recommend their workplace as a good place to work.	80%	-	Information available late 2017	-	-	
Local Indicators						
RSW/H&S/01 No. of planned SW Health & Safety Audits undertaken (both internal and 3rd party)	1	1	0	-	-	
SWPERSOD07b No. of SW employees, in the MTIPD process, with a completed IDP	599	609	493+50 on new pilot IDP = 543	-	-	
HSCP/CS/H&S/01 % of health staff with completed eKSF/PDP	71.0%	61.1%	68.9%	80%	-	
HSCP/CS/H&S/02 Health sickness absence rate	6.0%	7.0%	5.6%	4%		
HSCP/AS/SW/01 Absence and sickness rates for Social Work Adult Services Staff (work days lost per FTE)	-	3.68	3.65	2.69 days	-	
HSCP/CS/H&S/03 % of Health Care Support Worker staff with mandatory induction completed within the deadline	-	-	Jan 17: 100% Feb & Mar 17:N/A	100%	-	
HSCP/CS/H&S/04 % of Health Care Support Worker staff with standard induction completed within the deadline	-	100%	100%	100%	-	
HSCP/CORP/CMP/01 % of complaints within health responded to within 20 days	-	100%	92%	100%		

Renfrewshire Integration Joint Board Scorecard 2016-2017

National Outcome 9. Resources are used effectively in the provision of health and social care services, without waste.						
PI code & name	2014/15 Value	2015/16 Value	Latest 2016/17 Value	Target	Direction of Travel	Status
National Indicators						
HSCP/CI/HCES/14 Readmission to hospital within 28 days.	-	-	-	-	-	
HSCP/CI/HCES/20 Percentage of health and care resource spent on hospital stays where the patient was admitted in an emergency.	-	-	-	-	-	
Local Indicators						
RSW/ILGB/SW1 Care at home costs per hour (65 and over)	£14.95	£15.47	2016/17 information available early 2018	-	-	
RSW/ILGB/SW2 Direct Payment spend on adults 18+ as a % of total social work spend on adults 18+	1.86%	2%	2016/17 information available early 2018	-	-	
RSW/ILGB/SW3 Net Residential Costs Per Week for Older Persons (over 65)	£389	£369	2016/17 information available early 2018	-	-	
HSCP/AC/PHA/01 Prescribing variance from budget	-	1.07% over budget	0.83% underspent	-	-	
HSCP/AC/PHA/02 Formulary compliance	-	79.1%	79.5%	78%		
HSCP/AC/PHA/03 Prescribing cost per weighted patient	-	£14.55	£16.07	£15.65		