Notice of Meeting and Agenda
Community Care, Health & Wellbeing Thematic Board

Date	Time	Venue
Tuesday, 25 October 2016	14:30	CMR 1, Council Headquarters, Renfrewshire House, Cotton Street, Paisley, PA1 1AN

KENNETH GRAHAM
Head of Corporate Governance

Membership

Councillors I McMillan and M Brown (Renfrewshire Council); D Leese, Lead Officer and Chief Officer, F MacKay, I Beattie, R Robertson, C Walker and H Cunningham, Health & Social Care Partnership; J Ferrie, Engage Renfrewshire; S McLellan, Forum for Empowering Our Communities; M Gallacher, Scottish Fire and Rescue Service; A Kennedy, Police Scotland; A Campbell, West College Scotland; A Bonar, University of the West of Scotland (UWS); D Goodman, Renfrewshire Carers; J McKellar, Renfrew Leisure Limited; Dr A Van der Lee, GP Representative; D Reid, Renfrewshire ADP; R Telfer, Scottish Care; S McDonald, Active Communities; G Fitzpatrick and L Muirhead (both Renfrewshire Council).

Chair

Councillor I McMillan.

Members of the Press and Public

Members of the press and public wishing to attend the meeting should report to the customer service centre where they will be met and directed to the meeting.

Further Information

This is a meeting which is open to members of the public.

A copy of the agenda and reports for this meeting will be available for inspection prior to the meeting at the Customer Service Centre, Renfrewshire House, Cotton Street, Paisley and online at www.renfrewshire.cmis.uk.com/renfrewshire/CouncilandBoards.aspx

For further information, please either email democratic-services@renfrewshire.gov.uk or telephone 0141 618 7112.

Items of business

Apologies

Apologies from members.

Declarations of Interest

Members are asked to declare an interest in any item(s) on the agenda and to provide a brief explanation of the nature of the interest.

Minute of Meeting
Community Care, Health & Wellbeing Thematic Board

Date	Time	Venue
Wednesday, 14 September 2016	14:30	CMR 3, Council Headquarters, Renfrewshire House, Cotton Street, Paisley, PA1 1AN

PRESENT

Councillor I McMillan, Renfrewshire Council; S McDonald, Active Communities; J Ferrie, Engage Renfrewshire; A Kennedy, Police Scotland; D Leese, F MacKay, I Beattie, R Robertson, and C Walker (all Renfrewshire Health & Social Care Partnership); G Fitzpatrick and L Muirhead (both Renfrewshire Council); and A Campbell, West College Scotland.

CHAIR

Councillor McMillan, Chair, presided.

IN ATTENDANCE

A Dowd, DWP; B Rooney, Scottish Fire and Rescue Service; C Melville, Renfrewshire Carers; and Y Farquhar and C MacDonald (both Renfrewshire Council).

APOLOGIES

Councillor M Brown, Renfrewshire Council; D Reid, Renfrewshire ADP; Rhona Welch, DWP; S McLellan, Forum for Empowering Our Communities; Dr A Van der Lee, GP Representative; H Cunningham, Health & Social Care Partnership; R Telfer, Scottish Care; M Gallacher, Scottish Fire and Rescue Service; D Goodman, Renfrewshire Carers; and J McKellar, Renfrew Leisure Limited.

DECLARATIONS OF INTEREST

There were no declarations of interest intimated prior to commencement of the meeting.

1 **MINUTE OF PREVIOUS MEETING**

There was submitted the Minute of the meeting of the Community Care, Health and Wellbeing Thematic Board held on 2 June 2016.

DECIDED: That the Minute be noted.

2 **ROLLING ACTION LOG**

The Rolling Action Log was submitted for approval.

DECIDED:

(a) That the updates be noted; and

(b) That the Rolling Action Log be approved.

3 **RENFREWSHIRE INTEGRATION NETWORK PROPOSAL**

There was submitted a report by the Community Link Team Manager, Renfrewshire Health and Social Care Partnership relative to the establishment of a Renfrewshire Integration Network.

The report advised that Renfrewshire's strong history of welcoming people from other countries was acknowledged and welcomed by the Community Planning Partnership and recent developments at both local and national level had highlighted the need for a cohesive network to continue to support this work.

Integration Networks in the Greater Glasgow and Clyde area had been established over the years to support the idea of active and participative citizenship and it was proposed that an Integration Network was established in Renfrewshire.

DECIDED:

(a) That it be agreed that an Integration Network be established;

(b) That the report be noted.

4 **BRIGHTER RENFREWSHIRE ALCOHOL AWARENESS WEEK (BRAW)**

There was submitted a report by the Head of Planning & Health Improvement, Renfrewshire Health and Social Care Partnership relative to an update on the progress of Brighter Renfrewshire Alcohol Awareness Week (BRAW).

The report advised of the BRAW activities to date and that BRAW was now a recognisable brand with an associated logo and campaign materials. Renfrewshire ADP had allocated funding to develop a Festive BRAW campaign to highlight alcohol awareness messages. Festive BRAW would focus on the development of health information resources for distribution throughout Renfrewshire, rather than granting funding to local groups or services.

The report intimated that Renfrewshire Licensing Board had proposed extending the terminal hours for sales of alcohol over the festive period 2016. As a statutory

consultee, Renfrewshire HSCP had responded highlighting concerns relating to the extension of terminal hours and to the increase in alcohol consumption associated with increased availability. The HSCP response specified that extensions to the availability of alcohol via the extension to terminal hours was incongruent with initiatives which aimed to reduce the harms caused by excess alcohol consumption such as BRAW and the Safe Bus. The letter was attached as an appendix to this report.

Discussion took place on targets and performance and the adverse effect that the proposed extension of terminal hours would have over the festive period on people's health and wellbeing. It was agreed that a letter would be written to the Licensing Board asking for an opportunity to present to the Board. It was also agreed that the performance indicators and the community level awareness of alcohol would be put on the agenda for the next cycle of Local Area Committee meetings.

DECIDED:

(a) That the BRAW update be noted;

(b) That the Board's representation to Renfrewshire Licensing Board relating to the Festive Terminal Hours as contained within the appendix to the report, be agreed;

(c) That it be agreed that the Board write to Renfrewshire Licensing Board to ask for an opportunity to present on the harm caused by excess alcohol consumption; and

(d) That it be agreed that Renfrewshire HSCP and Police Scotland prepare a joint report/presentation for submission to the next cycle of Local Area Committees.

5 PHARMACY SHARED CARE PROJECTS

There was submitted a report and presentation by the Head of Planning & Health Improvement, Renfrewshire Health and Social Care Partnership relative to the 'Smokefree Pharmacy Shared Care Pilot' and the Making Advice Work Financial Literacy Project both of which had been carried out in Lloyds Tannahill pharmacy in Ferguslie Park and supported by the RHSCP Public Health pharmacist.

The report advised that both projects had demonstrated that community pharmacy were ideally placed to support vulnerable people and reduce barriers to improving health outcomes in our most deprived communities.

DECIDED: That the outcomes of both the Smokefree Pharmacy Shared Care and the Making Advice Work projects be noted.

6 TACKLING LONLINESS & ISOLATION IN RENFREWSHIRE

There was submitted a report by the Community Link Team Manager, Renfrewshire Health & Social Care Partnership relative to loneliness and isolation.

The report advised that Renfrewshire's Community Plan and the Health and Social Care Partnership's Strategic Plan both recognised the increasing population of older people and the need for preventative and responsive activities and services to maintain good health and independence for as long as possible. It was proposed that community research was carried out in a number of small localities or neighbourhoods, with a view to getting some useful evidence to develop practical approaches. It was noted that there were already a number of good organisations and

initiatives supporting older people, however there was also a recognition that the people most at risk of loneliness and/or isolation might not be linked into services or activities and there was a need to develop ways of identifying those individuals and supporting them in the most appropriate way.

DECIDED: That the need for work to tackle loneliness and isolation in Renfrewshire be noted.

7 RENFREWSHIRE'S LOCAL IMPROVEMENT PLAN - PROGRESS AGAINST YEAR 3 TARGETS

There was submitted a report by the Lead Officer which provided detail on the three year progress for the Community Care, Health & Wellbeing Thematic Board element of the Local Outcome Improvement Plan.

The report advised that steady progress had been made in respect of the Community Care, Health and Well Being theme. Overall there were 16 impact measures for this theme. Of the 12 impact measures that data was available for, seven met or exceeded the year 3 milestones, three targets measures were within 10% of target (amber warning) and two measures were 10% or more out-with target (red alert). Further details and remedial action for the measures were contained within the report.

The report also highlighted key achievements, areas for improvement and remedial action; revisions to Renfrewshire's Local Outcome Improvement Plan in respect of the Community Care, Health & Wellbeing Thematic Board element; and key areas of prevention.

DECIDED:

(a) That the progress on the year 3 targets of the Community Care, Health & Wellbeing element of Renfrewshire's Local Outcome Improvement Plan be noted; and

(b) That it be agreed that the report would be included as part of the Annual Community Planning performance report to the Renfrewshire Community Planning Partnership Board on 21 September 2016.

8 SCOTTISH MENTAL HEALTH ARTS & FILM FESTIVAL

R Robertson gave a verbal report relative to the Scottish Mental Health Arts & Film Festival (SMHAFF) which was due to take place in venues across Scotland from 10th - 31st October, aiming to support the arts and challenge preconceived ideas about mental health.

It was noted that SMHAFF was now in its tenth year and was one of Scotland's most diverse cultural events, covering everything from music, film and visual art to theatre, dance, and literature. Led by the Mental Health Foundation, it had expanded its arts activity with a year round programme, supported by See Me, Scotland's programme to end mental health stigma and open funding from Creative Scotland.
The Festival aimed to challenge perceptions, make connections, develop audiences, encourage participation and create great art events. The launch would take place within Renfrewshire Council Chambers on 10 October 2016 and an invitation was extended to all partners.

DECIDED: That the verbal report be noted.

9 **TIMETABLE OF MEETINGS FOR THE COMMUNITY CARE, HEALTH & WELLBEING THEMATIC BOARD - JANUARY 2017 TO JUNE 2017**

There was submitted a proposed timetable for meetings of the Community Care, Health & Wellbeing Thematic Board for the period January 2017 to June 2017.

DECIDED: That the timetable of meetings until June 2017 be approved.

KEY

Action is on track

Areas for concern that will impact on completion date if not fixed. Action required to bring up to satisfactory level

Past deadline date and action required.

RENFREWSHIRE COUNCIL

COMMUNITY CARE, HEALTH & WELLBEING ROLLING ACTION LOG

Action No.	Action	Action Owner	Status	Expected Date of Completion	Actual Date of Closure	Update & Comments
CCH&WB.04.09.14 (6)	Integrated Care Fund 2015/16 Integrated Care Fund Plan to be submitted to a future meeting.	Lead Officer		Future Meeting		CCH&WB.20.05.15(4) Update provided at meeting CCH&WB.08.09.15(9) Presentation and update provided at meeting CCH&WB.19.11.15(6) Verbal update given by R Robertson and noted.
CCH&WB.04.09.14 (9)	Renfrewshire Development Programme/Clinical Services Review Update to be submitted to a future meeting.	CHP		Future Meeting		CCH&WB.20.05.15(6) Update provided at meeting. CCH&WB.19.11.15(2) Update to be given at meeting on 11 Feb.
CCH&WB.04.09.14 (10)	Community Planning Update Annual review report be prepared to note progress against the impact measures in the Community Plan	CH&SCP				CCH&WB.02.06.16(7) Report noted and a further report be submitted to the next meeting of the Board highlighting gaps in the action plan. CCH&WB.14.09.16(7) A report on progress against Year 3 Targets was included as part of the Annual Community Planning performance report to the Renfrewshire Community Planning Partnership Board on 21 September 2016.

To: Community Care Health and Wellbeing Thematic Board

On: 25th October 2016

Report by:

Roisin Robertson, Community Link Team Manager, Renfrewshire HSCP

Community Connectors

1. Summary

In August 2015, Renfrewshire HSCP approved funding from the Integrated Care Fund (ICF) for four pilot projects designed as *infrastructure investment* projects, building capacity in the local third and community sectors to engage in health and well being activity. The HSCP's interim Integrated Care Fund Sub Group worked with four third sector organisations to develop the projects as a partnership pilot programme known as Community Connectors.

2. Recommendations

It is recommended that the Board

a) Notes the progress to-date and the need for work to connect people to non-medical sources of support and activities in the community as a means of preventative work.

3. Background

3.1 Community capacity-building in Renfrewshire

The ICF Sub Group and the four project lead organisations, in consultation with a wide range of stakeholders, identified key criteria for the Community Connectors programme which would demonstrate not only the delivery of high quality local services for people but build new partnerships and networks locally between all parties involved in, and concerned with, health and well being in local communities. These include:

- the development of partnership working, sharing responsibilities and resources in delivering coordinated support for local people
- developing further and promoting opportunities for local people and local organisations to become more involved in health and well being in their local areas

- building and strengthening partnerships between the local third and community sectors and the statutory health and care services, particularly with local GP practices
- developing sustainable models of services for long term impact in localities and communities.

Collectively, the pilots are the "Community Connectors" programme. Individually, they are known as:

Community Health Champions programme - recruiting, training and supporting local people in their communities to become community health champions, supporting local health and well-being activity and developing links between communities and local health and care services (partnership initiative in Linwood and Johnstone being led by Active Communities)

Community Link Workers programme – a pilot providing social prescribing in a number of GP practices to link patients with non-medical supports in their own communities (partnership initiative in Linwood, Johnstone and Bishopton being led by RAMH)

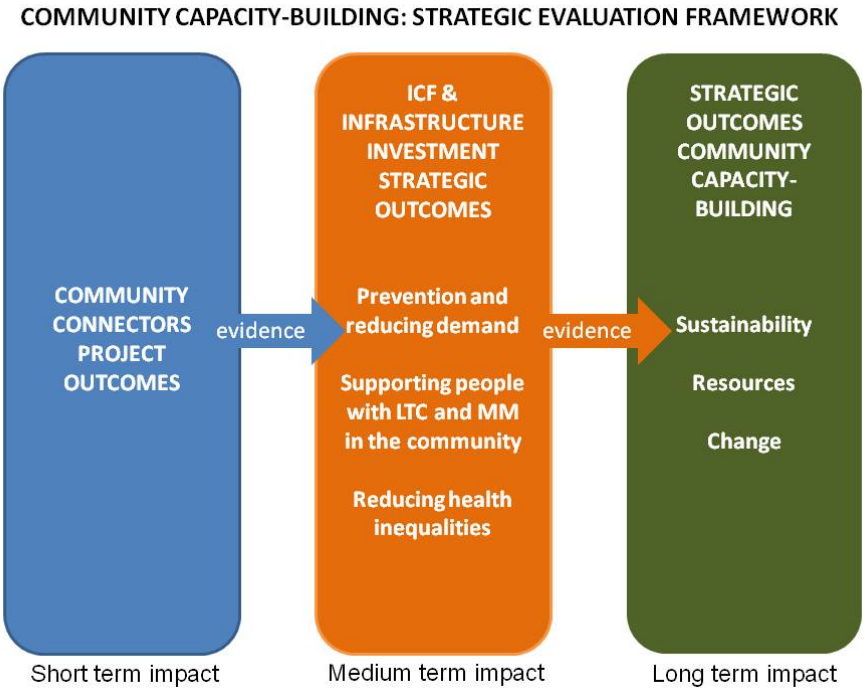
Housing and Health Information Access Points – piloting the delivery of access points of information for people about health and well being and health-related housing issues in local communities in points which the public are likely to use (Partnership initiative in Linwood and Johnstone being led by Linstone Housing Association).

Live Well, Stay Well Lifestyle Management Programme - support for people with long term conditions, setting up a pilot to test referrals from GPs, the Social Prescribing Scheme and other health and care providers into a structured self-management course and linking to local community supports (partnership initiative in Renfrew to be led by the Thistle Foundation)

3.2 Outcomes

The projects' impacts are assessed in terms of what lessons we will learn about how to support a wide range of stakeholders to be involved in future planning and delivery of health and care services in their localities. The three areas of interest are:

- Sustainability: the growth of viable locality-based networks and relationships around the health and care agenda in their areas
- Resources**:** what can we learn about the cost effectiveness of new ways of doing things
- Change**:** the potential for changes for improvement in service planning and delivery processes in localities



A strategic evaluation framework has been developed, designed to measure the collective impact of the four projects on the longer terms aims of the HSCP and the Integrated Care Fund. The Strategic Evaluation Framework will comprise quantitative and qualitative data and analyses measuring the impact of the programme through five sets of indicators:

- Levels of health-seeking/supporting activities in the local populations
- Levels of use of non medical supports to address health and well-being needs
- Levels of community-led health and well being engagement and action
- Potential changes to future service development and delivery processes
- Potential impacts on costs and cost effectiveness of preventative action in the community

Key elements of the Renfrewshire Strategic Plan 2016-2019 to which this evaluation will contribute are:

- Enable people to be better connected
- Support Tackling Poverty Programme
- Support and signpost to employment services
- Access to financial advice services
- Community capacity-building

3.3 Progress to date

To date the Community Connectors pilot project is progressing well with all targets either being exceeded or on target. Case studies are being gathered to give a qualitative picture and quantitative measures of success so far include:

- Community Champions recruited – 15 (annual target 10)
- Holistic Needs Assessment carried out (GP Social Prescribing) – 318 (annual target 60)
- People seen at the community hub – 67 (annual target 100)
- 2 Live Well Stay Well (long term conditions) practitioners in post and 58 referrals to-date (no targets set)

To best demonstrate the impact the service has had on individuals' situations, a number of case studies and qualitative information has been provided below. All the names have been changed to ensure anonymity.

Community Link Workers (GP Social Prescribing)
The service employs 3 Workers for 22.5 hours each week deployed at Johnstone, Linwood and Bishopton. Each GP practice has a dedicated, named worker. Each worker spends approximately 15 hours in the practice with the remaining hours supporting service users to engage and signpost and for admin tasks. The service in each practice is established, and feedback gathered from referrers is excellent.

The service has captured significant data with detailed outcomes and evaluation feedback. Outcomes recorded show that service users present with wide ranging issues, the highest needs being signposting to appropriate services and mental health issues followed by finance/budget issues.

The service works very closely with the 3 partner agencies and makes regular referrals, as appropriate to these services. However there are an extremely wide range of services which service users require. Significant signposting to the correct agency is an important outcome for this service, and gaps have been identified in community services to meet the needs and outcomes of service users, however the partner agencies have been able to respond to some of these, eg. buddying individuals to activities (Active Communities).

Anonymised case studies have been provided by the workers, however due to the sensitive and confidential nature of them the workers have requested that they are not shared at this time. It can be seen from the case studies that a wide range of interventions and supports are being utilised to improve the wellbeing and connections of individuals. Early findings from reviewing them demonstrates that while contacts with the practice may not change or may even increase initially, actual contacts with the GP practice appear to reduce and a significant number of the contacts are now with the Community Link Worker, rather than the GP or other practice staff.

Housing and Health Information Hubs
The Hubs provide local access to information and support across a range of issues that may be impacting on people's well-being. The Hub offers on site support re housing issues and also links people to other services such as financial advice, social and well being support groups, statutory and third sector services.

Case Study

Miss P was referred to us by the Link Worker based at her GP surgery. She is 22 years old and has one child aged 2. She is currently a Renfrewshire Council Tenant.

Miss P had a range of issues giving her concern, including dampness in her home and financial problems linked to a difficulties around tax credits, council tax and fuel arrears.

Her immediate desire was to move home.

The Hub staff acted on her behalf in chasing up housing issues and referring her to RAMH's financial literacy service and advised Miss P on how to deal with her fuel issues.

A follow up call was made to Miss P approximately a month later and a number of improvements had been made. While the dampness had not been resolved in her property as yet, repairs had been carried out to her windows and investigations into the dampness were ongoing.

Miss P had previously applied to Linstone for rehousing but following the support she was receiving decided to cancel her application as she actually would rather remain in her current property now that she feels the issues with repairs are being addressed.

Community Health Champions (CHCs)

Active Communities recruits, trains and supports local individuals to engage in and lead social and well-being action in a range of community based, fun-oriented group activities. It is successful in recruiting people across a wide range of age groups and backgrounds.

Case Study

Mr A came along to the 'Feel Good about You' (FGAY) programme having seen it advertised at one of the Johnstone Town Hall roadshows. He had a keen interest in walking/swimming and was at a loose end since retiring. He bonded well with other members of the group, and showed himself to be very personable. When we held CHC info sessions we asked if he would like to come along, he did and has become one of our most active CHCs. Mr A is now a busy volunteer across a number of community based activity and he has participated in a range of training events, including walking leadership and mental health awareness training. He is planning his future activities and is keen to develop programmes specifically aimed at men.

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CHC coordinator reports: “Mr A is a fantastic all-rounder. He is up for most challenges, gets on well with any group of people you introduce him to and genuinely seems to enjoy volunteering and training. He is of a good fitness level and his local knowledge of walking routes around the Johnstone area has proved invaluable to our walking group there. He has also brought to our attention some other groups in Johnstone which we have used to signpost people onto, and his knowledge of the area in general has proved to be very useful. He is also proving to be a very good ambassador for Active Communities and Community Connectors with the male population and especially those of retirement age – a notoriously difficult demographic to link in with. I see no end to Mr A’s potential in this role and consider him to be a real asset.”

Mr A says: “I was worried retirement would be a letdown for me. I was keen to maintain my fitness, but wasn’t sure how I would fill my days. Since getting involved with Active Communities I feel I have a new lease of life! It’s great to feel needed and that your experience counts for something. I have really enjoyed the training and volunteering and have made some great new friends, as well as meeting lots of different people when we are out and about. I am looking forward to taking part and leading some groups and it’s great to wake up every day with a purpose!”

Live Well, Stay Well (long term conditions)

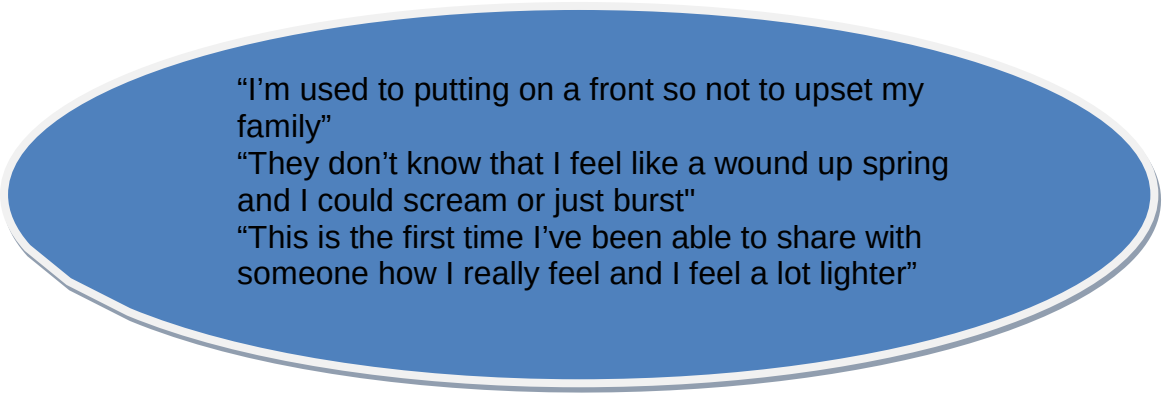
The Thistle Foundation delivers a lifestyle support programme at a number of GP surgeries, starting in Renfrew and now rolling out to Paisley. GPs refer individuals with long term conditions, who get a mixture of one-to-one sessions, group training activities and peer support to help them improve their management of their health conditions. Some individuals develop their own skills as volunteers to become peer supporters.

Feedback from people:
People are reporting the following as a result of support:

- Reduced physical symptoms, improved pain management
- Reduced psychological symptoms (depression, suicidal ideation, anxiety, loneliness, agoraphobia)
- Improved mood, as measured by WEMWBS.
- Improved confidence, coping and best hopes scores
- Increased skills and confidence to manage health problems
- Recording daily pain, rating pain (0-10) noticing patterns, triggers
- Compliance with prescribed medications
- Readiness to begin Pulmonary rehab/lifestyle management course
- Improved health outcomes such as weight loss

- Lifestyle modifications like becoming regularly physically active/making healthier food choices
- Stopping smoking, smoking less
- Reduced alcohol consumption
- Making social connections

Quotes :



Anonymised case studies have been provided by the workers, however due to the sensitive and confidential nature of them the workers have requested that they are not shared at this time

3.4 Conclusions

In the longer term, in terms of sustainability, the strategic evaluation framework includes the development of indicators around cost effectiveness and service change (to be fully developed in 2017) which will allow considerations of, for example, the potential to:

- release other, perhaps mainstream, resources to maintain the services under future contracts or service agreements, on the grounds that there will be evidence to show reducing demand on statutory services as a result of the services provided by the Community Connectors,
- come up with ways of developing new funding sources for community led health action e.g. lottery funding
- integrate Community Connectors services with cluster-based activities to support the services through packages of funding based on deliverables around the prevention agenda as outlined in the Strategic Evaluation Framework.

4. Resources

Funding for the Community Connectors projects pilot is currently provided from the Integrated Care Fund, a temporary programme of funding made available from the Scottish Government to HSCPs to support integration, with particular reference to:

- Reducing future demand on statutory services through preventative action

- Supporting people with multi-morbidity in the community

- Providing care for people most in need (addressing health inequalities)

Each of the Community Connectors projects brought resources to the pilots, some financial and some in kind, demonstrating the commitment of the local third sector to working co-productively with partners in bringing new services to local communities which are maximised through partnership working.

The Integrated Care Fund is scheduled to end in March 2018, and the Community Connectors project leads are preparing, through the implementation of the strategic evaluation framework, to develop business cases for the development and roll out of the services. Various funding options for 2018/19 onwards will then be explored.

To: The Community Care, Health and Wellbeing Thematic Board

On: 25th October 2016

Report by:

Head of Strategic Planning and Health Improvement, Renfrewshire HSCP

INTEGRATED CARE FUND – GOVERNANCE ARRANGEMENTS

1. Summary

1.1 The purpose of this paper is to inform the Community Care, Health and Wellbeing Thematic Board about the new governance arrangements for the Integrated Care Fund and the establishment of the new Third Sector, Providers and Community Group.

2. Recommendations

It is recommended that the Board:

a) Notes the new governance arrangements for the Integrated Care Fund;

b) Notes the establishment of a new Third Sector, Providers and Community Group

3. Integrated Care Fund

3.1 As of 1 April 2016, the Integration Joint Board (IJB) assumed responsibility for Renfrewshire's Integrated Care Fund (ICF). The current funding allocation is £4.14m per year which includes a Renfrewshire Council contribution of £650k.

3.2 At the last meeting on 24 June 2016, IJB members agreed that new local governance arrangements should be put in place and that supporting Terms of Reference for a reformed ICF Group would be brought to the next meeting.

3.3 In light of the new strengthened strategic financial planning approach being introduced by the HSCP, it has now been agreed that this fund is managed in line with all other IJB funding streams. This approach aligns with recent national guidance which recommends that "planning and reporting arrangements for the ICF should be congruent with the broader requirements on Health and Social Care Partnerships".

3.4 It is therefore recommended that the HSCP's new Finance and Planning Group plan for and manage Renfrewshire's ICF allocation as part of its wider, strategic approach to integrated service and financial planning which will work in collaboration with the IJB's Strategic Planning Group.

4. Third Sector, Providers and Community Group

4.1 A Third Sector, Providers and Community Group will be established to ensure that these communities of interest continue to have a strong voice in influencing the work of the HSCP. This will build on the previous Public Partnership Forum which was the primary mechanism by which the Community Health Partnership engaged, communicated and maintained contact with the community, stakeholders, service users and carers.

4.2 This new group will act as an appropriate interface forum, to provide strong engagement with the HSCP's strategic commissioning process; to influence the effective use of IJB resources and make recommendations on the allocation of resources available in line with local priorities.

To: The Community Care, Health and Wellbeing Thematic Board

On: 25th October 2016

Report by:

Head of Strategic Planning and Health Improvement, Renfrewshire HSCP

PLANNING FOR ACUTE HEALTH SERVICES

1. Summary

1.1 The purpose of this paper is to update the Community Care, Health and Wellbeing Thematic Board on the commissioning process for unscheduled hospital care, building on the work of the Renfrewshire Development Programme, and informed by the National Clinical Strategy.

2. Recommendations

It is recommended that the Board:

a) Notes the National Clinical Strategy;

b) Notes the evaluation of the Renfrewshire Development Programme; and

c) Notes the commissioning arrangements for unscheduled care.

3. Clinical Strategy

3.1 The National Clinical Strategy was published in February 2016. It sets out a framework for the development of health services across Scotland for the next 15 years. It gives a high level, evidence-based perspective of why change is needed. It does not give prescriptive details of exactly what developments are required. The strategy focuses on the delivery of healthcare services to meet assessed needs, rather than on initiatives to improve health.

3.2 The strategy describes the challenges of growing demand as the older population increases, and more services relating to diabetes, hypertension, cancer, sensory impairment, dementia, and impairment of mobility are needed. It also notes the

unacceptable degree of health inequality across Scotland. This is compounded by workforce and financial challenges, and the need to maximise patient value from the available resources.

3.3 The strategy describes the rationale for an increased diversion of resources to Primary and Community Care, with stronger integration with social care and the Third Sector. The emphasis on primary care supports the ambition of the Scottish Government's 2020 vision to provide the majority of care locally and to ensure we will have a healthcare system where we have integrated health and social care, a focus on prevention, anticipation and supported self-management.

3.4 The National Clinical Strategy also describes a number of changes that need to take place in secondary care settings, including a focus on improving processes within hospitals to make th ebest use of available resources. For example, we need to ensure timely discharge without delay, to reduce unnecessary outpatient reviews and to make better use of modern technology. Finally, the strategy describes some structural changes that are required in secondary care. These would support local service provision for outpatients, diagnostic and day care, but for some services, there would be fewer specialist inpatient units in a region. Planning will have to be done at a local, regional and national level.

3.5 The National Clinical Strategy is available at: www.gov.scot/publications/2016/02/8699

4. Renfrewshire Development Programme

4.1 The Renfrewshire Development Programme (RDP) is a service improvement and development programme involving the Royal Alexandra Hospital, 13 local Paisley GP practices, community health and Renfrewshire social care services. It has developed and assessed new service models which aim to:

- Improve the quality of healthcare including patient experience
- Improve care at the interface between hospital and community care
- Shorten length of stay
- Reduce avoidable admissions to hospital
- Maintain or improve rates of re-admission

4.2 **RDP Initiatives:**

1. Chest Pain Assessment Unit (CPAU): rapid assessment and follow-up for patients with low-risk cardiac chest pain at the RAH.
2. Older Adults Assessment Unit (OAAU): combined assessment and short-stay unit at the RAH to deliver early comprehensive geriatric assessment and multidisciplinary support for timely discharge of frail older adults.
3. Out of Hours Community Inreach Service: a transport, settle-in and coordination service to facilitate timely supported discharge from the RAH.

4. Enhanced Pharmacy Services: community and hospital medicines reconciliation, improved communication of discharge prescription, and actions to reduce high-risk co-prescribing.

5. Enhanced Anticipatory Care Planning: GP practices working with target patient groups and local staff to increase the number and use of ACPs.

4.3 A summary of the key project findings is shown below:

Project	Outcomes
Chest Pain Assessment Unit	High patient satisfaction and excellent feedback. Safely reduced length of stay (average 25 hours shorter than before project) and number of patients requiring an overnight stay (7% more patients home on the day they present to hospital).
Older Adults Assessment Unit	High patient satisfaction and excellent feedback from relatives and carers. Safely reduced length of stay (average 3.3 days shorter than patients in other clinical areas).
Out of Hours Community Inreach Service	Discharge support provided to patients from a range of clinical areas. Benefits of joint working between health and social care and co-location.
Enhanced Anticipatory Care Planning	Increased number of ACPs completed for patients in target groups. Information contained in the ACP was useful and supports clinical decision making for patients admitted as an emergency.
Enhanced Pharmacy Services	Initiation of improved medicines reconciliation mechanisms. Establishment of improved communication between hospital and community pharmacy to prevent medication errors.
The overall RDP approach to service development	Joint working has forged new relationships between hospital, community health and social care professionals which have supported ongoing service improvement. The RDP was a rewarding way of working and a successful means of tackling previously hard to address issues.

4.4 The RDP evaluation is available at:
http://www.nhsggc.org.uk/media/239143/nhsggc_ph_evaluation_of_the_renfrewshire_development_programme_2016-08.pdf

5. Commissioning Unscheduled Care

5.1 The NHS Board is responsible for the overall planning for acute services, working with IJBs on planning the delivery of unscheduled care and on the shaping of the primary care and community services which are critical to the delivery of acute care. The IJBs

are responsible for strategic planning for the health and social care services for which they are responsible and for the strategic commissioning of unscheduled care services. The set aside budget for unscheduled acute services is £32.3m.

5.2 The shape and delivery of acute services are critical to the responsibilities of the IJB and will also be an important issue for local people. Therefore active engagement as this work develops is important.

5.3 Renfrewshire's first Strategic Commissioning Plan has been developed and highlights the need to establish a real focus on changing the way our population uses hospital services. Work is ongoing with Acute Planning colleagues and other Health and Social Care Partnerships to develop a set of acute commissioning intentions.