

**JOINT INSPECTION (ADULTS)**

**The effectiveness of strategic planning  
in Renfrewshire Health and Social Care Partnership**

**April 2018**

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## 1. About this inspection

Scottish Ministers have asked the Care Inspectorate and Healthcare Improvement Scotland to report on the effectiveness of the strategic plans prepared by integration authorities, from April 2017. At this early stage in the integration of health and social care, our aim is to ensure that the integration authorities have building blocks in place to plan, commission and deliver high quality services in a co-ordinated and sustainable way, namely:

- a shared vision
- leadership of strategy and direction
- a culture of collaboration and partnership
- effective governance structures
- a needs analysis on which to plan and jointly commission services
- robust mechanisms to engage with communities
- a plan for effective use of financial resources, and
- a coherent integrated workforce plan which includes a strategy for continuous professional development and shared learning.

The purpose of this inspection is to help the integration authority answer the question “How well do we plan and commission services to achieve better outcomes for people?” To do this, we are assessing the vision, values and culture across the partnership, including leadership of strategy and direction, the operational and strategic planning arrangements (including progress towards effective joint commissioning), and improvements the partnership is making in both health and social care, in respect of the services that are provided for all adults.

In this inspection, we have not set out to evaluate how people experience services in their area. We recognise it will take time for the changes in service delivery brought about through integration to work through into better outcomes. Our aim is to assess the extent to which the health and social care partnership is making progress in its journey towards efficient, effective and integrated services which are likely to lead to better experiences and improved outcomes over time.

Both the Care Inspectorate and Healthcare Improvement Scotland undertake a variety of other scrutiny and improvement activities, in collaboration with other scrutiny bodies, which provides assurance about the quality of services and the difference those services are making to people in communities across the country.

We inspected Renfrewshire Health and Social Care Partnership. It comprises mainly of Renfrewshire Council and NHS Greater Glasgow and Clyde and is referred to as the partnership throughout this report. The inspection took place between October and December 2017. The quality indicators used are set out in Appendix 1 and there is a summary of the methodology in Appendix 2.

## 2. The Renfrewshire context

Renfrewshire is the tenth largest local authority in Scotland, with a population of approximately 174,560 people. Overall, Renfrewshire's population matches the rest of Scotland with the exception of the 45–59 age group where the percentage population is higher in Renfrewshire, and the 16–29 age group where the percentage population is slightly lower than the rest of Scotland. Although over the past few years life expectancy at birth has improved for both males and females in Renfrewshire, it remains below the Scottish average for both sexes.

Although Renfrewshire's population is predicted to remain stable, its age composition is anticipated to change significantly. Whilst numbers in the 0–64 age group will decline, the 65+ age group is set to increase over the next 20 years, with the biggest increase being in the 75+ age group. The projection is an expected increase of over 70% for those aged 75+ from 8% in 2014 to 13% in 2039.

Currently, evidence in Renfrewshire suggests that the growth in the numbers of older people has led to an increase in the complexity of cases handled by health and social care services. The number of available carers is also projected to come under pressure in the next 20 years. As the number of vulnerable older adults living alone increases and the working age population shrinks, a greater number of people will be reliant on public services alone to provide care.

Renfrewshire currently delivers 16.2 hours of care at home per 1,000 population to those people aged over 65. This is less than the Scottish average of 17.2 hours, but excludes the community meals service which provides significant additional support to Renfrewshire residents.

In 2016, 1,164 older adults were in residential or nursing care and 520 were receiving intensive home care. This equates to 5% of the population aged over 65. Social Care Services have experienced significant increases in demand from the 65+ age group. The number of care at home hours delivered to this group increased by 36% during 2011 and 2015.

The 2016 release of the Scottish Index of Multiple Deprivation (SIMD) identified health as a major factor in deprivation in Renfrewshire. Nearly one in three Renfrewshire residents live in an area identified as health deprived relative to the rest of Scotland.

Alcohol and drug misuse are major components of ill health in Renfrewshire. In 2015/16, Renfrewshire had the fourth highest rate of alcohol-related hospital stays in Scotland and the highest number of stays per patient. In 2015, Renfrewshire had the sixth highest rate of drug deaths in Scotland and the ninth highest rate of general acute hospital stays related to drug use.

Renfrewshire had the tenth highest rate of mental health in-patients in Scotland for the period 2014/15. SIMD 2016 data shows 19% of the Renfrewshire population was prescribed drugs for anxiety, depression or psychosis in 2014/15, above the 17% Scottish average.

*The Renfrewshire context was written by the Renfrewshire Health and Social Care Partnership in March 2018.*

### **3. Our inspection of the partnerships strategic planning**

#### **Needs assessment**

The partnership has produced a joint strategic needs assessment which informed its Strategic Plan (2016-2019). The joint strategic needs assessment has proved to be valuable in setting the partnership's priorities. As with other partnerships in Scotland, the baseline data is limited and further work is needed to build on the initial information provided by the joint strategic needs assessment.

There is evidence of planning being informed by local management data and information gathered from national sources such as Information Services Division<sup>1</sup> and SPARRA<sup>2</sup>. The council has also produced neighbourhood profiles. Thematic profiles on issues, such as health and wellbeing covering the whole of Renfrewshire, supported the preparation of the joint strategic plan. Additionally, the partnership invests in a health and wellbeing survey every three years. The data derived from this is used to inform the planning and prioritisation process.

The partnership does not fully use a range of comprehensive local data to produce detailed locality profiles for each of the two localities. Such profiles would enable each locality to use local data to identify and prioritise local need for service design and delivery. Locality profiles will be important in informing locality commissioning.

#### **Strategic commissioning**

Strategic commissioning is the term used for all the activities involved in assessing and forecasting needs, linking investment to agreed outcomes, considering options, planning the nature, range and quality of future services, and working in partnership to put these in place<sup>3</sup>. The partnership is at an early stage in the development of joint strategic commissioning. To date, activity has focused on older people. However, the partnership is in the process of agreeing to support a care group-led approach when developing its next three-year plan.

There is a mixed economy in the care home, care at home and day services markets. Therefore, constructive relationships with the third and private external providers are essential. The partnership is commissioning a wide range of externally provided services in areas such as care homes, care at home, day services and housing support. On the whole, these services are evaluated by the Care Inspectorate as 'Good'. The council has a substantial market share across care home, care at home and day care services. It has a long term commitment to its

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<sup>1</sup> Information Services Division (ISD) provides health information, health intelligence, statistical services and advice that support the NHS in progressing quality improvement in health and care and facilitates robust planning and decision making.

<sup>2</sup> SPARRA data is Scottish Patients at Risk of Readmission and Admission, which is a risk prediction tool developed by ISD. It predicts an individual's risk of being admitted to hospital as an emergency inpatient within the next year (ISD Scotland).

<sup>3</sup> Scottish Government Joint Strategic Plans guidance: [www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Implementation/ImplementationGuidance/SCPlans](http://www.gov.scot/Topics/Health/Policy/Adult-Health-SocialCare-Integration/Implementation/ImplementationGuidance/SCPlans)

directly provided care services. The regulated services were evaluated by the Care Inspectorate as generally 'Good'.

The partnership recognises that there are challenges in ensuring local supply, capacity, quality and choice in areas such as care homes, care at home, day care, respite care and self-directed support services. For example, there are issues of under occupancy and traditional service modelling. Ensuring sufficient supply and high quality of care are among the partnership's main priorities.

Care at home provision is a critical aspect of health and social care. The partnership is above the national average for rates of care at home delivery and overall balance of care. A care at home framework agreement has been established to try to improve the quality and reliability of service delivery. The framework identifies, in many cases, council services as the provider in the first instance, particularly for reablement. If the council cannot provide the service, it offers the business to one of the framework providers in each locality, effectively on a spot-purchase basis, for 'maintenance' packages. If these providers are unable to take up the package then a non-framework provider is selected.

Care packages are focused on those assessed as having critical or substantial need. Commissioned hours are sometimes referred back to the council from the independent sector when they do not have the capacity to provide the service. Longer term and sustainable business development has become challenging for some providers under the framework. Providers told us about recruitment and retention difficulties resulting from the lack of guaranteed hours for staff, together with the ability of providers to build a sustainable business and maintain service quality.

The partnership is undertaking a review of its directly provided care at home services. This review is focusing on four work streams: workforce efficiency and governance; data, referral processes and pathways; assessment; and review. In due course, the review will be extended to include third and independent sector providers.

The partnership is preparing to undertake a revised tender for care at home services in the spring of 2018. It aims to learn lessons from the existing framework, particularly around issues such as geographic 'patches', 'real-time electronic monitoring' and information sharing. External providers are keen to be involved in the framework review and the partnership stated that this will happen.

A whole system approach to the commissioning of care at home services as part of the review would be beneficial. This would mean incorporating all of the related aspects of service delivery, including supporting hospital discharge, preventing admission and promoting independence.

The partnership used a volunteer to gather feedback from people with lived experience of care at home services. The recommendations from this feedback were incorporated into the overall workplan for the care at home review. It would be helpful if the partnership continues to stress the importance of regularly collecting and analysing feedback from people with lived experience of services and their carers to inform the care at home review and future service delivery.

Within the day care market there are challenges with capacity, choice and service models. The partnership recognises that it needs to change the way it delivers day care services, moving on from centre-based models in some instances. The partnership aspires to focus on offering individual day opportunities, with a greater choice of more flexible options for people experiencing care and their carers. Greater clarity is needed on how the partnership demonstrates that people experiencing care are meaningfully involved in the review of their care provision. This needs to be an integral part of any service review and redesign.

The partnership acknowledges the challenges with the levels of capacity and type of demand in care homes. The partnership has above national average levels of care home places, but it is changing the balance of care by reducing the number of care home beds. There is a high level of under occupancy within some care homes.

There are increasing demands for placements for people with very complex needs in Renfrewshire. The emerging needs include people with dementia, people with substance misuse related conditions such as Korsakoff syndrome, and younger people with significant physical disabilities. Providers identify difficulties meeting the needs of people with these complex needs within the current care home provision. The partnership needs to update its position on its overarching approach to the commissioning of care home provision. This needs to include respite provision, access and availability as the partnership has a relatively low level of this kind of provision compared with the national average. Developing a cross-sector, long term approach to address the changing demands for care homes, including nursing provision, would be beneficial. It could include assessing overall capacity, as well as direct provision and reducing the length of a resident's stay, and fit with the partnership's strategic intentions for other elements of the care system.

A variety of stakeholders are concerned that financial considerations are sometimes too influential and the main factor in decision making in the commissioning of some services. There is concern that certain decisions lack the appropriate consideration of service users' and carers' needs. There is a need for a more sophisticated approach to commissioning decisions such as more detailed impact analyses, transparent option appraisals and comprehensive service evaluations.

Through the Change and Integrated Care Funds, the partnership has taken a joint approach to the deployment of resources to support improved outcomes for service users. Investment from these funds has led to positive service redesign in areas

such as reablement and care at home. The partnership's Change and Integrated Care Funds' expenditure has been successfully geared towards anticipatory care, proactive care and support at home. Commissioning for prevention services has started to help with shifting the balance of care. However, this is at an early stage.

The partnership needs to further develop and articulate its commissioning approach to shifting the balance of care. The partnership has carried out market testing exercises and prepared a draft market-shaping strategy for older people's services. This strategy has not been implemented and is now out of date. It has been superseded in part by the joint strategic plan. A new version of the market facilitation plan is expected to be delivered in 2018, which will set out the partnership's high level summary and medium term commissioning intentions. It would be beneficial if these were set out in further detail in a fully developed market facilitation plan and included in updates to the joint strategic plan.

The council delivers procurement services, on behalf of the partnership, using a 'business partner' arrangement. Procurement activity is delivered by different mechanisms such as tender/negotiation and review/National Care Home Contract/'Scotland Excel'. The partnership's contracts team focuses on contract monitoring.

When a new service is procured, the partnership sets the specification and the procurement services advise on contract strategy and the contract initiation documentation (CID). The finance and customer policy board of the council approves the CID. This was previously undertaken by the partnership. Joint documentation for the procurement and contracts team has not yet been developed to support the business model. New and updated formal partnership procurement/contract management arrangements need to be shared with providers.

Relationships are productive between the contracts team and procurement services. The absence of a strategic lead for commissioning has led to gaps in how joint strategic planning, commissioning and contract monitoring are managed. There is limited joint training, policies or procedures between the procurement and contracts teams.

### **Strategic planning**

The community planning partnership has set out its shared vision for Renfrewshire in its community plan 'Our Renfrewshire' (2017-27). This identifies the medium-term milestones the partners aim to achieve and how it related to the Scottish Government's national priorities.

The partnership, in co-operation with Engage Renfrewshire and Scottish Care, have set out their shared vision for adult services in their joint strategic plan (2016-19). This strategic statement of intent includes a Renfrewshire needs profile, demand and demographic challenges, the planning and delivery context, resources available, priorities and associated action plans. These action plans are based on care groups,

around the priority themes such as prevention, anticipatory care and early intervention, addressing inequalities, managing long term conditions, personalisation and choice, and support for carers.

This joint strategic plan complements other relevant strategies and plans, including the Renfrewshire Community Plan and NHS Greater Glasgow and Clyde's annual local delivery plan. The housing contribution statement, as part of the strategic plan, alongside the Local Housing Strategy, helpfully articulates the local housing-related priorities for health and wellbeing.

The joint strategic plan lacks a detailed implementation plan for future investment and disinvestment. Although the plans that are currently in place outline the direction of travel, they lack the finer details on how they will be achieved. This limits their use as delivery management and accountability tools. They tend not to be fully costed and delivery timescales are not always clearly identified. This is, in part, due to delays in reaching agreement about the overall partnership's financial plans.

The partnership's clear vision for Renfrewshire is 'a caring place where people are treated as individuals as well as being supported to live well'<sup>4</sup>. The partnership's aspiration to deliver this vision is evident during senior staff meetings. Integration joint board (IJB) members are confident that the partnership is able to deliver their ambitious vision. We heard from the IJB members that the key to delivering the vision with the current financial pressures is about working together and being cohesive. They demonstrate a commitment to doing so. Most frontline staff are aware of the partnership's vision and strategic intentions but were less confident that priorities set at partnership and team levels reflect this.

There is a stated commitment from NHS Greater Glasgow and Clyde that its transformation strategy 'Moving Forward Together', which is currently under development, will be aligned with the partnership's priorities. This strategy is underpinned by a range of workstreams that aim to dovetail with the strategic plans of the local partnerships within the NHS board area, including the partnership's Strategic Plan (2016-2019). Planning work and relationships with NHS Greater Glasgow and Clyde are productive and business like. A number of joint planning forums and meetings at senior levels exist and take place regularly. Regional planning processes are at an early stage. It is essential that NHS Greater Glasgow and Clyde's and the partnership's priorities are concurrent.

The partnership has a joint asset and property management strategy in place. Although this is not a requirement from the Scottish Government, a joint approach to the management of assets is a positive method of ensuring the best use of existing and planned assets. The partnership is expressing an intention to move towards co-

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<sup>4</sup> Renfrewshire Health and Social Care Partnership Strategic Plan 2016-19.

location, where appropriate, and use buildings flexibly across the health, social care and wider estate. This work is at a very early stage.

### **Integration joint board and the strategic planning group**

The partnership has given detailed attention to the structures and governance arrangements to support integration. The partnership is at a stage where it is acting increasingly as an integrated body in adopting a joint strategic approach to service planning and delivery.

The IJB has recently experienced a turnover in membership. Seven new members have joined the IJB since the 2017 local government elections, including newly elected councillors. IJB members have already forged constructive working relationships and are committed to taking forward the work of the board and the delivery of integration. It is also clear that they feel that members and officers are working well together.

The partnership is committed to supporting IJB members and helping them to develop the knowledge, skills and abilities required for the role. Elected members of the IJB told us that the leader of the council and senior staff have been very supportive in helping them to understand their responsibilities and how to balance their constituency and IJB roles.

Several IJB members acknowledge that they need to further develop their understanding of integrated services, particularly service areas that are less familiar to them. There has been a good uptake of the induction and development sessions provided for IJB members. IJB members told us these sessions are helpful, particularly those in relation to financial matters. Although the IJB members are regularly invited to identify areas for development opportunities, it can be difficult to identify future knowledge needs in a new role. The partnership has not carried out a formal training needs analysis to support identifying the members' development needs. We heard from several IJB members that a timetable of development sessions providing advance notice of dates would be helpful as it would allow them to prioritise these and not miss sessions due to prior commitments. The partnership should take a more structured approach to the development of IJB members, including identifying areas for development to address gaps in knowledge and a programme of dates.

IJB members are satisfied that they receive adequate information about agenda items to make informed decisions. If they require additional information, this is provided on request. IJB members acknowledge that they are well supported, expressing confidence in the function of the board and their role within it. Positive and trusting relationships exist between the IJB members and the Joint Chief Officer and Joint Chief Financial Officer.

The IJB has appropriate governance arrangements in place, including an annual audit of its performance. The audit is undertaken by the council's internal auditor.

This process allows the IJB to review its work and to ensure that it is meeting its obligations.

The IJB audit subgroup leads on governance for assurance on service delivery and quality. This is part of the wider governance of performance and quality for the partnership which also includes the quality improvement clinical governance group. The priorities of the IJB audit programme are discussed with the Joint Chief Officer. The audit meetings are held to dovetail with the overall council programme, but are not aligned to the programme for NHS Greater Glasgow and Clyde. The audit subgroup scrutinises areas such as internal audit reports. It does not scrutinise in detail areas such as risk management and performance, as the IJB itself wished to do this as a whole. In due course, the audit subgroup intends to focus in greater detail on risk management and performance.

The IJB has developed an agreed risk management strategy and associated policies. These identify possible risks and mitigating actions. However, the partnership and IJB have separate risk management registers for operational and strategic risks respectively. It would strengthen the partnership's approach to risk management if these were aligned and developed as well as linking them to local risk registers.

The role of the Strategic Planning Group (SPG) is to help shape and develop the IJB's strategic proposals, policy documents, plans and services by giving due consideration to the draft materials produced by the IJB. The SPG has an appropriate range of stakeholders from across the partnership, including representatives from the partnership, the third sector, people who have experienced care services and carers. Meetings of the group take place every two months. The group has 70 members. Initially, more than 50 people attended the meetings, but over time this has reduced to approximately 35. There is concern for group members that, due to a large number of people present in meetings, the flow of discussion is impaired which dilutes the function of the group. One solution offered by group members is for more of the detailed work of the SPG to be allocated to subgroups to help focus on specific issues.

There are limited opportunities in place to let the SPG members know if their feedback has reached the IJB or indeed influenced it. This means there is a lack of certainty from SPG members that they are contributing effectively to decision making by the IJB. There needs to be clear, two-way communication between the SPG and the IJB. The partnership intends to review the relationship between the IJB and SPG as well as the membership of the SPG in 2018. This will provide an opportunity to improve communication between the two groups which will help make the effectiveness of the SPG more transparent.

### **Finance**

The partnership had an overall underspend of £5.494m in 2016/17. This figure included primary care balances carried forward by the partnership (as the host

authority) on behalf of the six NHS Greater Glasgow and Clyde Health and Social Care Partnerships. The primary care balances were put into an earmarked reserve and reallocated immediately in 2017/18 and were therefore not available to the partnership. Earmarked reserves were also created to fund specific projects, such as district nursing training in future years, with a residual balance held in general reserves.

According to budget monitoring reports in 2017/18, the partnership will require to draw down a proportion of the general reserves in order to deliver a year-end breakeven position. The budget monitoring reports and the financial plan also highlight that the partnership will need to take into account the level of reserves as well as the additional funding for 2017/18 and how these will impact on its flexibility in future years in addition to the partnership's ability to plan for contingencies.

The partnership's financial plan 2018/19–2020/21 incorporates scenario planning to assess the impact that pressures and demands will have on its financial position. The forecasting and scenario planning has identified a budget gap within a range of £16m to £21m for this period to fund new rising demand and cost pressures, assuming that no additional funding is received from its partner organisations or the Scottish Government. The assumptions used to prepare the forecasts are based on current data and indicate that the partnership has a good level of understanding of local needs and pressures.

In order to address the budget gap, the partnership has set a target to deliver savings of approximately £6m per annum over the period 2018/19–2020/21, assuming no additional funding is received from either partner organisation or the Scottish Government. Historically, the partnership has been able to deliver the required savings targets but these have not been at as high a level as those required for future years. Therefore, a risk exists that the partnership may come under pressure when trying to achieve its targets and may not be able to realise these savings. The financial plan includes a refined approach to identifying savings proposals.

A reserves strategy is also included as part of the IJB's financial planning, which aims to ensure the partnership maintains an adequate level of reserves to address unforeseen circumstances. This is sound financial planning. However, due to the level of reserves used in 2017/18 to break even and the budget gap going forward, it will be challenging to achieve the reserves strategy. As outlined above, this impact on the flexibility of the partnership in future years could lead to the partnership overspending if there are insufficient reserves. This could impact on its ability to maintain the direction of travel and sustain service provision.

### **Workforce planning**

The partnership has made some good progress with the development of a strategic approach to workforce planning. The partnership's Workforce Plan 2017-19 sets out the main policy, social, digital and financial drivers which identify the staff skills

required to deliver high quality services for service users and their carers. The partnership has carried out existing and projected workforce profiling to help identify future priorities. These priorities were used to develop an action plan which focuses on delivering and sustaining a capable and integrated workforce.

There is a history of effective joint working between the staff responsible for workforce development across the partnership. Specific groups, such as the Workforce, People and Change Group, have been established to focus on workforce and organisational change.

Recruitment and retention, particularly in some key posts, is an ongoing challenge. Deployment of the majority of staff is currently at an individual agency level in the council and the health board. Staff we met with were positive about the support and training they receive, but feel more work needs to be done to develop joint learning opportunities. The partnership does not demonstrate evidence of including the third and independent sectors in their workforce plan. The advantage of doing so could help the sustainable recruitment and retention of staff, building capacity and ensuring a suitable skills mix to deliver high quality services for the community.

### **Stakeholder engagement**

The partnership demonstrates its awareness of the importance of stakeholder involvement in service design in the Participation, Engagement and Communication Strategy. This outlines the intention to engage with stakeholders, including partnership staff, external providers and people with experience of care and their carers. The partnership has adopted a proactive approach to implement this strategy, including high visibility of senior staff. During the inspection, most staff advised that the senior management team are both visible and supportive of the work undertaken at the front line. The IJB members are considered less visible, but IJB members are aware of this and intend to address the situation.

Staff expressed mixed views about the level of influence they felt they have in the design of services. We found that senior managers felt involved in development and improvement activity. However, there is limited evidence that operational staff are engaged in service planning, or informed of developments. Less than half of the staff (47%) responding to our staff survey agree that their views are taken into account when planning services at a strategic level. Frontline staff have a good knowledge and understanding of where there are significant challenges around choice, availability and access to services. They told us they are keen to be more involved in planning for service changes.

People who have experienced services and carers are part of many relevant strategic planning groups. There is also evidence of consultation in areas such as helping to inform service specifications. However, they are not always directly involved in the commissioning of services which affect them. Therefore, we are not confident that they are able to influence decisions from the outset or in all phases of the commissioning process.

The partnership has arrangements in place with independent advocacy providers, such as 'You First Advocacy,' to help people who have experienced services to articulate their views and wishes. This includes support to express their wishes whilst preparing care plans, liaising with housing services and during adult support and protection processes. Referral procedures are straightforward and the advocacy services are able to respond quickly when they receive a referral.

The partnership recognises potential for improvement in their consultation with stakeholders about service design and is actively addressing this. Previously, the partnership had separate groups for the different types of care which people experienced. However, this is no longer the case as a result of a greater focus on the development of the joint strategic needs assessment and strategic plan. People experiencing care and providers advised that this meant they are less involved in making decisions about care services. Senior managers acknowledge that people experiencing care could be better involved in service planning and redesign and they have started to re-establish joint care group planning for services. Initially, the groups are focusing on areas of new legislation and national policy. This could improve engagement in service planning for people experiencing care and carers.

Housing provider representatives are encouraged to participate in joint strategic planning in forums such as the joint strategic health and housing planning group. Representatives from housing told us they are keen to be involved in service design from the outset. However, this has not always been the case. Closer joint working is under way in developments such as 'extra care housing' and 'grouped amenity housing'. Integrated Care Fund investment in housing-related services has been limited. This is a missed opportunity to develop further innovative preventative service models. Registered social landlords told us they have a generally positive working relationship with the council and would like to be more involved in discussions with the partnership on the future of housing and related support. They want greater clarity on what is to be commissioned and to have a greater recognition of their potential role and contribution.

### **Building capacity in communities**

Locality planning is an important aspect of community development and building stronger communities. The partnership is at a very early stage of locality planning and commissioning. Localised operational service delivery and locality leadership teams have been established. It is anticipated that these teams will link with emerging local area committees to help identify and deliver on priorities.

It is evident from our meetings with IJB members and senior managers that they recognise the need to develop community capacity. They realise the important role that local communities and community organisations could play in providing support and that there is unrealised potential for the third sector to be more involved in the delivery of services.

Frontline staff are less confident about the relevance of building community capacity. From our focus groups with health and social work services staff, we found there is limited awareness about the partnership having an important role to play in developing community capacity. Just over half (56%) of staff who responded to our staff survey agreed that there are clear joint strategies promoting and expanding community involvement. The partnership could improve the way it promotes the importance of community engagement and involvement with their staff to enable them to take an active role in developing community capacity.

Several initiatives have been developed and subsequently delivered through a collaboration between health, social care and community partners. The Health Improvement Team has a key role in many of these. One example is the development of a programme to raise awareness of safe alcohol limits and to improve outcomes for people in recovery from substance misuse. Job Centre staff in Paisley are trained in alcohol brief interventions and can provide assessments to any individuals for whom it is relevant. Another example is the “Community Connectors” programme: three local third sector organisations are working together to provide support for patients with social issues. This led to a reduction in the number of repeat attendances individuals made to their GP. There are plans to roll this out across the partnership.

The partnership could continue to develop its joint community capacity and co-production approaches showing how local services can be supported. This could be backed up with a measurable action plan that clearly sets out the role of community support interventions in delivering the overarching joint strategic plan and associated outcomes.

### **Integrated working**

A culture of integrated working to deliver effective services is embedded in the partnership. Most staff we spoke with have a positive perspective of how well services work together. Several staff advised that co-location and integration allow for a better understanding of each other’s roles and a flexible approach to working together. Staff indicate that this contributes to the delivery of effective services and positive outcomes for individuals. Of those who responded to our survey, 76% indicated that staff are working well together to reduce avoidable hospital admissions and 83% agree that together they are helping adults lead as independent a life as possible. Additionally, 78% of respondents agree that the services they provide jointly are successful in helping adults lead less isolated lives.

Renfrewshire is an early adopter of the GP cluster<sup>5</sup> approach, starting with a small cluster of three practices in 2015, led by the current deputy clinical director. The practices are supportive of each other and helped each other through any early

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<sup>5</sup> GP clusters are groups of between 5-8 GP practices in a close geographical location. The purpose of the clusters is to encourage GPs to take part in quality improvement activity with their peers and to contribute to the oversight and development of their local healthcare system.

issues experienced. Practice resilience and business continuity are among the topics that were tackled by the cluster. All practices and clusters now have practice quality leads and cluster quality leads in place, with a view to developing further quality assurance work from April 2018.

Good relationships are evident between the clusters and the partnership. GPs told us the partnership is good at listening and supporting them in terms of workforce issues, including support to get pharmacy support and a locum GP when required.

### **Supporting people to live safely at home**

Forward looking care planning is a key aspect of avoiding unscheduled care and promoting positive outcomes for individuals. The partnership has focused resources on the completion of Anticipatory Care Plans (ACPs) and an Electronic Key Information Summary (eKIS). Local GPs completed ACPs well in excess of the target set for them during 2015/16. The number of active ACPs is not known as it is not easy to obtain this information from the eKIS system. The partnership is continuing to make improvements in its approach to ACPs. Work is ongoing to allow other health staff to update the ACPs. This includes four care home liaison staff who are able to remotely access GP notes and update the ACPs. Currently, the partnership has no strategic oversight of the quality and impact of ACPs.

Concerns about the quality of the ACPs on eKIS were identified by other health services and shared with the clinical director. The partnership met colleagues from the Scottish Ambulance Service to explore eKIS and ACP use with a view to ensuring joined-up care for patients with complex care needs or at the end of life. The Scottish Ambulance Service highlighted the fact that they cannot access eKIS without an individual's Community Health Index (CHI) number – something individual patients and carers do not usually know or provide when calling an ambulance. It is important that information on this system, such as whether a Do Not Attempt Cardiopulmonary Resuscitation<sup>6</sup> form is in place, is shared with the Scottish Ambulance Service. In order to overcome this, one GP cluster has piloted a programme encouraging people to learn their CHI number and share it with the Scottish Ambulance Service should they have to make a 999 emergency call. The GP cluster has not yet evaluated the success of this approach.

The partnership has a clear focus on reducing unscheduled care and preventing delayed discharge. The partnership recognises that unscheduled care rates are higher than the national average. People aged over 65 years have a comparatively higher rate of emergency admission bed day use, despite having a lower rate of emergency admissions than those aged under 65 years. There is also a comparatively high rate of multiple emergency admissions in Renfrewshire. The partnership has a Commissioning Unscheduled Care Plan 2017/2018. This includes

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<sup>6</sup> A DNACPR form indicates to medical and emergency response staff that an individual does not want cardiopulmonary resuscitation to be attempted to save their life in event of cardiac arrest or sudden death (Resuscitation council 2018).

a comprehensive understanding of current use of unscheduled care and outlines actions to shift the balance of care. The detailed action plans target a reduction in attendances at accident and emergency, as well as a reduction in emergency admissions.

The partnership has supported the development of 'hot' clinics which operate in the Royal Alexandra Hospital, Paisley, for surgical, medical assessment and geriatric services. GPs refer people to this service so that people can be assessed in a short timescale without going to accident and emergency in order to prevent short-term hospital admissions. The partnership's website has a dedicated section for GPs that allows them rapid access to the various alternatives of admissions at the hospital and within the community. Ongoing monitoring of unscheduled care rates will indicate the impact of this and other initiatives.

Although the partnership has developed some intermediate care services, it has decided not to develop step up/step down services. Instead, the partnership is investing heavily in care at home provision. This appears to be effective in delivering positive outcomes for individuals, but further evaluation of the impact on avoiding hospital admission could evidence that this is the correct approach.

The partnership has introduced care home liaison nurses as another good initiative to reduce unscheduled care. The care home liaison nurses are aligned to a number of care homes within the council and offer support and guidance to care staff, helping them to care for individuals. The liaison nurses have good links with local GPs who support this work. The partnership has also carried out work to help staff recognise the early signs of any resident's deterioration in the care home, allowing them to intervene earlier and ensure that individuals have appropriate support when they require it.

The partnership has established a short-term working group to explore the inconsistent admission rates identified across the care home sector. The group found that factors contributing to care home services with high admission rates included management issues, staff retention, staff vacancies and use of agency staff. Work is currently under way to identify the resources required to help these homes reduce their unscheduled care rate.

The rate of unscheduled care is high, however this is similar to other partnerships in Greater Glasgow and Clyde. The partnership is continuing to focus on alternative approaches in order to reduce unscheduled care. Evaluation of these to understand the impact would be beneficial.

The efficiency and effectiveness of discharge procedures are of importance for those who are admitted to hospital. The partnership is performing well in facilitating timely discharge. A systematic approach to resource allocation contributes to this. Managers review discharges on a daily basis to ensure that resources are used as efficiently as possible and that individual care is progressed as quickly as possible.

Many of the small number of delayed discharges in Renfrewshire are due to code 9<sup>7</sup> delays. The partnership is proactively addressing delays caused by incapacity. Currently, the partnership is considering the best approach for an awareness campaign about power of attorney. Additionally, a Mental Health Officer (MHO) has now been allocated to the discharge team. As soon as an adult with incapacity issue is highlighted, the MHO receives the individual's details to ensure that interventions will be of benefit to the individual. Liaison with local solicitors also aims to raise awareness of the importance of being timeous with guardianship applications.

The partnership is continuing to perform well in preventing delayed discharges and demonstrates an ongoing commitment to this.

### **Self-directed Support**

Historically, the partnership has had a low level of direct payments and related expenditure compared with the national average. However, there are positive signs of improvement over recent months. There has also been an increase in the number of Self-directed Support<sup>8</sup> (SDS) assessments being offered.

The partnership is working to ensure that the SDS assessment process is more streamlined and that staff have access to relevant training. The partnership has an ongoing training programme for the implementation of SDS. The partnership has also redesigned the training based on feedback from participants. Over 1,000 members of staff have completed this training. However, we heard from some staff that their training took place some time ago and they currently lack confidence in taking forward SDS.

In frontline staff focus groups and in our staff survey, some staff commented that they find it difficult to complete SDS assessments. They told us it was time consuming, cumbersome and takes time away from delivering care. Some staff reported frustration with the resource approval process. We heard that some staff feel it is process driven rather than supporting informed choice by people and can involve a reduction in the individual's budget. Such changes in resources allocated to an individual can adversely affect relationships between staff and the individual. It is important that staff are confident and competent in completing SDS assessments so that individuals can make a meaningful choice about how they receive their support.

Some individuals told us they chose option one and were very positive about the benefits of having more control whilst employing their personal assistants. They

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<sup>7</sup> Code 9 delays were introduced for very limited circumstances where NHS Chief Executives and local authority Directors of Social Work (or their nominated representatives) could explain why the discharge of patients was outwith their control. These would include patients delayed due to awaiting place availability in a high level needs' specialist facility where no facilities exist and where an interim option is not appropriate, patients for whom an interim move is deemed unreasonable or where an adult may lack capacity under adults with incapacity legislation (Source: ISD Scotland).

<sup>8</sup> Self-directed Support options are: direct payments (option one); individual chooses the service and the service provider and the local authority makes the arrangements (option two); local authority-arranged support (option three); and option four (a combination of the other options).

enjoy the increased flexibility that this option gives them. However, other individuals expressed concern that it was not easy to choose an option other than 'local authority provided care'. There are limited purchasing options for those service users who wish to choose from the full range of SDS options. We also learned that there are a range of individual community support services but demand on existing capacity can result in a lack of choice. Information about local groups and services could be accessed through 'Well in Renfrewshire'<sup>9</sup>. The partnership should continue to ensure that SDS is used to promote greater choice and control for all service users in line with the principles of the legislation.

### **Provider relationships**

Relationships between frontline staff in the statutory agencies and third and independent sector providers are positive. There are good links between community-based staff who work in the hospital to facilitate discharge and the in-house reablement and rapid response teams who support individuals immediately on discharge. Additionally, liaison nurses and district nurses provide training to care homes. The district nurses also have input to the care at home induction training and carry out joint visits with home care staff. The partnership and providers work collaboratively to overcome any challenges. For example, there had been frustration about new care homes opening and the impact this had on GP practices. The partnership and the GPs responded positively to this, and minimised impact by sharing the workload across practices.

Relationships at the front line are positive. However, we heard mixed opinions about wider engagement between the third and independent sector and the partnership. Senior partnership managers and independent sector representatives told us that consultation, engagement and involvement with providers is an ongoing activity. Some providers, however, told us that engagement with them could be improved, particularly on operational matters such as assessment, care planning, allocation of cases and service redesign. The partnership recently re-established care at home and care home liaison forums. These take place alongside a specialist provider forum as a means to improving communication. These forums provide an opportunity to raise awareness and learn about relevant policies and legislation. Care at home and care home forums take place irregularly, but there is a commitment from the partnership and providers to maintain these forums. These could help ensure that providers feel engagement is always timely and meaningful.

We also heard mixed views from the independent and third sector providers about the level of support they receive. Most are content with the level of support provided by the partnership to improve their performance, however, some identified further support needs to help them improve. The support provided focuses on areas such as tendering processes, policies and protocol development, and highlighting good

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<sup>9</sup> Well in Renfrewshire is an online portal which provides people with up-to-date information about local clubs, groups and activities across Renfrewshire in one place.

practice in other services. We heard from some providers that there is limited support with workforce development. There was a mixed picture about their inclusion in statutory agency training opportunities. We learnt that logistics are impacting on communication around this, for example current contact details are not available for all providers to inform them about opportunities. The partnership is striving to overcome this logistical issue by developing its website to help organisations contact them for help, support and training availability.

### **Commissioned palliative care services**

There are positive relationships between the providers of palliative care services and the partnership. At strategic level, the partnership's Palliative Care Joint Planning, Performance Implementation Group has been in place for a number of years. The group membership represents all areas within Renfrewshire that have an interest or involvement in providing and improving palliative and end of life care services. The group has a comprehensive and detailed action plan, with a clear focus on improving service delivery and outcomes for people. The partnership Chief Nurse attends the hospice governance groups, and provides an advisory role in relation to training and development, local and national policy and best practice.

The partnership has commissioned, from specialist hospice providers, a range of palliative care services such as in-patient beds, day hospice, out of hours advice, clinical assessment, review and treatment, education, consultant medical and occupational health services. These are complemented by care at home, allied health professionals and community nursing services supported by specialist Macmillan and Marie Curie nurses.

At frontline staff level, there is a collaborative approach, especially to training. Staff from the hospice provide training to statutory staff. The partnership also provides training and development opportunities to the providers.

### **Contract compliance and monitoring**

The contracts team have a focus on contracts monitoring. The partnership takes a risk-based approach to identify those providers needing closer contract monitoring. There are 85 approved providers within the Renfrewshire area, of whom 69 have a current contract. Around 20-25 providers receive a two-day monitoring visit each year based on a risk-based assessment. Any improvements are identified in an action plan, prepared by the provider and monitored by the contracts team. Practical support to providers needing improvement includes help with policies, protocols, paperwork and highlighting other agencies examples of good practice. Most third and independent sector providers are generally content with the level of support the partnership gives them to improve their performance. There are limited opportunities for the contracts team or the partnership to help with training or capacity support.

Positively, the contracts team has recently become involved in discussions on service specification and monitoring on health-related externally commissioned services such as hospice services. However, the approach to commissioned services and to Renfrewshire-hosted services delivered on behalf of NHS Greater Glasgow and Clyde remains inconsistent. Relationships with other partnerships for cross-boundary placements are not fully formalised.

### **Quality assurance**

Senior managers are keen to stress that service quality is assessed and feedback is received through a range of means. At the heart of this, assessment and care management arrangements are in place in order to understand how people feel about services and the support they receive. The partnership relies on processes, such as caseload management, clinical supervision, service reviews and mid-year appraisals, to contribute to assurance of the quality of service. The partnership is also using more proactive measures such as seeking feedback from a patient experience worker within the hospitals. Additionally, reactive measures are used, including reviewing adult support and protection, large scale investigations, and complaints and compliments from staff and people with experience of care. Furthermore, the Quality, Care and Professional Governance group focus on issues arising from complaints, clinical incidents and people with experience of services. These all provide a vital source of learning and a basis for improvement actions. However, there is limited evidence of a joint and integrated strategic approach to gather feedback from people with experience of services and ensure that learning impacts on service improvement.

The partnership brought together elements from established quality assurance models rather than following a single framework. As yet, the partnership does not have a joint integrated framework for quality assurance. However, it has been working towards a quality assurance model built around its Clinical and Care Governance Framework. The partnership intends to build on this early work and further develop this model. The IJB has not yet reached a decision on a paper considering future quality assurance options.

Despite the lack of a joint and integrated model, most staff's perception of the partnership's approach to quality assurance is positive. Of the staff who responded to our staff survey, 80% agree that their service has quality assurance processes in place and regular evaluation of the work takes place. However, just over half (53%) agree that these approaches have led to service improvements in the last year. We heard about a series of self-evaluation exercises in areas such as the implementation of the SDS legislation. There is a limited but targeted multi-agency review of case records every two years. The results of this are shared with the Adult Protection Committee with recommended follow-up actions.

The partnership needs to demonstrate that it is using performance management information and other means to identify priority areas for self-evaluation and self-

assessment. It also needs to evidence a strategic approach to ensure that intelligence gained from quality assurance mechanisms influences improvement.

### **Monitoring performance**

The partnership uses a joint scorecard based on national and local indicators to display statistics and a traffic light system to monitor and describe performance. This helps the partnership to identify the performance trend. Overall, performance is positive: 60% of the indicators highlighted good performance.

The scorecard is a useful performance monitoring tool, but there are areas where it could be improved. Some of the targets are not designed to drive improvement. Senior managers recognise there is a need to review the rationale for targets. Additionally, some targets are in need of review and there are a few which will not have targets assigned until 2018. Managers also agree that some data clean-up is required in order to ensure accuracy. Furthermore, the scorecard does not gather qualitative or outcome-focused data. Individual outcomes are not measured, aggregated, analysed or used to influence service delivery. Managers and staff recognise that they need to do more to evidence positive personal outcomes and the impact of service delivery for people with experience of care and carers. It would strengthen the partnership's approach to improvement if all of the indicators were designed to drive improvement and the scorecard is updated to include personal outcomes as well as more qualitative indicators.

The performance scorecard is regularly reviewed by managers. Reports are generated which could be used to review the performance of a single team or service. These regular performance reports are reviewed by managers who address concerns arising. The reports are also sent to the Joint Chief Officer and heads of service and shared regularly with the IJB. The information includes a narrative to explain recent progress and further detail such as exception reports. The reports are considered to be clear and helpful. However, the IJB is not provided with the rationale for targets which would contribute to a more comprehensive understanding of performance. This could increase the IJB members' understanding of the importance of target achievement and trends. After reviewing the performance reports, the IJB members can request special reports to clarify data provided. Senior managers are confident in the performance management processes. This robust approach ensures that changes in performance are monitored, and working groups and action plans to address these are evident.

The partnership's NHS and social work systems can generate performance information and reports. We saw an improving picture of how the partnership was using its performance data. From being previously data rich rather than data specific, there was a shift in ensuring that the right data was being sought and used.

There is limited evidence that the partnership is undertaking benchmarking against other partnerships and using this to inform planning and commissioning decisions. Regular meetings with colleagues in the NHS Greater Glasgow and Clyde area

provide an opportunity to share good practice and concerns, but there is limited evidence of this extending to other partnership areas. Good performance in other partnership areas of the country can highlight new and different ways of working which may influence strategic plans and service design. Therefore, it is important that the partnership is able to review its performance with more health and social care partnerships to drive improvement.

## 4. Summary and conclusion

Scottish Ministers have asked the Care Inspectorate and Healthcare Improvement Scotland to assess the progress made by health and social care partnerships to delivering better, more effective and person-led services through integration. In doing so, we have taken into account leaders' commitment to innovation and improvement and to cultivate a culture of collaboration and shared accountability. We also inspected the partnership's ability to identify appropriate priorities and its capacity to drive forward progress at pace. By taking appropriate action to develop the plans and structures currently in place and ensuring a proactive approach to the management of operational performance, we are confident that the Renfrewshire partnership will continue to move forward with the integration of health and social care.

### **Our evaluation of quality indicators 1 and 6**

The Care Inspectorate and Healthcare Improvement Scotland together with key stakeholders have developed a set of quality indicators and illustrations to support partnerships to evaluate and improve the quality of work and the outcomes they are achieving for individuals, carers and communities. Inspection teams use this same set of indicators and illustrations to support their assessments of quality and what needs to be improved. During these inspections, we agreed to focus particularly on three of these indicators (Quality indicators 1, 6 and 9) and to publish an evaluation of quality indicators one and six (Appendix 1) using a six-point scale.

### **Quality indicator 1: Key performance outcomes**

#### ***Evaluation: Good***

In this section, we focus on improvements in performance in health and social work services. The partnership has been evaluated as good.

The Renfrewshire partnership demonstrates a commitment to ongoing monitoring and improvement in key performance outcomes. A joint performance scorecard is in use which includes both local and national indicators to oversee performance trends and target completion. The scorecard indicates good overall performance.

One limitation of the scorecard is its focus on quantitative data gathering. It does not reflect qualitative and outcomes focused feedback from people who experience services and carers. The partnership has a limited approach to this. The inclusion of this important information in the scorecard could ensure a strategic approach to gathering this information, and ensure it is used to influence improvement.

The partnership has a robust, structured approach to monitoring progress in performance. Regular reports are produced and these are reviewed by senior managers and the IJB. Exception reports are also produced for the IJB. The reports helpfully indicate recent trends and whether the performance target has been

achieved. When poor trends are identified, positive steps are taken to address these. There is evidence that SMART action plans are developed and implemented. An example of this is the unscheduled care commissioning intentions which have been developed in response to the high rates of emergency admissions.

The partnership is performing well against national targets. A key area of success is the timely discharge of individuals from hospital. The partnership has a history of low rates of delayed discharge and is continuing to perform well. There is an improving trend in the number of care home beds and the provision of SDS. The implementation of SDS could be further improved by continuing to develop staff confidence and motivation to undertake the assessments and improve availability of choice and capacity in the market.

**Area for improvement:**

The partnership should undertake benchmarking with other partnerships outwith the NHS Greater Glasgow and Clyde area.

**Quality indicator 6: Strategic planning and commissioning arrangements**

***Evaluation: Good***

In this section, we report on the contribution that strategic planning made to the lives of adults and their carers. We focus on the partnership's strategic plans, needs analysis, strategic commissioning, consultation and involvement.

The partnership's approach and delivery of strategic planning has been evaluated as good. The partnership has completed a joint strategic needs analysis, supporting the development of its joint strategic plan and related plans. These plans set out the case for change and a clear overall direction for the future planning and delivery of services for adults. However, implementation plans lack detail on how the plans would be achieved.

Productive joint planning arrangements helpfully involve adults and carers and key stakeholders, including the third and independent sectors, but need to become more meaningful, particularly at an earlier stage, when services are being planned or (re)designed.

The partnership recognises local care market challenges and is beginning to address them. Joint strategic commissioning activity to date has been limited and primarily focused on older people's services. We saw evidence of cross-sector engagement and involvement between health and social work partners.

The partnership has successfully begun the development of a range of early intervention and support services for adults and their carers. These developments need to be built upon. The partnership needs to develop its commissioning approach to further shift the balance of care towards community services and to add to the progress made so far.

**Areas for improvement:**

The partnership should work with the local community and with other stakeholders to develop and implement a cross-sector market facilitation strategy.

The partnership should develop joint robust quality assurance systems and a joint programme of quality assurance activity that are embedded in practice. This should help to prioritise areas for self-evaluation and, in turn, joint service improvements.

Joint planning arrangements need to involve people who experience services, carers and key stakeholders, including the third and independent sectors, in a more meaningful, way and at an earlier stage when services are being planned or (re)designed.

The partnership should produce a revised and updated strategic commissioning plan with detail on:

- how priorities are to be resourced
- how joint organisational development planning to support this is to be taken forward
- how consultation, engagement and involvement are to be maintained
- fully costed action plans, including plans for investment and disinvestment based on identified future needs, and
- expected measurable outcomes.

**Quality indicator 9: Leadership and direction that promotes partnership**  
***Not subject to evaluation against the six-point scale***

The partnership has a clear vision which is understood and shared by all grades of staff. There is a strong commitment to the delivery of health and social care services in line with this vision. There are clear connections between the vision and the strategic plan.

Recently, there have been changes in the IJB membership, with several new members being appointed. Despite this, IJB members have developed good working relationships with each other, with the Joint Chief Officer and the Joint Chief Financial Officer. The IJB members are well supported by the partnership through the delivery of development sessions to ensure they have the knowledge required to perform their roles.

Members of the senior management team are highly visible, and supportive of frontline staff. Joint working is promoted and a culture of integrated working is evident. This joint working is contributing to the delivery of positive outcomes for people experiencing health and social care services.

## Appendix 1 – Quality Improvement Framework

<b>1. Key performance outcomes</b>	<b>4. Impact on the community</b>	<b>6. Policy development and plans to support improvement in service</b>	<b>7. Management and support of staff</b>	<b>9. Leadership and direction that promotes partnership</b>
<b>We assessed 1.1</b> Improvements in partnership performance in both healthcare and social care	4.1 Public confidence in community services and community engagement	<b>We assessed 6.1</b> Operational and strategic planning arrangements	7.1 Recruitment and retention	<b>We assessed 9.1</b> Vision, values and culture across the partnership
1.2 Improvements in the health and wellbeing and outcomes for people, carers and families	<b>5. Delivery of key processes</b>	6.2 Partnership development of a range of early intervention and support services	7.2 Deployment, joint working and team work	<b>We assessed 9.2</b> Leadership of strategy and direction
<b>2. Getting help at the right time</b>	5.1 Access to support	6.3 Quality assurance, self evaluation and improvement	7.3 Training, development and support	9.3 Leadership of people across the partnership
2.1 Experience of individuals and carers of improved health, wellbeing, care and support	5.2 Assessing need, planning for individuals and delivering care and support	6.4 Involving individuals who use services, carers and other stakeholders	8. Partnership working	9.4 Leadership of change and improvement
2.2 Prevention, early identification and intervention at the right time	5.3 Shared approach to protecting individuals who are at risk of harm, assessing risk and managing and mitigating risks	<b>We assessed 6.5</b> Commissioning arrangements	8.1 Management of resources	<b>10. Capacity for improvement</b>
2.3 Access to information about support options including self directed support	5.4 Involvement of individuals and carers in directing their own support		8.2 Information systems	10.1 Judgement based on an evaluation of performance against the quality indicators
<b>3. Impact on staff</b>			8.3 Partnership arrangements	
3.1 Staff motivation and support				

## **Appendix 2 – Methodology**

Our inspection of Renfrewshire Health and Social Care Partnership was carried out over the following three phases.

### **Phase 1 – Planning and information gathering**

The inspection team collated and analysed information requested from the partnership and any other information sourced by the inspection team before the inspection started and additional information provided during fieldwork.

### **Phase 2 – Staff survey and fieldwork**

We issued a survey to 2,051 staff. Of those, 705 responded and 597 completed the full survey. We also carried out field work over seven and a half days during which we interviewed a number of people who hold a range of responsibilities across the partnership.

### **Phase 3 – Reporting**

The Care Inspectorate and Healthcare Improvement Scotland jointly publish an inspection report. The report format for this inspection focuses on strategic planning and commissioning and links this to evidence gathered on current performance and the development of the integrated leadership team. Unlike previous joint reports, comment is provided on our level of confidence in respect of the partnership's ability to successfully take forward its strategic plans from intentions to changes in operational delivery.

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