Healthcare Improvement Scotland

care inspectorate

**JOINT INSPECTION (ADULTS)**

The effectiveness of strategic planning in the
**East Dunbartonshire Health and Social Care Partnership**

**JULY 2019**

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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 strategic planning by integration authorities.[1] This includes how integration authorities plan, commission and deliver high-quality services in a co-ordinated and sustainable way.  In this inspection, the focus was on how well the partnership had:

- improved performance in both health and social care
- developed and implemented operational and strategic planning arrangements, and commissioning arrangements
- established the vision, values and aims across the partnership, and the leadership of strategy and direction.

To do this, we assessed the vision, values and culture across the partnership, including leadership of strategy and direction. We evaluated the operational and strategic planning arrangements (including progress towards effective commissioning) and we assessed the improvements the partnership has made in health and social care services that are provided for all adults.

Integration brings changes in service delivery, but we recognise that it takes time for this to work through into better outcomes. Indeed, at this early stage of integration, we would expect to see data showing some room for improvement in the outcomes for people using health and care services, even where leadership is effective and planning robust. In these inspections of strategic planning we do not set out to evaluate people's experience of services in their area. Our aim is to assess the extent to which the health and social care partnership (HSCP) is making progress in its journey towards efficient, effective and integrated services that are likely to lead to better experiences and improved outcomes for people who use services and their carers 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 Scotland.

The East Dunbartonshire HSCP comprises East Dunbartonshire council and NHS Greater Glasgow and Clyde and is referred to as 'the partnership' throughout this report. All acute hospital services and many community-based services were hosted by other health and social care partnerships in NHS Greater Glasgow and Clyde area with local East Dunbartonshire management arrangements in place. The partnership hosts NHS Greater Glasgow and Clyde's primary care oral health directorate on behalf of the six partnerships within the NHS Greater Glasgow and Clyde area.

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[1] The Public Bodies (Joint Working) (Scotland) Act 2014 places a duty on integration authorities to develop a strategic plan for integrated functions and budgets under their control.

The Integration Joint Board[2] is known locally as the Health and Social Care Partnership (HSCP) board and therefore it is referred to as such in this report.

This inspection took place between November 2018 and February 2019. The conclusions within this report reflect our findings during the period of inspection. An outline of the quality improvement framework is shown in appendix one. There is a summary of the methodology in appendix two. In order that our joint inspections remain relevant and add value, we may refine our scrutiny methods and tools as we learn from each inspection.

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[2] Under The Public Bodies (Joint Working) (Scotland) Act 2014, Integration Joint Boards are responsible for the planning of integrated arrangements and onward service delivery of the functions and resources delegated to it from the health board and local authorities.

## 2. East Dunbartonshire context

East Dunbartonshire was the sixth Integration Joint Board to formally establish in Scotland, in September 2015. In July 2016, the scope of the integration scheme was extended from adult services to include NHS and social work children's service functions and social work criminal justice services functions.

East Dunbartonshire has a population of approximately 108,000 and is a mix of urban and rural communities. Life expectancy, employment levels and school performance are much higher than the Scottish average. Economic activity and employment rates are high and the level of crime is significantly below the Scottish average. Despite this, inequalities exist and there are pockets of deprivation where people's quality of life fall well below the national average.

East Dunbartonshire has eight data zones which fall into the top 25% of most deprived in Scotland. These data zones are located in Hillhead, Lennoxtown, Auchinairn and Milngavie (Keystone/Dougalston).  According to the Scottish index of multiple deprivation (SIMD) for 2012, certain parts of Hillhead, East Dunbartonshire's most deprived area, were among the 5% most deprived areas in Scotland. According to the 2014 SIMD, 8.2% of the working age population in East Dunbartonshire overall was employment deprived, which was below the Scottish average, but with significant local variation showing 14.2% in Auchinairn, 14.7% in Twechar and Harestanes East, 15.8% in Harestanes and 22.1% in Hillhead.

Compared with the rest of Scotland, people living in East Dunbartonshire are relatively healthy.  More people take part in sports, fewer smoke and breast-feeding rates are higher than the Scottish average.  Although East Dunbartonshire is in the highest decile for life expectancy in Scotland for both men and women, there is a 10-year gap of life expectancy in the Westerton area, compared to Hillhead.

In the 2011 Census, 5.6% of the adult population in East Dunbartonshire reported a disability, with hearing impairments and/or physical disability being the main disabilities. The number of long-term conditions rose with age. The most diagnosed long-term condition was hypertension. The prevalence for this condition, cancer and atrial fibrillation, were all higher than the rate for Scotland.

East Dunbartonshire has seen a 40% increase in people aged over 75 years since 2002. This is a positive reflection of advances in health and social care but has placed considerable pressure on services. With an increase in the frail older population, service pressure has been experienced in both the community and secondary healthcare settings. Demand on services for other adult care groups has also increased. The partnership has established two locality planning areas to help support the understanding, planning and delivery of services around communities within these localities. They comprise:

- East locality (Bishopbriggs, Torrance, Lenzie, Lennoxtown, and Kirkintilloch)

- West locality (Bearsden and Milngavie).

## 3. Performance

At the time of our inspection, the partnership was performing comparatively well against other integration authorities, measured against a range of nationally published datasets, the national health and wellbeing outcomes[3] and the Scottish Government's health and social care integration indicators[4]. It performed well, in 2017/18, in the following areas:

- The proportion of adults rating the care and support they received as good or excellent.

- Reducing the numbers of people attending hospital as a result of an emergency and the associated bed days occupied.

- Minimising the numbers of people who experienced a delayed hospital discharge and ensuring that people were discharged from hospital timeously. The associated bed days occupied were lower whether this was due to code nine[5] delays or delays due to health and social care reasons[6].

- Delivering care at home services to help adults meet their needs and deliver their personal outcomes.

- Shifting the balance of care towards community settings.

- Supporting people reaching the end of their life to die in their preferred place of care and support.

- The proportion of adults agreeing that the services they received had allowed them to maintain or improve their quality of life.

Particular areas for the partnership to improve its performance were:

- The use of assistive technology (telecare) to maintain people's independence and ability to realise their choice to remain at home.

- Reducing the number of falls experienced by adults and the number of hospital admissions resulting from a fall.

- The proportion of people diagnosed with dementia referred for post dementia diagnostic support and the numbers who get it.

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[3] Public Bodies (Joint Working) (National Health and Wellbeing Outcomes) (Scotland) Regulations 2014 provide a strategic framework for the planning and delivery of health and social care services. They focus on the experiences and quality of services for people using those services, carers and their families.
[4] Criteria that measures the effectiveness of health and social care integration in a partnership area.
[5] Code nine delayed discharges are mainly due to patients who lack capacity and require powers from a court to move them from an acute bed to a care home. Code nine delays can be due to the need to secure a specialist health resource for a patient.
[6] Place availability, assessment reasons, funding reasons, care arrangements and transport.

The partnership had published an annual performance report for the year 2017/18. It contained a range of well-presented and accessible statistical information on the performance of health and social care services. The document had helpful case studies that augmented the statistical data and provided concrete examples of how the partnership's services could positively transform lives.

The partnership's performance on its own key target areas was good. Of the 19 core indicators reported in the annual performance report, it had improved or maintained its performance in 17 of them. There was an improving picture of how the partnership was using its performance data. Quarterly performance reports were reviewed by the senior management team and presented to the HSCP board. These provided a suite of national and local measures and targets for services delivered by the partnership, including children's and criminal justice services. These clear and helpful reports identified recent trends, a situational analysis and paths for improvement for each indicator. This helped the partnership to identify performance trends. This approach helped ensure that changes in performance were monitored, and some actions to address deficits were evident.

The HSCP board and its performance, audit and risk committee received mostly appropriate reports on performance activity, set against national and local targets. HSCP board members considered that the partnership's performance overall was good and that the reporting arrangements were satisfactory. Performance management information was regularly reviewed by managers.

An improved performance management and reporting framework was in development and due for implementation by spring 2019. It aimed to provide a comprehensive means of measuring and reporting partnership performance. It included data to be reported to the HSCP board, senior management team, directorate, operational management and individual teams. It would link performance information and data to the strategic plan, national health and wellbeing outcomes, and the Scottish Government core suite of integration indicators. Links to the national Health and Social Care Standards were yet to be developed. It was too early to assess the framework's effectiveness in supporting the measurement and improvement of the partnership's performance across the range of its responsibilities.

There was less evidence of a systematic use of national and local performance data to drive identified improvements. Around half of the respondents to our staff survey agreed that the partnership provided full feedback to staff on how well the partnership was doing to meet locally and nationally set targets and how it compared to other partnerships around Scotland. Reports that could be used to review the performance of a single team, service or locality were not routinely available.

There were substantial differences in the profiles of the partnership's two localities. As yet, the partnership had not sought to understand its performance at locality level and there was scope to develop a greater focus on areas of deprivation.

It was important that the partnership understood its performance across all areas to ensure it was targeting resources and improvements to meet the needs of its most vulnerable people.

There was room for improvement in ensuring that individual staff performance was linked to team performance and thereafter to service performance and overall strategic level performance. The partnership was not demonstrating how its performance management was helping it to deliver best value, for example, in its annual performance report. These were areas that the emergent performance management and reporting framework aimed to address.

Performance management reporting did not gather, in the main, qualitative or outcome-focused data. While individual outcomes could be measured through a review of care and support plans, they were not generally aggregated, analysed or used to influence service delivery. Managers and staff recognised that they needed to do more to evidence positive personal outcomes and the impact of service delivery for people with experience of care and carers.[7] It would further strengthen the partnership's approach to improvement if the emergent performance management framework was updated to include personal outcomes as well as more qualitative indicators. The partnership was not always using its performance management information to identify priority areas for self-evaluation and self-assessment either.

The partnership had undertaken some good work on eliciting the views of people about the services they received. For example, the partnership had commissioned the Scottish Drugs Forum to survey those who used substance misuse services. A survey of people who used community mental health team services was a good example of performance measurement activity generating information that was subsequently used to drive improvement. While the partnership could review individual outcomes, it did not regularly and systematically aggregate or analyse the data to understand at a strategic or service planning level, the care experience of people who used services delivered by externally commissioned providers. There was room for improvement in this respect.

The partnership had used some performance information, including feedback from people who used services to inform improvement. However, there was limited evidence that the partnership's benchmarking against other integration authorities was being used to fully inform planning and commissioning decisions. Regular meetings with colleagues in the NHS Greater Glasgow and Clyde area provided an opportunity to share good practice and concerns, but there was limited evidence of this extending to other partnership areas. Good performance in other partnership areas of the country could highlight new and different ways of working that may influence strategic plans and service design.

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[7] In this report, when we refer to carers this means unpaid carers.

## 4. Strategic planning and commissioning

### Strategic planning

The partnership had set out its shared priorities in its strategic plan (2018 – 2021)[8]. This was a well-presented, public facing document that outlined the partnership's intentions. The strategic plan was a high-level statement of intent that helpfully included a needs profile, information on locality planning, health and social care expenditure, and a series of actions based around eight priority themes. The strategic plan's priorities aligned well with other relevant strategies such as the East Dunbartonshire local outcome improvement plan, NHS Greater Glasgow and Clyde's Moving Forward Together transformation strategy and local delivery plan.

The partnership had prepared a supporting annual business plan. This helpfully focused on strategic improvement and transformational change associated with the implementation of the strategic plan. There was a lack of detailed and clearly recorded action planning. For example, the partnership's annual business plan and transformation plans lacked detailed supporting action plans in some cases. The partnership was preparing a refreshed approach to business planning for the forthcoming year.

The partnership had developed a range of strategies to inform service planning. It had a suite of supporting plans in areas such as finance and workforce development. Operational service planning arrangements existed to help deliver care group strategy implementation and service redesigns. While individual care group planning arrangements were well developed, they sometimes lacked detail for example, in progress tracking, and in locality and team planning.

The partnership had clear priorities and plans at strategic and service level. However, locality and team level priorities did not always connect clearly with strategic plans. Service and team level improvement activity in support of the strategic plan could have been better recorded and reported. Service plans that linked to strategic planning priorities were not fully developed.

The partnership had complex planning processes, but they lacked detail on implementation plans for future investment and disinvestment in services. The actions tended not to be fully costed and delivery timescales were not always clearly identified. They did not meet SMART (Specific, Measurable, Achievable, Realistic and Time-bound) criteria. This limited their use as delivery management and accountability tools. It was difficult to track how the partnership intended to deliver on its strategic intentions. The strategic plan was limited in that it was not complemented by a detailed commissioning strategy and associated market facilitation plans.

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[8] The document setting out the arrangements for carrying out the integration functions and how these are intended to achieve or contribute to the achievement of the relevant national health and wellbeing outcomes for the population of the integration authority.

In some cases, the partnership did not clearly report on the progress achieved in previous strategies and plans, for example, the previous strategic plan. This meant that opportunities were not always taken to report on the progress or incompletion of actions, or to reflect on and implement lessons learned from previous actions and plans. Partnership planning processes were not always SMART. They were not always regularly monitored, evaluated and reviewed by the partnership.

Service planning and redesign activity was taking place in areas such as the carer's strategy, learning disability services, aspects of the mental health strategy and a range of actions as part of the older people's strategy. The partnership did not always demonstrate that people experiencing care were meaningfully involved in service reviews or were an integral part of any service review and redesign.

The partnership was undertaking a series of service reviews using the council's multi-stage service review approach. This was a very sophisticated tool that helped to inform future commissioning decisions. However, there were some unintended consequences of this approach. These included that not all relevant stakeholders were afforded the opportunity to contribute to the reviews at all of the stages, particularly in the early scoping and evidence-gathering phases. Many staff, at practitioner and team level, while aware of the broad direction of travel, were not familiar with the detail of key strategic change agendas, such as the redesign of learning disability services and the care at home review. It would help if the whole process was fully informed from the beginning and in all stages, where appropriate, for example, by people who had experienced care and their carers.

There was a limited rationale for why particular service areas had been prioritised for review and redesign. The service redesign process could take substantially longer than intended, for example, review of accommodation with support for people with learning disabilities. Timeframes for review completion had been regularly extended. This had led to additional uncertainty among providers and staff, and people experiencing care and their carers about the future direction of services.

The service redesign process was not fully integrated. Many of the resources considered as part of the reviews were single-agency. While the main contributors to the redesigns were from the council and the NHS, there were missed opportunities to fully undertake truly integrated service reviews that explored opportunities for investment and disinvestment from multi-agency resources.

The partnership was one of the six health and social care partnerships within the NHS Greater Glasgow and Clyde area. This bought an added level of complexity to the planning and delivery of some services. There were some challenges for the partnership in terms of attending the numerous NHS Greater Glasgow and Clyde planning groups. However, the partnership engaged as fully as possible with the NHS Greater Glasgow and Clyde agenda and with the broader West of Scotland regional agenda. The benefits of doing so outweighed any possible disadvantages.

There were productive and business-like planning relationships with NHS Greater Glasgow and several planning forums at senior and operational levels took place regularly.

There were economies of scale in being able to approach aspects of service planning on a NHS Greater Glasgow and Clyde basis. The partnership had identified and agreed with its partner authorities which elements of individual service planning could be done on a Greater Glasgow and Clyde basis and what elements it needed to have ownership of for East Dunbartonshire. The chief officer was a member of the NHS Greater Glasgow and Clyde corporate management team, which provided positive opportunities to engage and work with the five other chief officers. Overall, the partnership's working arrangements with NHS Greater Glasgow and Clyde's was a mature and positive one.

The partnership benefitted from the additional capacity and expertise available as part of the wider NHS Greater Glasgow and Clyde and council planning arrangements.

**Strategic needs assessment**

The partnership had produced a comprehensive and detailed strategic needs assessment[9] in 2016 that included rich relevant data and was available to support the preparation of the current strategic plan (2018-21). It contained meaningful demographic, health and wellbeing and social care activity, including information on specific care groups. It also included information on health and social care expenditure.

The strategic needs assessment employed strong data analysis alongside positive engagement with a wide range of stakeholders, to help inform the assessment of needs and priorities based on their knowledge and experience. There were some stakeholders, for example some staff and externally commissioned providers, who had not participated in the strategic needs assessment process but had wished to do so. To ensure that strategic assessment of needs was fully co-produced, a full range of stakeholders should have been involved.

The partnership did not produce an updated assessment to additionally inform the current strategic plan (2018-21). The partnership view of the 2016 assessment's main findings was that they were still relevant and needs information was updated as and when required, for example, as part of service redesigns. Some of the needs data was some years old, particularly at a locality level. It would be beneficial if there was a review of strategic needs assessment information on a regular basis to help inform and update the partnership's priorities. The partnership had recently commissioned extensive needs assessments on housing for older people and people with housing support needs as well as assessing the demand for mental health and substance misuse services.

It had invested in sampling additional numbers of people for NHS Greater Glasgow and Clyde's health and wellbeing surveys to better understand the wishes and health and wellbeing needs of its population. The data derived from this would be used to inform the planning and prioritisation process.

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[9] A strategic needs assessment analyses the needs of local populations and informs and guides the commissioning of health, wellbeing and social care services within the area.

**Locality planning**

The partnership was at a very early stage of delivering effective locality planning and commissioning. In 2016, the partnership had successfully established a planning group for each locality with each contributing to a locality plan for their respective area. Membership and terms of reference for locality planning groups had recently been reviewed. These had been updated to better focus on ensuring that national and local priorities were identified and planned for and that services were better aligned to each locality. There was suitable representation from a range of stakeholders. Meetings were becoming more regular and better attended. However, not all potentially constructive contributing agencies were attending.

The two locality planning groups aimed to identify the needs in their areas, map the services available, identify gaps and promote priorities for service development. There was a modest budget allocated to locality groups for projects such as research and start-up funding for local initiatives. Locality groups were not yet effectively planning for the delivery of health and social care services. Action plans were very high-level and insufficiently detailed.

The partnership had produced two locality profiles. These included a detailed analysis of need and demand. This included extensive demographic data, health and wellbeing indicators and health and social care service activity data. However, much of this information needed to be refreshed. The partnership did not have locality plans based on recent data about the needs of their community and service performance. It had not used a range of local management data to enhance its understanding of the locality profiles. Such profiles would enable each locality to use local data to identify and prioritise local need for service design and delivery.

The partnership had devolved a small amount (£5,000) of its budget to support locality development. It was aiming to strengthen its future financial accountability and ability to support locality managers to inform locality commissioning and service delivery. This work was at a relatively early stage of development. The council had also produced Planning for Places plans as part of its community planning role. The links between these plans and the partnership's locality planning were at an early stage and were not yet well aligned.

**Building capacity in communities**

The partnership's progress in building community capacity and resilience and delivering on co-production approaches was at an early stage. It was evident that the partnership recognised the role that health improvement activities could play in shifting the balance of care and the need to develop community capacity to help deliver this. This was partly set out in the partnership's health improvement strategy.

The partnership acknowledged the important role that local communities and community organisations could play in providing support. There was unrealised potential for the third sector[10] to be more involved in the delivery of services.

Health improvement was a key theme in the strategic plan. Several valuable initiatives had been developed and delivered through co-operation between health, social care and other partners such as the council's leisure services.

However, there was room for health improvement approaches to play a more prominent role in enabling community interventions to help deliver the partnership's ambitions. The partnership understood well the importance of how enabling and assisting volunteering could help deliver on these aims. The partnership was working with other key agencies and services across a range of forums and strategic groups to help build an area-wide approach to volunteering. This approach to volunteer recruitment, training, retention and allocation was not yet fully co-ordinated.

The health improvement team had made progress on a series of targets in areas such alcohol interventions, smoking cessation and cancer screening. There was an opportunity to further measure the potential positive impacts that the investment in community interventions was making, for example, in the social return on the partnership's investment[11]. The partnership did not yet have an overarching measurable action plan that clearly set out the role of community support interventions to help deliver the strategic plan and associated outcomes.

**Engagement with people who experienced care and their carers**

A small number of people who had experienced care and their carers were meaningfully involved in many relevant planning groups. The partnership had established a public, service user and carer (PSUC) representative group to strengthen accountability and help influence the strategic planning of services. For example, two PSUC representatives were members of the HSCP board.

The partnership had prepared a comprehensive communications framework and plan in August 2017. It had helpfully undertaken a consultation and engagement mapping exercise to review and improve its future partnership engagement methods.

The partnership and the Carers Link organisation effectively supported PSUC representatives to participate in strategic, service planning and service redesign. PSUC members reported directly to the HSCP board, presenting the minutes of their meetings and highlighting key developments in their own standing agenda item. PSUC members felt listened to and were mostly satisfied with their involvement in decision making processes.

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[10] Third sector bodies include non-commercial providers of health and social care, representative groups, interest groups, social enterprises and community organisations.
[11] Social return on investment is way of measuring extra-financial value (such as environmental or social value. It can be used by any entity to evaluate impact on stakeholders, identify ways to improve performance, and enhance the performance of investments.

Outwith the PSUC there was less evidence of engagement with service users and carers. Less than half (49%) of respondents to our staff survey agreed that the views of people experiencing care and those of their carers and families were fully considered when planning services at strategic level. There was no representation from people experiencing care or their carers at the older people's strategy group. Carers did participate in some condition-specific subgroups, for example, the dementia subgroup.

**Engagement with partnership staff**

There was limited evidence that the partnership's operational staff were fully engaged in service planning or that they were well informed about developments however, the level and quality of engagement with staff was improving. There was an increasing staff awareness of the partnership's identity, priorities and work. The partnership's main vehicles for engagement with its staff were the staff forum, the Our News newsletter, the 'iMatter' annual staff survey, regular team meetings and an annual staff award ceremony. Staff expressed mixed views about the level of influence they felt they had in the design of services. Senior and middle managers felt involved in development and improvement activity.

Around a third of the staff (34%) responding to our survey agreed that their views were taken into account when planning services at a strategic level. Just over half (53%) agreed that there was a strong connection between strategy, development and service delivery. These results of our survey broadly reflected the partnership's own iMatter survey in areas that required further improvement. Frontline staff had a good knowledge and understanding of where there were significant challenges around choice, availability and access to services. They were keen to be more fully involved in planning for service changes.

Some staff would have liked to have seen a clearer link between the strategic vision, service redesign and day-to-day priorities. Staff also wanted improved communication and to have greater involvement in informing decisions. The partnership had recognised the need for further development in these areas and had commenced staff engagement events in December 2018. As the partnership's culture developed, communicating changes in a more inclusive manner would be a key way to promote further integration.

**Engagement with the third and independent sectors**

The third and independent sectors had very mixed experiences of their engagement with the partnership. The vast majority of providers informed us that they were unhappy with their relationship with the partnership. Most providers' experience of engagement with the partnership could be substantially improved. There were limited opportunities for the third sector to become involved in how services were planned and commissioned. Where there were examples of engagement, these were inconsistent and piecemeal. Many providers had not been involved in relevant strategic planning or service reviews from the outset.

This was reflected in our staff survey, with less than half (48%) of respondents agreeing that the partnership worked closely with health and social care providers when planning services at a strategic level.

The partnership relied heavily on providers of externally commissioned services. A lack of successful engagement was a high risk to existing and future service delivery. East Dunbartonshire Voluntary Action, the local third sector interface[12], had built up good relationships with some organisations within the third sector. However, the majority of third sector organisations were not adequately represented in strategic and service planning.

The partnership was beginning to set out arrangements to improve its relationship with providers of externally commissioned services. This included arrangements for earlier and fuller involvement in strategic and service planning. The third sector was represented on some strategic and local planning groups. The independent sector was less so. The third sector interface representative was a member of the HSCP board, the strategic planning group[13] and the commissioning strategy group.

There was a range of care group-specific and service-type providers' forums. These were welcomed by providers but in the past they had taken place intermittently and attendance had not always been good. The partnership had recently placed a greater emphasis on these forums and they were happening more regularly.

While engagement and involvement with the third and independent sectors had been inconsistent, opportunities for a greater level of closer dialogue and productive joint working were emerging. The partnership's intention was for externally commissioned providers to have a greater focus on prevention and early intervention agendas, and to develop more meaningful cross-cutting community-based services.

Work was underway to prepare a commissioning strategy. This was due for completion in the spring of 2019. The partnership, with support from Healthcare Improvement Scotland's ihub[14], was aiming to design and deliver this in a co-produced way, with the third and independent sector providing substantial input.

Most independent and third sector providers were not content with the level of engagement with, and support provided by, the partnership. The partnership had taken some steps to address this and it intended to continue developing its work in this area. Improvements on how the partnership liaised with providers were needed in areas such as tendering processes, training and development.

The third sector interface was recruiting for a post to help enable the third sector to be a more effective collaborator in commissioning decisions. The partnership had more work to do to ensure that third and independent sector providers were meaningfully and sustainably involved in productive collaborative leadership on an ongoing basis.

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[12] Third sector interfaces (TSI) ensure the third sector is supported, developed and represented.
[13] The Public Bodies (Joint Working) (Scotland) Act 2014 requires each integration authority to establish a strategic planning group, which should be involved in all stages of developing and reviewing plans.
[14] Improvement Hub Healthcare Improvement Scotland provides support for the redesign and continuous improvement of health and social care services.

**Strategic commissioning**

The partnership did not have an overarching approach to the commissioning of services across all care settings to demonstrate how it would shift the balance of care. The partnership had yet to produce a formal commissioning strategy and market facilitation statement with accompanying plans. The partnership's understanding of local care markets was limited. Its approach to commissioning had been mostly single-agency based.

The partnership was at an early stage in linking investment to agreed outcomes, considering strategic options, planning the nature, range and quality of future services and working in partnership to put these in place.

Providers were keen to learn from the partnership about its market intelligence and its key messages for future service development. Helpfully, the partnership was working with Healthcare Improvement Scotland's ihub to re-energise its approaches to strategic commissioning.

The forthcoming commissioning strategy and accompanying market facilitation plans would set out the partnership's summary and medium-term commissioning intentions. The production of the commissioning strategy was not concurrent with strategic plan and its supporting financial plan.

There were challenges in ensuring local supply, capacity, quality and choice across social care services. There was a mixed economy in the care home, care at home and day services markets. The partnership's directly provided services had a minority share in key care markets. So, constructive relationships with third and independent sector providers were essential.

The partnership commissioned a wide range of externally provided services. Overall, these services were evaluated by the Care Inspectorate as 'good' with some exceptions in the care home sector. Directly provided regulated care services, evaluated by the Care Inspectorate, were underperforming in the care at home and housing support sectors. Other directly provided regulated care services were performing well.

To date, joint commissioning activity had focused on aspects of some older people's services. For example, bed-based intermediate care[15] service at a care home was successfully introduced as part of integrated care funding. The home for me project was in development and would support the partnership's performance on unscheduled care. Alcohol brief interventions projects had been purposefully commissioned too.

The partnership had successfully commissioned, with the council's housing services, several initiatives such as the Canal and Rapid Rehousing projects for homeless people.

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[15] An umbrella term describing services that provide a 'bridge' at key points of transition in a person's life, in particular from hospital to home (and from home to hospital) and from illness or injury to recovery and independence.

Jointly commissioned research on the housing and support needs of older people and the jointly funded care and repair service for older people and people with a physical disability were positive examples of close working with partner agencies.

Commissioning for some prevention services had started to help positively shift the balance of care. This was part of an approach aimed at developing provision delivered by small and medium-sized enterprises. However there had been limited movement in commissioning patterns of spend towards more preventative services with these types of providers.

**Care homes**

The partnership did not have a long-term, cross-sector approach that included its own direct provision and fitted with its strategic intentions for other elements of the care system. It did not have a comprehensive understanding of local needs and markets and was not fully engaged with providers to develop and deliver its future intentions for care home provision.

The partnership had experienced some success in changing the balance of care for older people by reducing the level of care home beds. It was still in the process of developing medium- to long-term plans for the provision of further community-based support for people with a physical disability or a mental health problem.

There were substantial numbers of people experiencing care whose needs were unable to be met within the East Dunbartonshire area and were receiving care at locations elsewhere. This was not always as a result of the person's choice. This was particularly true in care home and day services.

**Care at home**

The partnership did not have a whole-system approach to the commissioning of care at home services that incorporated all related aspects of service delivery such as supporting hospital discharge, preventing admission and promoting independence.

Care at home provision is a critical aspect of health and social care, so it was a major focus for the partnership in its attempt to achieve a shift in the balance of care towards community settings. Despite there being good performance in shifting the balance of care there were significant challenges in the care at home market. There were some difficulties associated with the implementation of the care at home framework agreement made four years previously to improve the quality and reliability of service delivery. A review of care at home, including directly provided services, was underway but taking longer than the partnership had anticipated.

The partnership had a high dependency on externally commissioned providers but there was as a lack of market facilitation. These providers were keen to be involved in the review but consultation and engagement had been limited and there was widespread concern from stakeholders that commissioning decisions were not always well informed. This combination of factors had led to ongoing and substantial risks for the partnership on the delivery of care at home services.

**Day services**

Within the day services market for older people and for people with learning disabilities there were challenges with capacity and choice. The partnership had a significant investment in centre-based service models. Some progress had been made in moving towards enabling greater choice for people with a learning disability, through local area co-ordination. This offered individual day opportunities with a greater choice of more flexible options for people experiencing care and their carers. However, this was at an early stage for older people.

**Commissioning, contract compliance and monitoring**

The partnership did not have universally effective approaches to procurement and contract management to help deliver the commissioning intentions and directions from the HSCP board. There were significant weaknesses in the delivery of the partnership's commissioning and contracting function. These included deploying sufficient resources to support the effective management of the current volume of contracts.

There were problems with the information systems that supported commissioning and contracting processes. The partnership was planning to introduce a new electronic system to help assist in this area. Contractual terms and conditions were in need of updating to better reflect current and future outcomes-based commissioning. Contract models did not always reflect the personalisation agenda and needed to offer more flexibility. Procurement procedures needed to be reviewed to reduce duplication. Some providers did not have written contracts. There were at least 170 purchasing arrangements with providers operating in different partnerships areas outside East Dunbartonshire. The commissioning team was not involved in cross-boundary commissioning, and relationships with other partnerships for cross-boundary placements were not always fully formalised.

A formal contract management, monitoring and review framework set out a risk-based approach to help ensure that contract management and monitoring activities were proportionate to risk. Overall, there was an inconsistent approach to how the contract management framework was implemented even within similar types of providers and care groups. The partnership had a well-trained commissioning and contracts team who demonstrated a suitable range of skills and expertise. Commissioning guidance was in draft form. Once published and shared, this would help inform a better understanding of the commissioning process across the partnership.

Many third and independent sector providers were generally dissatisfied with the level of contact they had or support the partnership provided to them. Where support had been offered, providers were very appreciative of the partnership's interest and input.

Commissioning officers were involved in relevant strategic planning and service redesign. The commissioning team was not formally involved with in-house services but had informed some improvements in the quality of in-house provision.

The partnership delivered its procurement services with the council, using a 'business partner' arrangement. Relationships were productive between the partnership's commissioning and contracts team and the council's procurement services. Formal 'business partner' documentation had not yet been developed. Partnership procurement and contract management arrangements needed to be shared with providers once produced.

Externally commissioned services were not prominently featured in the partnership's risk registers given the contract values and volume of services purchased. For example, there were substantial risks to the partnership in that many providers did not have a written contract. This had been highlighted by the council's internal audit service for several years. This was one of several risk areas relating to commissioning and contracting that had not been addressed over the same period.

Performance of external providers and themes, and issues identified through contract monitoring were reported to the senior management team but not reported regularly to the HSCP board and its performance, audit and risk committee.

**Housing agencies' contribution**

There were potential opportunities for housing agencies to play a more encompassed role in the work of the partnership in areas such as housing with care and support, telecare, intermediate care and day services. There were untapped resources that housing agencies could offer.

As the strategic housing body, the council was encouraged, as and when required, to participate in strategic planning forums such as the HSCP board meetings and the strategic planning group. Local authority housing representatives were invited to the locality groups. Attendance has been intermittent due to capacity challenges. Housing agency representatives had participated in some, but not all, care group planning and service redesign forums.

The partnership had a co-operative relationship with the strategic housing body. For example, regular housing and social work liaison meetings had been re-established. Areas of positive joint working included helping to deliver the council's strategic housing investment plan, with a focus on amenity and wheelchair-standard housing, and a review of older people's housing with care model.

Representatives from housing agencies and both council and registered social landlords were keen to be closely involved in service design from the outset. This had not always been the case. This was a missed opportunity to develop innovative preventative service models.

Relationships with other housing-with-care providers were mixed. These providers would benefit from more involvement in discussions on the future of housing and related support and their contribution to future commissioning intentions.

The housing contribution statement from the partnership's strategic plan had not fully set out what housing agencies could deliver together with health and social care organisations. The partnership's emergent-market facilitation plans could better complement the council's strategic housing investment plan.

This would help to demonstrate how the partnership intended to prioritise and allocate its resources, in cooperation with its housing partners, to realise the ambitions of the strategic plan.

**Primary care**

There was a positive and improving culture across primary care services. Staff described a culture in which communication across disciplines had improved. There were good working relationships between community-facing services across primary care services, for example, district nurses, allied health professionals and community mental health teams.

The partnership had developed a primary-care improvement plan. This helpfully showed how the partnership would facilitate the development of additional primary care services to help shift the balance of care and enable more integrated care service delivery in localities.

For example, the partnership had successfully established GP clusters[16]. There were examples of good-practice sharing across primary-care settings. There was a high level of engagement and involvement of clinical staff in supporting the improvements in performance.

Primary care staff had been involved in the preparation of the partnership's strategic plan and primary-care improvement plan. They were making a prominent contribution to the work of the clinical and care governance group and to locality planning. However, they were not always consulted on all relevant strategic planning matters.

Some GPs were mentoring staff who had taken on enhanced roles such as district nurses. Wellbeing workers effectively supported a number of GP practices with activities such as social prescribing[17]. Most care home residents had benefitted from well-developed enhanced GP services.

**Intermediate care and technology enabled care**

The partnership's intention was to develop a continuum model of intermediate care to help prevent avoidable hospital admissions and support people to receive care within their community. This included reablement[18] and technology enabled care.

As part of this approach, a bed-based intermediate care service at a care home was successfully introduced as part of integrated care funding in 2016. A positive evaluation of the intermediate care unit found that the project was successful in returning some service users back to their own home. This reduced the number of bed days lost and the number of people placed within care homes.

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[16] GP clusters are groups of GP practices in a close geographical location. Their purpose is to encourage GPs to take part in quality improvement activity with their peers and contribute to the oversight and development of their local healthcare system.

[17] Social prescribing involves helping people to improve their health and wellbeing by connecting them to community services.

[18] Reablement is a short and intensive service, usually delivered in the home, which is offered to people with disabilities, those who are frail or recovering from an illness or injury. It is generally given for up to a period of six weeks. The aim is to return people to an optimal level of functioning and maximise their capacity for self-care.

For these individuals, it had effectively delivered outcome-focused, person-centred support. On this basis, the project had been continued.

The care at home framework agreement set out that externally commissioned providers were expected, where possible, to adopt a reablement approach. In practice, it was mainly delivered directly by the partnership. This was being reviewed as part of the care at home review.

Technology enabled care was an area where the partnership performed poorly compared to other areas in Scotland. The partnership had recently published an assistive technology strategy (2018-23). It was not fully clear within the strategy's action plan how the partnership would meet the strategy's ambitions. To further develop its intermediate care options, the partnership was developing a supported hospital discharge home for me project to help reduce delayed discharges. Key elements of the continuum model of intermediate care were in place. There was additional work needed to fully deliver on its promise.

### Self-directed support[19]

While in 2017/18, the partnership had a higher level of direct payments recipients and associated expenditure compared to the national average, it had yet to fully demonstrate that its commissioning approaches were delivering a greater choice of personalised services. The further roll out of self-directed support was limited by a lack of care provider choice and limited third and independent sector service provider capacity. This meant that the ability to select direct payments, choose the service and the service provider, or a combination of all options was constrained.

### Quality assurance, self-evaluation and improvement

The partnership had developed a wide ranging and well organised clinical and care governance framework. Clinical governance arrangements were embedded and effective. A clinical and care governance group was directly accountable for continuously improving the quality of services, safeguarding standards of care and fostering an environment where excellence could grow within an integrated service. The group had suitable representation from a wide range of service areas.

The clinical and care governance group had a major role in managing operational risk and in interpreting the impact of strategic risk. It considered matters relating to strategic plan development, governance, risk management, service user feedback and complaints, standards, education, professional registration and validation, learning, continuous improvement, and inspection activity.

The work of the clinical and care governance group was mostly healthcare orientated and not yet fully integrated. There was a developing focus on social care services.

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[19] The Social Care (Self-Directed Support) (Scotland) Act 2013 placed a duty on local authority social work departments to offer people who are eligible for social care a range of choices over how they receive their support. Self-directed support options were: 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).

The group recognised that this was an area still under development and had taken some steps to develop a more integrated agenda. It acknowledged that there was also scope to ensure that there was closer alignment between the group's activities and the professional advisory group.

Clinical and care governance group reports were well focused on the Scottish Government's national health agendas on patient safety, clinical effectiveness and person-centred care. The reports also helpfully addressed wider aspects such as the partnership's organisational culture.

There were comprehensive and effective clinical and care reporting structures, liaison arrangements with appropriate links to the HSCP board, relevant NHS Greater Glasgow and Clyde forums, and the council's integrated social work services group and policy and resource committee. Care governance arrangements were in place for public protection.

The partnership did not always involve a wide enough range of stakeholders to provide feedback on the quality of services. There was limited evidence that services provided by externally commissioned providers were routinely considered by the group and this was an area for improvement. The partnership was not regularly collecting and analysing feedback from people with lived experience of services and their carers, who were receiving services from third and independent sector providers, to inform service review and future service health and social care delivery.

The partnership had a clear approach to quality assurance. It had brought together elements from established quality assurance models rather than following a single integrated framework. Service- and team-level arrangements comprised a combination of quantitative and qualitative methods.

These included indicators and measures reflecting national and local priorities and a range of self-evaluation, audit and consultative mechanisms to test the quality and performance of customer experience, organisational processes, and customer and organisational outcomes.

The partnership had undertaken a range of purposeful self-evaluation activities. These activities varied considerably in terms of the scale, detail and comprehensiveness. There were good examples of clinical and social care audits with recommended follow-up actions. These were usually undertaken in-house or occasionally by external bodies to help ensure a more independent approach.

Quantitative measures were included in the performance management framework. The partnership had also mapped more qualitative methods, including customer consultations, compliments and complaints, audits of the case records for people who experienced care and audits of performance against the partnership's own standards.

Complaints about health and social care services were recorded on the Datix management information system, investigated in accordance with the relevant corporate policy and discussed at the clinical care and governance group. Operational risks were discussed at the group.

High risks were escalated to the corporate risk register. There were clear governance arrangements in place for managing performance and risk and these contributed to service development and improvement.

Staff's perception of the partnership's approach to quality assurance was broadly positive but only a minority of respondents to our staff survey were confident that improvement plans were continually monitored and evaluated and just over half agreed that the quality of services for adults had improved since integration.

The partnership did not demonstrate how it identified priority areas for self-evaluation. It did not have a strategic and co-ordinated approach to ensure that intelligence gained from quality assurance mechanisms would better influence improvement. Linking self-evaluation directly to the priorities of the strategic plan to support overall performance delivery would be beneficial.

**Financial planning and sustainability**

There had been significant recent improvements in the level and effectiveness of joint working between the partnership and the council and NHS in the budget setting process for 2019/20. This included the creation of a financial planning and governance group that met regularly.

The HSCP board was responsible for scrutinising financial performance and ensuring that prompt corrective actions were taken where appropriate. Budget monitoring reports were reported to all meetings of the HSCP board. These reports provided good quality information to facilitate scrutiny and challenge by board members on the partnership's financial position.

Performance reporting and budget reporting were considered separately at meetings of the HSCP board and its performance, audit and risk committee respectively. HSCP board members did not therefore have a clear sight of the impact of variances against budget in terms of service performance.

The 2018/19 budget allocation to the HSCP was agreed at the June 2018 HSCP board meeting (£51.9 million from the council and £77.2 million from NHS Greater Glasgow and Clyde Health, which excluded the set-aside[20] funding for acute hospital sites). This identified a £4.6 million funding gap.

NHS Greater Glasgow and Clyde Health had undertaken work to more accurately estimate hospital and acute (set-aside) services usage to provide a realistic set-aside budget for a three-year period. The HSCP board was implementing a medium-term financial plan, however, a long-term (five years and over) financial plan had yet to be produced. This was in part due to longer-term financial uncertainties in financial settlements from the council and the NHS. The partnership's reserves policy, approved in August 2016, set out the arrangements for addressing and financing any overspends or underspends.

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[20] Activity based budget for commissioned hospital services used by the integration authority population as set out in the strategic plan. This is the amount required to be set aside by the health board for use by the integration authority

The policy provided for a prudent level of reserves linked to net expenditure, which was recommended to be 2%. Following the projected draw down in 2018/19, the level of closing reserves projected placed the application of the reserves policy at risk. The financial recovery plan approved by the HSCP board in May 2018 demonstrated that plans were in place to return to compliance with the reserves policy.

As at November 2018, the partnership was projecting an overspend of £2.885 million for 2018/19. Financial planning for 2019/20 identified a projected substantial financial gap and therefore a further significant level of savings would be required. There were substantial risks to the successful delivery of these savings. As part of the partnership's transformation programme, identified savings included service reviews of care at home, disability services, eligibility of access to social work services and charging arrangements. The identification and achievement of recurring savings would be essential to the long-term sustainability of the partnership's financial position. It was important that the partnership delivered its transformational change at a pace that facilitated the service redesign that was required to meet its integration agenda and the strategic plan's priorities. The pace of transformation needed be accelerated for significant recurring savings to be achieved.

Some recent developments had been planned in detail, had clear strategic objectives and took account of the financial position. For example, the policy on fair access to community care was designed to ensure that the partnership met its statutory responsibilities, but did so in a way so that increasing demand could be met within the overall allocation of resources and be financially sustainable. Likewise, the associated eligibility criteria were designed to more clearly reflect the important role for early intervention and prevention.

## 5. Leadership and direction

### Leadership of vision, values and culture

The partnership had a clearly articulated vision, values and aims for health and social care services. Leaders had invested time and effort into developing and agreeing the partnership's values and vision. However, it was evident that a wider range of stakeholders did not always reflect it in their own vision, values, aims and plans. The professional advisory group had initially led work on creating and promoting the partnership's vision. It focused on engagement with staff, and people experiencing care and their carers on the professional values for the partnership. During 2018, work was further undertaken to share, promote and cascade the vision and values to staff at all levels. A manager's toolkit was helpfully developed to support this.

Leaders strongly held the view that successful integration had to be built on a shared vision and values. The partnership's approach to creating its vision had been inclusive. Leaders' efforts to develop and share the vision and values had started to deliver results. This was commendable, particularly as leaders had had to engage with staff working in children's and criminal justice social work services as well as all adult services staff. (These services had not originally been included in the partnership's integration scheme but were introduced in July 2016). In our staff survey, nearly three-quarters (73%) of respondents agreed that they were aware of the partnership's vision for health and social care services. However, there was a substantial variability in the extent to which staff, in particular at practitioner and team manager levels, were aware of the partnership's vision.

The findings for questions related to leadership in our survey were generally positive (with levels of agreement greater than levels of disagreement). However, the levels of agreement within NHS staff cohorts were noticeably higher than among council employed staff. Most staff, both NHS and council, expressed the view that the level and quality of communication from senior management had recently improved but there was still some way to go.

In general, staff saw managers at all levels as being supportive and visible. In our staff survey, 59% of respondents agreed that leaders were visible. Likewise, 53% of respondents agreed that leaders created a trusting, positive, sharing and open organisational structure. HSCP board members were not as visible to many staff, particularly at practitioner and team manager levels, or to people experiencing care. It could be a challenge for them to be regularly visible to all stakeholders. Promoting the HSCP board's profile to help make its role and membership more prominent to all stakeholders and provide a better recognition of its purpose, aims and values was included in the partnership's 2017 communications framework. This would benefit from being refreshed.

## Leadership of strategy and direction

There had been several significant changes in the senior management of the partnership during the previous two years. Staff and managers particularly welcomed the arrival of two heads of service after a period in which there had been a gap in management capacity at this level. During this period there had been limited progress in taking forward the integration agenda. The relatively new senior leadership team had focused on the immediate priorities, ensuring that the essential building blocks of integration were in place. They were yet to deliver on the partnership's wider transformational agenda.

There were key areas where leaders had yet to fully demonstrate how their leadership was realising the partnership's strategy. There were risks that leaders were not achieving change at a pace required to meet the strategic plan's priorities. These included delivering the financial recovery plan, developing innovative services that were positively changing the balance of care, and improving services such as those delivered directly by the partnership in sectors such as care at home and housing support. Leaders had not yet set out their overarching approach to the commissioning of services across all care settings and had yet to undertake market facilitation in key care sectors. The partnership had detailed operational planning processes, but it was not ensuring that all of these were joined up. There were limited opportunities for some key stakeholders such as the third and independent sector providers to fully contribute to how services were planned, commissioned and delivered.

Leaders were aware of the need to move forward at pace, partly because of financial imperatives. However, some areas of service redesign had been going on for some considerable time. The partnership had set itself some challenging timescales and while this was positive, in light of its recent track record on delivering timeous improvements, the partnership's ability to achieve these were overly optimistic. Timescales for service reviews and redesign had been frequently extended. The delivery of the required major improvement projects and programmes had some way to go.

## Workforce planning

Leaders had made efforts to bring staff together in a way that built upon their existing values, while creating a distinct new identity and shared vision for the partnership. A commitment to supporting a healthy working culture was a feature of both the partnership's strategic and workforce and organisational development plans (2018–2021). The establishment of the partnership brought together a diverse workforce from two organisations (the council and NHS Greater Glasgow and Clyde) and both had their own established cultures and subcultures. The position was further complicated because, as well as its initial focus on staff working in adult services, the leadership then had to include staff working in children's and criminal justice social work services.

Leaders were trying to ameliorate the effects of persistently very high sickness absence levels, in particular among council staff. This was a particular issue for long-term absences. These absence levels were contributing to the risks of delivering the partnership's improvement plans and future financial viability. Improvements were needed in how appropriate professional development and supervision was undertaken and recorded.

The partnership's workforce and organisational development plan was based on a six-step model for integrated health and social care services. It usefully laid out a profile of the current workforce, the future demand drivers and, on a high-level basis, some of the workforce changes and developments that were likely to be required as integration and new models of care developed. It was not yet at a stage where there were detailed plans of how this would be achieved.

The partnership had purposefully concentrated its workforce planning on its own staff. It had given limited consideration to the broader workforce in health and social care such as those working in the third and independent sector. This reflected to some degree the national picture. Leaders reported that they planned to consider the broader workforce during 2019/20 as part of the development of the commissioning strategy and as part of their work priorities for that year. In our staff survey, exactly half of respondents agreed that they were aware of the workforce planning arrangements currently in place to support the integration of health and social care across the partnership and within localities.

Embedded human resources and organisational development support from NHS Greater Glasgow and Clyde and East Dunbartonshire worked well, with the range of human resources functions being delivered effectively.

The partnership faced several recruitment and retention pressures, including for band-six community nurses who hold the specialist practitioner qualifications, care at home staff and mental health officers. It had plans in place to address these.

Staff, managers and HSCP board members were generally positive about how integrated working relationships had progressed. In our staff survey, almost all (94%) of respondents agreed that they clearly understood their role and responsibilities.

A majority agreed that they had good opportunities for single-agency training and professional development and that senior managers identified and disseminated good practice. An area for further development was access to integrated training and development opportunities. Leaders should build on what is currently available to further support the integration of its workforce.

The co-location of staff at the health and social care centre in Kirkintilloch was widely described as having significantly enhanced integrated working, particularly in the east locality. Things were less well developed in the west locality. There were plans to develop a health and care service site in the west locality and to co-locate staff there. An interim plan had been developed to promote co-location pending site development. The delivery was dependent on agreement on capital investment from the council and the NHS.

The partnership had helpfully produced a property strategy that was agreed in May 2018. NHS Greater Glasgow and Clyde and the council confirmed their intention to support co-location, where possible, across the health, social care and wider property estate.

**Governance**

Leaders had given detailed attention to the structures and governance arrangements to support integration. HSCP board members and senior officers had forged constructive working relationships. Leaders understood how the strategic plan helped to implement the partnership's vision. HSCP board members expressed confidence in the function of the board and their role within it.

Leaders were committed to supporting HSCP members and helping them to develop the knowledge, skills and abilities required for the role. There was a programme of support and development for both the elected and non-elected members of the HSCP board to improve its functioning. HSCP board members' levels of understanding of key strategic planning commissioning and communication issues were varied. They acknowledged that they needed to further develop their knowledge and understanding of integrated services, particularly service areas that were less familiar to them.

Improvements were needed to help enable the HSCP board and the strategic planning group to more effectively discharge their responsibilities. The HSCP board was not always pro-actively driving the partnership's change agendas. The strategic planning group was not always effectively informing the HSCP board's decision making. Many of the partnership's key strategies, plans and service redesigns were not given enough prominence in the work of the group. This was a missed opportunity. The strategic planning group had a satisfactory range of stakeholder representation but there were inconsistencies in membership attendance. This hampered the group's work and its capacity to exercise appropriate leadership.

Strategic planning group members did not always have a fully rounded understanding of anticipated emergent trends and how these may relate to service design and strategic commissioning. They did not all have access to a programme of support and development that HSCP board members had. The strategic planning group had recently reviewed its remit and practice. The chief officer chaired the strategic planning group but recognised that to strengthen the accountability of the group's work, the chair should be a HSCP board member. Further improvements were in preparation but not yet implemented.

Leaders had ensured that there was effective clinical and professional leadership that supported the delivery of services. There were effective clinical and care reporting structures with appropriate links to the HSCP board, relevant NHS Greater Glasgow and Clyde governance forums, the council's integrated social work services group, and the policy and resource committee. While there was potential to further integrate its approach, the partnership was generally making progress.

**Risk**

The partnership's approach to strategic risk assessment and management was satisfactory but still evolving. It had strengthened its approach but needed to develop it further. In August 2017, the partnership approved its risk management policy and in November 2017 approved a refreshed and updated corporate risk register.

Information on the performance of social care services, by externally commissioned providers on behalf of the partnership, was reported to the senior management team. It was not reported regularly to the HSCP board or its performance, audit and risk subcommittee. The partnership should review this given the scale of its commissioned activity and the potential risks involved.

There were risks that leaders were not achieving transformational change at a pace required to meet the partnership's strategic priorities. The senior leadership team had focused on the immediate governance and organisational priorities were in place to support integration. They were yet to deliver on the required transformation agenda.

A substantial financial gap was projected in future years. There were major risks for the partnership that were associated with the delivery of its current financial recovery plan and its medium-term financial plans. If not successfully managed, these risks would adversely affect the partnership's ability to deliver the transformation programme essential to delivering integrated heath and social care services and the long-term sustainability of the partnership's financial position.

## 6. Evaluations and areas for development

### Quality indicator 1: Key performance outcomes
### 1.1 Improvements in partnership performance in both healthcare and social care

The partnership was performing comparatively well against other integration authorities, as measured against a range of nationally published datasets. The partnership was improving how it measured its performance and was regularly reporting clearly what progress it was making. It had undertaken some good work on finding out the views of people about the services they experienced. There was an improving picture on how the partnership was using this information to make further improvements.

However, performance management reporting was not always used to identify priority areas for self-evaluation or to demonstrate best value. The way in which the partnership compared its performance with other integration authorities was limited and this did not help to inform planning and commissioning decisions.

**Evaluation: Good**


### Quality indicator 6: Policy development and plans to support improvement in service
### 6.1 Operational and strategic planning arrangements
### 6.3 Quality assurance, self-evaluation and improvement
### 6.5 Commissioning arrangements

The partnership had clear strategic priorities and plans. There was a comprehensive strategic needs assessment in place. There were productive planning relationships with other partnerships across NHS Greater Glasgow and Clyde.

There were complex planning processes that lacked detail on how the priorities would be delivered. It was difficult to track how the partnership intended to deliver on its strategic intentions. Relevant stakeholders were not always afforded the opportunity to contribute to the strategic planning or service reviews at all the key moments. The strategic plan was not backed up by a detailed commissioning strategy and associated market facilitation plans.

There were big challenges in ensuring an appropriate supply, quality and choice across services. There were weaknesses in how services were procured and monitored. The partnership had developed wide ranging and well organised clinical and care governance arrangements. These were embedded and effective, particularly in clinical settings, but not yet fully integrated.

**Evaluation: Adequate**

**Quality indicator 9: Leadership and direction that promotes partnership**

**9.1 Vision, values and culture across the partnership**
**9.2 Leadership of strategy and direction**

Leaders had made positive efforts to bring staff together in a way that built upon their existing values, while creating a shared vision. Recent senior managerial changes had provided a fresh sense of positive momentum. However, there was room for improvement in ensuring effective communication across all staff groups. Leaders had given detailed attention to the structures and governance arrangements to support integration. Improvements were needed to help enable the strategic planning group and HSCP board to more effectively discharge their responsibilities.

The partnership's workforce planning usefully focused on integration. It needed to continue to address longstanding challenges in reducing high absence levels in its own workforce, in particular the council's.

There were risks for the partnership associated with the delivery with its current financial recovery plan as well as delivering on its medium-term financial plans. These risks, if not successfully managed, would adversely affect the partnership's ability to deliver the transformation programme essential to the delivery of integrated health and social care services and the long-term sustainability of the partnership's financial position.

**Evaluation: Adequate**

**Evaluation summary**

| Quality indicator | | Evaluation | Evaluation criteria |
|---|---|---|---|
| 1 | Performance | **Good** | **Excellent** – outstanding, sector leading |
| | | | **Very good** – major strengths |
| | | | **Good** – important strengths with some areas for improvement |
| 6 | Strategic planning and commissioning | **Adequate** | **Adequate** – strengths just outweigh weaknesses |
| 9 | Leadership and direction | **Adequate** | **Weak** – important weaknesses |
| | | | **Unsatisfactory** – major weaknesses |

| | Areas for development |
|---|---|
| 1 | The partnership should improve its approaches to performance measurement and management of:<br>• national and local datasets<br>• teams, services and localities<br>• benchmarking<br>• qualitative data<br>• outcome-focused data.<br><br>It should ensure that it uses relevant information to identify priority areas for self-evaluation and self-assessment, and drive identified improvements. |
| 2 | The partnership should improve its strategic planning processes showing how:<br>• SMART principles are met<br>• strategic and locality needs information is updated<br>• priorities are to be resourced<br>• organisational development planning will be taken forward<br>• fully costed action plans including plans for investment and disinvestment will be implemented based on identified future needs<br>• expected measurable outcomes will be delivered. |
| 3 | The partnership should improve its approaches to engagement and involvement with stakeholders in relation to:<br>• strategic and local planning<br>• transformation<br>• service redesign<br>• commissioning<br>• market facilitation. |
| 4 | The partnership should work closely with a full range of stakeholders to develop and implement a commissioning strategy and associated cross-sector market facilitation plans. |
| 5 | The partnership should develop and implement a detailed long-term financial plan to ensure a sustainable financial position is achieved by the HSCP board. |

**7. Conclusion**

Scottish Ministers have asked the Care Inspectorate and Healthcare Improvement Scotland to assess the progress made by health and social care partnerships in delivering better, more effective and person-led services through integration. In doing so, we took into account the partnership's ability to:

- improve performance in both health and social care
- develop and implement operational and strategic planning arrangements, and commissioning arrangements
- establish a vision, values and aims across the partnership and the leadership of strategy and direction.

We concluded that there was clear evidence the partnership was progressing integration across health and social care settings and a positive culture of collaborative leadership was developing. We were confident that the partnership had the capacity to make further progress. Our confidence in its ability to do so was tempered by the scale of transformation required and the very challenging financial context.

This joint inspection's findings indicate that the partnership has the capacity to progress the identified areas for improvement. We anticipate that it can build on the progress made to date and move towards the more efficient and effective integration of health and social care services.

It is important that the partnership progresses the identified areas for improvement in relation to its performance, strategic planning and commissioning and leadership on integration. If the partnership does this, we can be more confident that the partnership will move forward with the integration of health and social care.

# Appendix 1 - Quality improvement framework

**Appendix 1 – Quality Improvement Framework**

| 1. Key performance outcomes | 4. Impact on the community | 6. Policy development and plans to support improvement in service | 7. Management and support of staff | 9. Leadership and direction that promotes partnership |
|---|---|---|---|---|
| **We assessed 1.1** Improvements in partnership performance in both healthcare and social care | 4.1 Public confidence in community services and community engagement | **We assessed 6.1** Operational and strategic planning arrangements | 7.1 Recruitment and retention | **We assessed 9.1** Vision, values and culture across the partnership |
| 1.2 Improvements in the health and wellbeing and outcomes for people, carers and families | **5. Delivery of key processes** | 6.2 Partnership development of a range of early intervention and support services | 7.2 Deployment, joint working and team work | **We assessed 9.2** Leadership of strategy and direction |
| **2. Getting help at the right time** | 5.1 Access to support | **We assessed 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 | **We assessed 6.5** Commissioning arrangements | 8.1 Management of resources | **10. Capacity for improvement** |
| 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 |
| **3. Impact on staff** | | | 8.3 Partnership arrangements | |
| 3.1 Staff motivation and support | | | | |

◀ ─────────── **What is our capacity for improvement?** ─────────── ▶
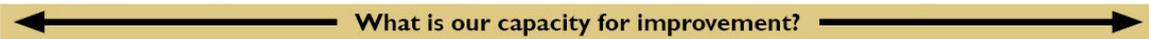
## Appendix 2 – Inspection methodology

Our inspection of the East Dunbartonshire health and social care partnership was carried out over three phases.

### Phase 1 – Planning and information gathering

The inspection team collated and analysed information requested from the partnership. The inspection team sourced other information before the inspection started. Additional information was provided during fieldwork.

### Phase 2 – Staff survey and fieldwork

We issued a survey to 662 staff. Of those, 279 (45%) responded. We also carried out fieldwork activity over 7.5 days, during which we interviewed a number of people who hold a range of responsibilities across the partnership. The partnership offered a number of observational sessions, which inspectors attended where they had capacity.

### Phase 3 – Reporting

The Care Inspectorate and Healthcare Improvement Scotland have jointly published this 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.

To find out more visit www.careinspectorate.com or www.healthcareimprovementscotland.org.

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The Healthcare Environment Inspectorate, the Scottish Health Council, the Scottish Health Technologies Group, the Scottish Intercollegiate Guidelines Network (SIGN) and the Scottish Medicines Consortium are part of our organisation.