JOINT INSPECTION (ADULTS)

The effectiveness of strategic planning in

Perth & Kinross Health and Social Care Partnership

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September 2019

The Care Inspectorate is the official body responsible for inspecting standards of care in Scotland. That means we regulate and inspect care services to make sure they meet the right standards. We also carry out joint inspections with other bodies to check how well different organisations in local areas are working to support adults and children. We help ensure social work, including criminal justice social work, meets high standards.

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Contents

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 coordinated 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, and
- 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 Perth & Kinross Health and Social Care Partnership (HSCP) 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 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. This provides assurance about the quality of services and the difference those services are making to people in communities across Scotland.

The HSCP comprised Perth & Kinross Council and NHS Tayside, and is referred to as 'the partnership' throughout this report. The scope of the inspection covered a period of two years from February 2017 to February 2019. The inspection activity took place between January 2019 and March 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 2. There is a summary of the methodology in Appendix 3. In order that our joint inspections remain relevant and

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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.

add value, we may refine our scrutiny methods and tools as we learn from each inspection.

2. Perth and Kinross context

Geographical
Perth and Kinross is located in Central Scotland, covering 5,286 square kilometres, and shares borders with the areas of Aberdeenshire, Angus, Highland, Clackmannanshire, Dundee, Fife and Stirling.

Demographic
On 30 June 2018, the population of Perth and Kinross was 151,290. This was an increase of 0.1% from 151,100 in 2017. In terms of overall size, the 45-64 age group was the largest in 2018, with a population of 43,900. In contrast the 15-24 age group was the smallest, with a population of 15,753.

Demographic projections
Over the next ten years, the population of Perth and Kinross is projected to both increase by 4.5% and shift in composition. Contributing factors are a projected 1.9% decrease due to natural change (more deaths than births) but total net migration is projected to contribute a population increase of 6.5% over the same period.

The average age of the population of Perth and Kinross is projected to increase as the "baby boomer" generation ages and more people are expected to live longer.

Between 2016 and 2026, the 16 to 24 age group is projected to see the largest percentage decrease (-9.9%) and the 75 and over age group is projected to see the largest percentage increase (+33.1%). In terms of size, however the 45 to 64 age group is projected to remain the largest age group.

Service demand impacts
The key challenges for Perth and Kinross in response to the shift in composition of the population include the rising demand for services, whilst managing changes to public services and the impact of a reduction in the financial budget. There is also a predicted increase in the number of people in Perth and Kinross living with dementia and long term conditions. To address this, new models of care are required in order to reduce the use of large hospital services and there needs to be greater investment in community health and social care services. These will enable people to be supported in and by their local community, for example through the Communities First Transformation Project.

Reducing unplanned admissions to hospital and delayed discharges remains a key priority for the partnership. This is a difficult priority as it requires a large number of partners to work collaboratively including GPs, the Scottish Ambulance Service, independent care providers and third sector health and social work staff to deliver person-centred care.

Political

Perth & Kinross Council comprises 12 electoral wards and 40 elected members. Currently the administrative partnership includes the Scottish Conservative and Unionist Party Group and the Scottish Liberal Democrat Group.

At the Scottish Parliament, Perth and Kinross is represented by two constituency seats – Perthshire South & Kinross-shire and Perthshire North, both represented by the Scottish National Party. At the UK Parliament, Perth and North Perthshire is represented by the Scottish National Party and Ochil and South Perthshire by the Conservative and Unionist Party.

Economic

In 2018, 77.9% of people of working age (16–64) in Perth and Kinross were in employment. This shows an increase of 1.1% against the previous full year and is well above the average for Scotland. In 2017, the percentage of workless households in Perth and Kinross remained steady at 15.3% continuing to remain below the average across Scotland (18%) for the same period.

Inequalities

Although Perth and Kinross has relatively low levels of deprivation compared to other areas of Scotland, it has key areas of deprivation. The 2016 Scottish Index of Multiple Deprivation (SIMD) identified that parts of Perth City and Rattray are among the 10% most deprived areas of Scotland. Approximately 85% of the most deprived residents live in Perth City, with the remainder living in North Perthshire, acknowledging the weaknesses in SIMD to understand deprivation across an area of this nature. "Access deprived" people in rural communities have challenges accessing services and support. These inequalities between different communities are in part responsible for the significant health inequalities that exist locally.

Individuals living in an area of high deprivation are more likely to experience poor health over the long term compared to individuals in a less deprived area. Life expectancy in Perth and Kinross for males and females decreased where levels of deprivation increased, particularly for males. Inequalities in health between people living in the most deprived and least deprived areas are evident given that male life expectancy ranges from 75–81 years and female life expectancy ranges from 80-84 years, depending on where people live within Perth and Kinross.

Governance

Perth and Kinross Integrated Joint Board (IJB) was formed in November 2016. The IJB has responsibility for strategic commissioning and planning. It also manages a range of hosted services on behalf of NHS Tayside, Angus and Dundee partnerships. Hosted services include all general adult psychiatry, learning disability, substance misuse, inpatient services for Tayside, prisoner healthcare, community dentistry and podiatry.

Financial position

The budget as at the end of 2018/19 for Perth and Kinross HSCP was £213 million. Strong financial planning is required to ensure that the partnership's limited resources are targeted to maximise the contribution to their objectives. The partnership, like other public sector bodies, is facing financial challenges and will need to operate within tight constraints as a result of the difficult national economic outlook and the increasing demand for services.

During 2017/18, the partnership achieved a balanced budget position despite there being key pressures on the system, where demand is currently outstripping available resources.

3. Inspection findings

Performance

A review of the partnership's performance against national outcome measures showed that across several indicators the partnership's performance was in line with the Scottish average. Senior partnership staff recognised that the performance focus had been on capacity and flow in the hospital. This had resulted in improvements in the number of people delayed in hospital and the number of people being readmitted within 28 days of going home. The progress that the partnership had made in reducing unscheduled care[2] was evident in the staff survey. Respondents mostly agreed (68%) that the partnership promoted early intervention and prevention to ensure that fewer people were admitted to hospital.

The partnership's delayed discharge levels were historically high. To enable the partnership to address this, a number of initiatives had been implemented. These included the discharge hub, frailty model and the Home Assessment and Rehabilitation Team (HART). The partnership also ensured that each adult in hospital was regularly monitored and had a planned date for discharge from hospital. As a result of this, the number of lost bed days due to delayed discharges had decreased. The partnership was performing slightly better than the national average. There had been a modest decrease for the 18–74 age group and there had been a greater decrease for the older age group aged 75+. Both age groups showed a further reduction over the three or four months prior to the inspection. These are positive developments, however it is too soon to ascertain if this reduction will be sustainable.

The partnership's performance was better than the Scottish average in some areas when 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]. These included:

- the number of people attending hospital as a result of an emergency and the associated bed days occupied
- the number of people being readmitted to hospital within 28 days of going home
- delivery of care at home and intensive home care for adults aged under 65
- the percentage of the last six months of life spent at home or in the community, and
- the proportion of people both referred for dementia post-diagnostic support and completing it.

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[2] Unscheduled Care" is defined as NHS care which cannot reasonably be foreseen or planned in advance of contact with the relevant healthcare professional, or is care which, unavoidably, is out with the core working period of NHS Scotland. It follows that such demand can occur at any time and that services to meet this demand must be available 24 hours a day.
[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.

Areas in which the partnership did not perform as well as other partnerships in Scotland included:

- delivery of care at home and intensive home care for adults aged over 65
- the use of community alarms and assistive technology to maintain people's independence and ability to realise their choice to remain at home
- the proportion of adults agreeing that the services they received had allowed them to maintain or improve their quality of life
- the number of long stay residents in care homes, and
- the average length of stay for people living in care homes.

Operational performance monitoring

The partnership had not put in place a robust performance framework that allowed it to systematically monitor performance across all its activities and service areas. This meant that whilst there was some performance information available in relation to specific initiatives or for specific teams, senior managers and the IJB did not have a comprehensive picture of how well the partnership was performing. They could not, therefore, routinely identify and capitalise on areas of strength or effectively focus resources and improvement activity where it was needed.

The partnership demonstrated the ability to capture and analyse performance information effectively in a number of key areas which were a focus for their attention. A performance monitoring framework had been implemented in the mental health inpatient unit and for HMP Perth health services, in response to identified operational risks. Other areas where performance information was used effectively included unscheduled care and prescribing.

In unscheduled care, the partnership had developed an integrated discharge hub and frailty models for Perth Royal Infirmary, which were introduced to address the unsustainable use of elective care beds for acute medical care and to ensure timely discharge. Robust performance monitoring of the impact of these services had shown improvement. There had been a reduction in the number of people with acute medical conditions using beds designated for planned surgery. This had reduced the number of planned surgeries being cancelled. The discharge and frailty teams had a clear understanding of their performance and had used this to continually monitor the impact of the improvements. The teams were planning to include personal outcomes in their performance monitoring to make it more robust and meaningful.

In prescribing, the associate medical director of the partnership had reviewed the prescribing budget in order to gain a better understanding of the factors affecting prescribing and ultimately, to reduce costs. This led to the identification of areas of improvement and further discussions relating to the variance in prescribing across different GP clusters. This work identified factors for prescribing which were believed to be specific to the Perth and Kinross population within the NHS Tayside area. This data will be used to seek a review of the funding arrangement with NHS Tayside to

reflect the differential prescribing needs of the three partnerships. Detailed monthly reports have been developed in conjunction with information services division Scotland to assess spend and variance.

Another new initiative, the HART team, could evidence through the use of performance information that it had a positive impact on reducing delayed discharge. However, despite anecdotal evidence of positive outcomes from people as a result of the team's interventions, there was no formal mechanism in place to monitor the performance or wider impact of the team. The HART team focused on supporting people being discharged from hospital and combined care at home and reablement. It was providing a "discharge to assess[5]" model. The HART team provided support for up to six weeks after discharge and carried out assessments in a person's home. The team then agreed the package of care required for the individual and made the necessary arrangements for a provider to deliver. The HART team delivered positive results and reduced the number of delayed discharges. However, for the positive outcomes to be sustained there had to be effective community services with sufficient capacity. The partnership was not monitoring the impact on community services. Specifically, we heard about frequent onward referral from the HART team for 15-minute care at home community check visits. Fulfilling these visits posed a problem for care at home providers as these visits increase travel time between visits. The partnership has not developed an action plan to evaluate or address this impact.

Unfortunately, these positive examples of the use of performance monitoring information were not representative of a more comprehensive approach.

Performance management
The partnership was at an early stage in developing a more systematic approach to performance management which could inform strategic planning. It planned to do this through the clinical and care governance forum and the new strategic programme boards that the partnership has established to support improvement in key areas of service delivery.

The partnership intended that its Care and Clinical Governance Performance Management Framework would be aligned to the national Health and Social Care Standards. It would illustrate demand for services and associated workforce planning requirements. It would also support the allocation of resources, including finances to ensure that both care and support met the partnership's aims. Community health data would be a key component of this framework, however, the partnership and NHS Tayside had so far been unable to agree a process for sharing this.

The partnership had implemented new strategic programme boards to drive the strategic direction for primary care, older people's unscheduled care, support for

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[5] Discharge to Assess is an integrated person-centred approach to the safe and timely transfer of medically ready patients from an acute hospital to a community setting for the assessment of their health and/or social care needs.

unpaid carers and mental health. It is in the terms of reference for each of these boards (with the exception of mental health and wellbeing) that they would be responsible for developing a performance framework. The partnership had set out, in its draft strategic framework for the programme boards, how they would be supported to develop their performance frameworks and use data. However, there was not always capacity to provide this support in practice. There was no mechanism to develop an overall integrated performance framework for oversight of the IJB's performance, or to ensure that the performance frameworks would be aligned with each other to provide a coherent overall picture.

During the two year period of the inspection the partnership had poor strategic leadership of performance. Senior members of staff had responsibilities for leading performance. However, the partnership acknowledged that there was confusion about the different roles and responsibilities. There was no evidence of an integrated approach to monitoring and reporting performance data. Senior staff meetings did not prioritise performance analysis. Meaningful use of data at locality level was hindered by a lack of support resource available to staff. The partnership did not have a robust performance framework aligned to the Strategic Commissioning Plan (SCP) to measure progress, or to measure performance against their strategic priorities.

The partnership also lacked a structure for the development of integrated performance reporting arrangements which are required for risk management, locality managers and the IJB. Performance information did not appear as a routine standing item on the agenda of senior staff meetings. Until recently the IJB audit and performance committees did not regularly receive performance information. It was noted that minimal performance information was shared with the IJB – the exceptions being one delayed discharge report in March 2018 and their own annual report. The Older People's Unscheduled Care Board report in February 2019 was the first of a regular series of reports to be scrutinised by the members. The partnership staff who created the report and IJB members agreed that more work needed to be done to agree the format and content of the report and improve the quality.

There was a lack of clarity about what data was available to staff or how it might be accessed, used or shared. Just over a third (38%) of respondents agreed that the partnership provides feedback to staff on how well they are doing to meet locally and nationally set targets and how this compares to other partnerships around Scotland. Staff need the skills and knowledge on how to make the best use of data to support key outcomes, and to prioritise and allocate resources.

There was a lack of clarity about where the data was routinely sent to and where responsibility for reviewing performance and monitoring of the data was located. Limited performance information was available to locality managers, although they could access caseload and operational activity data from the social care case

recording system and were provided with delayed discharge data. However, similar operational and caseload information is not routinely drawn from community health data. The three localities reported that this had led to difficulties in demonstrating the impact of service provision and delivery and identifying areas of need within their respective localities.

Annual performance report

The partnership published its annual performance reports in line with legislative requirements. The format was useful, and made the reports easy to read and understand. The reports demonstrated how significant decisions had contributed to progress towards the health and wellbeing outcomes. Additionally, the partnership's performance was compared to the national average. However, performance was not assessed against the intentions stated in the strategic commissioning plan. There was no evidence about how stakeholders had been engaged and consulted. The annual reports were missing information which best practice would suggest should be included. For example, the financial statement in the performance reports did not include how the money spent had contributed to achieving the health and wellbeing outcomes. Additionally, there was no information about budgets or expenditure at locality level.

Strategic needs assessment

Strategic needs assessment data was integrated into the partnership's first strategic commissioning plan. This data supported the strategic priorities and actions set out in the plan. However, the entirety of the data had not been published by the partnership and it was not available to the partner organisations to assist them in planning and developing their services. Additionally, the information had not been systematically updated and reviewed on an ongoing basis in order to identify changes in patterns of need, trends and service activity. A number of factors contributed to the inconsistency of updating the information. These included data being on different systems, limited analyst capacity, data sharing restrictions and delays in accessing data.

It was positive that the partnership had developed an improved strategic needs assessment to support its next strategic commissioning plan and locality working. This aimed to provide a wider range of data on demographic profiles, service activity and costs at a locality level. This should support the identification of service gaps, help to predict future need and drive improvement.

Strategic planning 2016–2019

The partnership's first strategic commissioning plan (2016–2019) set out five strategic priorities. These were underpinned by a wide range of ambitious actions across the services and activities for which the partnership had responsibility. The partnership had not maintained a balanced and effective approach to implementing all of its priorities. The partnership had allocated significantly more management

capacity, effort and performance management in reaction to existing operational pressures rather than addressing longer term strategic challenges. As a result, the partnership had made progress in some key priority areas such as reducing delayed discharges and maintaining slightly lower levels of unscheduled care than the Scottish average. Other priorities like workforce and complex care were progressing slowly, without a developed strategy.

The capacity required to take forward the redesign of hosted mental health and learning disability inpatient services had impacted negatively on the delivery of other priorities. However, it was not possible to conclude that this was the single reason for lack of progress in some areas. This is because the partnership had not sufficiently taken into account its capacity to deliver the ambitious range of actions within its plans. It had also not given enough consideration to whether the actions were achievable and realistic or how their success would be measured. Timescales were routinely extended, indicating that plans were not grounded in effective programme and project management. Oversight from management teams was ineffective and there were infrequent attempts to evaluate the impact of actions in order to inform future planning.

The partnership had made significant progress in implementing a number of actions from its strategic commissioning plan (2016–2019), including:

- retendering care at home services
- development of the HART "discharge to assess" model
- redesign of day services
- development of localities
- implementation of communities first (building community capacity to respond to need in different ways)
- engagement with NHS Tayside to establish an integrated clinical strategy, and
- successfully moving resources from inpatient provision for people with dementia to post diagnostic support and care home liaison.

The partnership's approach to unscheduled care and reducing delayed discharges demonstrated its ability to develop and implement a coordinated approach to addressing challenges faced by different parts of the health and social care system. The multi-agency Older Persons Service Improvement Group (OPSIG) coordinated the planning and development of the frailty model, discharge hub and HART team. These services aimed to maintain patient flow from hospital to the community. The plans were founded through the development of positive working relationships with clinicians at Perth Royal Infirmary and other NHS Tayside colleagues.

The partnership had devoted significant effort and capacity to consultation, development and selection of options for the redesign of inpatient mental health and learning disability services, which it hosted on behalf of the three Tayside HSCPs. It was concerning that the partnership did not take a coordinated approach to

redesigning mental health services from the outset. Early plans for mental health and learning disability inpatient services did not include redesign of community services. They also did not take sufficient account of the inpatient care context and ensure that workforce challenges would be addressed and the environments would be suitable for future care provision. The partnership has sought to improve the coordination of planning by the recent development of the Mental Health Alliance. This brought together the knowledge and expertise of the three partnerships to work collaboratively to develop community pathways and improve mental health provision. Recent intelligence gathering from community mental health services also aimed to inform the transformation process. The transformation of inpatient services had been under way for a significant period of time before coordinated planning activities which included community services commenced.

There was limited progress in developing and implementing some key strategies. Workforce challenges were identified clearly in the first strategic commissioning plan. The partnership had not maintained a clear focus on this priority. It was not evident that workforce issues had been a key consideration in the development and implementation of the partnership's plans.

The provision of care for people with complex needs was a source of overspend for the partnership. The partnership's response to this challenge had lacked a wider long term strategic approach. Positive steps had been taken to understand and manage demand. However, these had simply focused on managing budget pressures.

Senior managers took the view that increased demand was unavoidable as it was not possible to predict when the complexity and resources required by some individuals would increase. While this was true, they had not considered if the partnership's existing comparatively high levels of provision of intensive homecare for adults aged under 65 indicated the requirement for a wider strategy. Especially when cost pressures from implementing the Scottish Living Wage and the limited availability of the workforce is taken into account.

The partnership has missed opportunities by not moving early enough to redesign services which combined accommodation with care and support to meet need in a more sustainable way. It had also not fully engaged with key partners such as care providers and housing to co-produce a solution when the budget pressures from complex care were first identified.

This was being improved in relation to housing but co-production with care providers was still underdeveloped. A housing contribution statement had been integrated into the partnership's first strategic commissioning plan (2016–2019). The contribution of housing had been reviewed and reported to the IJB. The IJB had agreed to build on this by integrating housing planning into the revised strategic plan that the partnership was developing. This was focused on the work of the independent living

group which brought together housing staff with managers from the partnership to analyse the demand, supply, pathways and new housing models to support independent living for both older people and adults. The commissioning and contracts team had worked closely with housing to identify a register of adapted tenancies. Housing had worked to respond to individuals identified by social workers requiring specific adaptations in order to live independently.

There was little evidence that the partnership had considered whether it had capacity to deliver the ambitious range of actions within its plans. The partnership maintained a number of existing strategies that had been developed before the development of its strategic commissioning plan (2016–2019). The effectiveness, consistency and relative priority of these existing strategies were not reviewed in relation to the new strategic priorities. There was no reprioritisation of capacity to ensure effort was focused on those priorities. The risk that capacity was not used effectively appeared to have continued when a number of these strategies became out of date. Planning groups continued to monitor progress and review actions despite the plan having expired.

There had been little attempt to evaluate the impact of the partnership's previously established strategies and plans in order to inform and align them to future strategies and plans. Several actions within the strategies had been identified as being achievable within existing resources. This suggested that the partnership was not seeking to achieve significant service redesign and transformation in a way that would overcome the key challenges of increasing demand, limited workforce and increasing budget pressures. For example, the Autism Strategy and Keys to Life Strategy Groups continued with no focus on the increasing demand for people with complex needs. The documentation used to monitor progress against these strategies was confusing and inconsistent, making it difficult to identify which actions remained outstanding and where new actions had been added.

The strategic planning group had not been operating effectively for almost a year prior to March 2018. It did not offer opportunities for a range of stakeholders to review progress. A number of meetings had either been cancelled or postponed. In March 2018 this was recognised and there was a successful revitalisation of the group.

Revised strategic planning and commissioning arrangements
The partnership had taken positive steps to review its strategic planning and commissioning processes. The most significant change as a result of this was to establish four strategic programme boards to improve the development of coordinated and coherent plans in key areas:

- older people and unscheduled care
- primary care
- mental health and wellbeing, and

- carers.

Senior managers explained that this approach was in recognition of the fact that despite excellent work at a locality level, localities by themselves were not able to deliver the transformational change needed to sustain improved outcomes.

Staff and managers recognised the need for developments in localities to be more connected with the partnership's strategic direction and priorities, and that the programme boards were designed to facilitate this. However, concern was expressed about the lack of consultation with locality managers in the creation of the programme boards. IJB members also expressed concern at the length of time it has taken the partnership to establish the programme boards.

The partnership envisaged that the four programme boards will report to a strategic commissioning board, chaired by the chief officer. The strategic commissioning board will report to the partnership's strategic planning group, which reports to the IJB. There will also be links with the care and clinical governance and workforce planning arrangements. The role of the strategic commissioning board is to review the support provided to the programme boards to identify gaps and emerging need. Terms of reference had been developed for the programme boards but had not been developed for the strategic commissioning board. Programme boards were developing their strategic delivery plans but continuing this process without establishing the role of the strategic commissioning board risks a lack of coordination and consistent prioritisation across these plans.

It was too early to assess whether the strategic programme boards will prove to be more effective in ensuring the robust implementation of the partnership's strategies. The existing strategy groups for mental health and wellbeing, learning disability, substance misuse and autism will report to the mental health and wellbeing programme board. The other programme boards will also review any other existing strategy groups which are relevant to their work. This brings a positive opportunity to ensure that strategic planning and commissioning capacity and activities are better aligned with the partnership's priorities. However, if this process does not include an effort to streamline and focus capacity on key priorities there will be a continued risk of slow progress. Senior managers were aware of the need to ensure that strategic programme boards should be supported with robust project management, a clear performance management framework and locality working as a cross-cutting theme. It is too early to tell whether this awareness will result in action being taken to reduce the risk and that the partnership will make better use of its capacity to deliver against its priorities.

The older people and unscheduled care programme board and primary care programme board were at a more advanced stage in developing their strategies than the mental health and wellbeing and carers programme boards. There was clearly identified investment to implement proposals developed by the older people and unscheduled care programme board in the partnership's three-year financial plan.

These proposals are well developed and seek to invest in order to shift the balance of care to achieve savings. Service redesign is planned in a number of areas, including rehabilitation beds, community respiratory teams, enhanced community response teams, advanced nurse practitioners and technology enabled care. The three-year financial plan also identified additional expenditure pressures in relation to people with complex needs and carers. The additional expenditure identified for carers is based on the assumption that all of the associated financial pressure from implementation of the Carers Scotland Act (2016) will be funded from new income from the Scottish Government. The projected savings in relation to services for people with a learning disability and autism are predicated on a transformational review of current models of supported living by the mental health and wellbeing programme board which is at a relatively early stage. Primary care costs are currently outside the scope of the three-year financial plan.

The variance in progress between the different strategic programme boards prevents the partnership from basing decisions on how resources are allocated on a comparison of the benefits each plan will deliver. It also increases the risk that early opportunities for service redesign will be missed and additional resources will need to be allocated simply to maintain existing models that are increasingly unsustainable. It also may mean that resource allocations need to be based on assumptions instead of fully developed strategic plans. This may mean that opportunities to move resources between different priorities are missed.

Senior managers believe that this is unlikely because of the potential to shift resources from inpatient mental health services as a result of NHS Tayside having comparatively high levels of mental inpatient bed usage compared to the rest of Scotland.

Releasing resources to shift the balance of care in mental health provision involves the effective engagement of the partnership with all stakeholders. This will facilitate the development of robust plans that deliver a coordinated approach across the health and social care system. Effective engagement with people experiencing care, their families and stakeholders, such as housing services, registered social landlords and the third and independent sectors, is essential to the success of this approach.

The partnership started the process of revising its strategic commissioning plan (2016–2019) in March 2018. This began with the successful revitalisation of its strategic planning group as mentioned earlier in this report. The plan was in draft format, however senior officers indicated that there would be a delay before the final version was completed. This allowed time for the new chief officer to develop and take ownership of the plan, reflect on the recommendations from the joint inspection report and allow for engagement and ownership of the strategic plan from IJB members which had not been facilitated previously.

Involvement of stakeholders

Engagement and consultation was variable, and had significant scope for improvement. A systematic and consistent approach to engagement and consultation was not evident.

Staff of all grades expressed a commitment to involve people experiencing care, carers, the third and independent sectors, and staff in the partnership's activities. The partnership had endorsed the Perth and Kinross third sector health and social care strategic forum as the main channel for it to engage with third sector organisations. Third sector representatives on the IJB, strategic planning group and care and professional governance group came from the forum. The partnership had both a participation and engagement strategy and a communication strategy. Programme board terms of reference required them to have communication, participation and engagement strategies but stakeholder engagement has been limited because of the pressure of tight deadlines for the development of their plans. This represents a risk that if the partnership consults on completed strategies and plans, external stakeholders will continue to maintain their view that decisions are made in advance. There was no evidence of a process to report on communication and engagement activity or to scrutinise its impact and effectiveness.

There were some areas of consultation and communication which were positive in relation to the integration agenda and the partnership's vision and values. Areas of good practice included the following.

- Consultation with 4,000 people to identify the partnership's priorities in the first strategic commissioning plan (2016–2019). This was supported by the Communities First Initiative.
- Participatory budgets gave local communities the chance to determine which organisations and processes are funded.
- Funding for a staff member from Scottish Care, the national independent sector care providers' umbrella body, to facilitate the involvement of independent sector providers.
- Positive working relationships between the partnership's commissioning and contracts team and care providers from the third and independent sectors, including facilitating a care at home providers' forum and participating in a learning disability providers' forum.

Involvement of stakeholders in the partnership's activities was variable. Feedback from carers, service users and third sector services indicated they viewed much of the partnership's consultation activity as tokenistic. There was a common perception that decisions had already been made before they were consulted and that many decisions were finance driven, rather than needs led.

There was little evidence that the partnership had considered the capacity required by the third sector to engage with the large number of planning groups the partnership has developed and be represented in all community planning priorities.

There was no evidence of a systematic approach to meaningful communicating, consulting or engaging with the workforce and wider population with regards to the partnership's vision and strategic priorities. Examples of these included the following.

- The mental health review and care home review were cited as examples of consultation when the partnership had reached a decision before consultation being carried out.
- Commitments in the Perth and Kinross Carers Strategy (2015–2018) did not resonate with carers. Some carers who had been involved in developing a new carers strategy also commented that while they supported its aspirations, they had concerns about whether it was capable of implementation.
- Specialist care providers felt that they had not had the opportunity to be involved with the development of a strategy nor had they been asked to co-produce solutions to the increase in demand for complex care.
- Almost two thirds (63%) of respondents to our staff survey did not agree that the views of staff are fully taken into account when services are being planned at strategic level.

Locality planning

The partnership has worked hard to develop its three localities: North Perthshire, Perth City and South Perthshire. There was a well-developed locality planning and management structure. The development of localities has been central to the partnership's approach to developing early intervention and prevention as well as joint health and social care teams. This had been led at local level with strategic direction and oversight from the integrated management team and executive management team forums.

A key aspect of locality working is to create opportunities for professionals to contribute across primary care, secondary care, social work and housing teams. The partnership had examples of practical developments across professions at a locality level. Furthermore, locality Integrated Care Team meetings had been established to share good practice. This was a relatively recent development. The meetings were frequent and had focused effectively on delayed discharge, unscheduled care and avoiding crises. Locality meetings relating to complex care had also been established. It was too early to assess the impact of these.

Overall, the positive developments were primarily driven by locality staff. Processes and structures to ensure that developments were contributing to the partnership's strategic priorities were underdeveloped. The opportunities to maximise the benefits of locality working were limited by budgets which were not disaggregated at a locality level. The partnership was finalising locality budgets for the 2019/20 budget monitoring process.

Hosted services

When the IJBs were formed, NHS Tayside delegated health services to be hosted[6] by each of the three partnerships. For example, Perth and Kinross partnership hosts community dentistry, podiatry, healthcare in prisons and in-patient mental health services, Angus hosts forensic medicine and the Dundee partnership hosts psychology services for the whole of NHS Tayside.

The allocation and arrangements for hosted services were an area of difficulty for the partnership. The need for transformation of mental health inpatient services had already been identified when the service was delegated. It was recognised that significant leadership capacity had subsequently been drawn from the partnership to develop and drive the transformation plan. There had also been inquiries into the quality of care provided in the inpatient units. These highly publicised inquiries have had a damaging effect on staff morale. There had been difficulties recruiting and retaining the number and specialism of staff to deliver a safe model of care. A significant overspend resulted from locum staffing costs. The responsibility for financial planning for inpatient mental health is a collaboration between the partnership and NHS Tayside. This was recognised as an area for improvement and a three-year financial plan for inpatient mental health services was under development.

Leading the transformation of the inpatient mental health service had taken significant amounts of time and resource from the partnership. Despite this, workforce planning, a mental health strategy and a coordinated approach to planning services linking the new inpatient units and community services, were at an early stage.

Hosting prison services also proved to be an area requiring significant leadership investment. A recent inspection report for HMP Perth[7] highlighted gaps in health and social care provision. Additionally, the changing demographic in prisons was recognised as requiring more specialist health and social care input than had previously been anticipated. The report of a subsequent follow-up inspection, published April 2019, has identified significant improvement and an ongoing improvement plan is in place.

These hosted service arrangements placed a pressure and resource requirement on the partnership which impacted on capacity to focus on other aspects of integration. It was widely recognised as a contributing factor to the slow pace of integration.

There was a lack of structure or identified frameworks across Tayside for the evaluation of the performance of hosted services to provide reassurance to partner IJBs. There was also a lack of formalised communication networks to express

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[6] Hosted services are health services that one partnership manages and provides for people throughout Tayside.
[7] The full inspection report is available here: https://www.prisonsinspectoratescotland.gov.uk/publications/report-full-inspection-hmp-perth-14-25-may-2018?page=1

concern if a service hosted by a partnership was not meeting local need. A regular forum for the NHS Tayside Chief Executive and the three council Chief Executives to meet began in January 2019 to discuss the performance of these services.

Self-directed support
The partnership did not have a separate strategy for the implementation and development of self-directed support (SDS). Instead it saw SDS part of its mainstream processes for providing support. There was an action to increase SDS take-up in the strategic commissioning plan but this was not underpinned by a specific action plan through which progress could be monitored and reviewed. The partnership had not illustrated how SDS links with the partnership's strategic priorities or key challenges such as complex care. In the future, a workstream of the Mental Health and Wellbeing Programme Board will review SDS procedures.

SDS option one refers to people who receive a direct payment. SDS option two refers to people who choose how they will be supported and this is arranged by the council. Option three is when the council chooses and arranges services, and option four is a mixture of options one, two and/or three.

The partnership reported that the number of people using SDS options one and two increased between 2016–2017 and 2017–2018. However, the rate of people choosing these options is still less than the Scotland average. Part of the increase in people choosing option two resulted from adults having a desire to keep their existing provider during the care at home retender. In rural areas, the choice of using SDS option one can be driven by difficulties in securing traditional care at home services (SDS option three). The partnership told us outcomes had been carefully monitored in these situations. During the period 2016–2018, there was a corresponding decrease in the number of adults using option three. However, the rate of people accessing this option was still above the national average. This may be a consequence of the difficulties in maintaining a diverse market of care providers in rural areas. The partnership was also just beginning to develop its approach to facilitating the development of more diverse care markets, to promote innovation and increased choice.

Commissioning managers recognised a challenge in offering adults different choices under SDS in rural areas where there were limited numbers of care providers. To address this they sought to develop an outcomes-focussed approach which will enable people using services to negotiate arrangements directly with providers. The aim is to deliver flexibility and choice in line with each individual's requirements by a single provider instead of relying on a choice of different providers. The commissioning team highlighted that this approach has proven challenging and slow to establish as a result of the pressures on the care at home market.

The partnership was working to move away from traditional service responses through seeking to develop better links with support delivered by third sector organisations and other community groups at a locality level. For example, attending

a local dance group can avoid social isolation and promote physical activity. To support early intervention, the partnership provided investment to stimulate the creation of new third sector organisations. It also developed social prescribing by investing in staff, linked with GP practices. Social prescribing provides opportunities for people with a range of social, psychological and physical issues to access a wide range of local interventions and services provided by the voluntary and third sectors. It aims to help people improve their health and wellbeing, for example by reducing their social isolation or providing opportunities to be more physically active.

Self-evaluation and quality assurance
Overall, there was limited evidence to suggest that the partnership had prioritised self-evaluation and quality assurance. This mirrors the low level of priority given to performance management. It also reflected the apparent absence of a systematic and robust approach to evaluating the impact of the actions set out in the partnership's first strategic commissioning plan and the lack of processes used to monitor and review existing strategies.

One of a few exceptions was the development of outcome-focused service specifications for third sector projects. This moved away from services reporting against high level strategic outcomes and towards service level outcomes. This was completed with support which the partnership commissioned from Evaluation Scotland's[8] Threading the Needle project[9]. Another good example was the systematic and detailed evaluation of the discharge hub at Perth Royal Infirmary. Evaluation Scotland also offered support to the partnership to pilot integrating third sector data with NHS statistics, but this was unsuccessful due to workload pressures and protocol barriers. The follow-up consultation commissioned from an independent advocacy service following the day services review was also positive.

The partnership undertook a large-scale self-evaluation of its strategic planning and commissioning arrangements in 2018. Senior managers told us that this was in preparation for our inspection. There was a commitment to using the results of the self-evaluation to improve strategic planning and commissioning arrangements.

Finance
The partnership continues to face significant financial challenges, despite a significant increase in the level of funding provided by Perth & Kinross Council for the financial year 2019/20, as well as NHS Tayside allocating a full share of the uplift received from Scottish Government and additional NHSScotland Resource Allocation funding for GP prescribing and prisoner healthcare.

The partnership has focused on the delivery of recurring savings to avoid reliance on non-recurring solutions and the build-up of a 'masked' underlying deficit. Where

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[8] Evaluation Support Scotland is an independent organisation that supports third sector organisations to measure the impact of their activities on improving outcomes.
[9] Threading the Needle was a Scottish Government funded programme to support health and social care commissioners use third sector evidence to commission outcomes for health and social care.

non-recurring offsets have been available these have been set out separately so that the underlying position is always clear. Being able to report on the underlying position has been critical given that the IJB was not able to sign off the budgets for prescribing or inpatient mental health services as sufficient at inception. The partnership has had challenging savings targets to deliver each year. Significant recurring savings have been delivered each year in line with its financial plan. However, the IJB has been unable to balance its financial plan at the beginning of each year since it was formed. In addition during 2018/19, significant unanticipated pressures emerged. A recovery plan was put in place and is likely to significantly reduce the forecast overspend. In all years, non-recurring budget was required from NHS Tayside at the year-end driven by the underlying deficit in the financial plan. In 2018/19, non-recurring funding is likely to be required from Perth & Kinross Council due to the very significant unanticipated pressures not fully manageable through recovery plan actions.

Ambitious savings plans delivered over the last three years have changed the way in which services are being delivered in line with strategic plan direction. As part of the budget-setting process there is a significant testing of each saving plan to reassure IJB members of the positive impact on service delivery and alignment to strategic plan objectives.

The partnership's budget allocation for the previous two financial years and the current year is as follows:

Financial year	Perth & Kinross Council	NHS Tayside	Total IJB core budget*
2017/18	£49.1 million	£45.7 million	£94.8 million
2018/19	£47.1 million	£46.4 million	£93.5 million
2019/20	£52.4 million	£47.9 million	£100.3 million

*Core budgets relate to the social care and community health and hospital services that have been delegated to the IJB. In addition, the partnership receives a further £100.2 million (2018/19) for hosted services and the large hospital set aside.

There was a significant increase of funding from Perth & Kinross Council of 11%, however resources are still stretched as cost pressures outweigh savings achieved. NHS Tayside has given the partnership a full share of the uplift received from the Scottish Government and additional NRAC funding for GP Prescribing and Prisoner Healthcare.

There is evidence of a strong link between strategic and financial planning. This is more developed in the work of the OPUSC Board which enabled investment and disinvestment priorities to be set out in the three-year financial plan. Cost pressures and projected savings are also identified in relation to the carers and mental health and wellbeing programme board, but the detailed strategies and plans need to

ensure their delivery are still under development. The work of the Primary Care Programme Board was out with the scope of the three year financial plan.

The three year plan from 2019/2021 was approved by the IJB in March 2019. The three year budget setting process was a considerable improvement on previous years and is built on the good practice of Perth and Kinross Council's three-year planning. The budget-setting process is collaborative, with the finance team looking at what has happened in the past, what trends exist and what adjustments they need to make. A forward look is also applied using factors such as demographic change and growth as well as pay and price pressures. This provides an overview of anticipated future need. There is a clear link to strategic planning for 2019/20 onwards. The process of developing the financial plan was time consuming as can be expected in doing a three-year plan for the first time, and should become more streamlined going forward. The need to ensure that effective financial planning can be delivered on a timely basis, within the financial capacity, was recognised by the partnership and senior managers who are meeting to review the lessons learned from the process undertaken this year.

The limited capacity of the finance team aligned to the IJB by the parent bodies, had caused slippage in areas such as a three-year plan for adult mental health services and created a challenge in developing the three-year financial plan. NHS Tayside has not carried out detailed three-year planning before now so this has been a significant change in process for the staff. The three-year plan was very beneficial because it allowed early warning signs to be identified and for both Perth & Kinross Council and NHS Tayside to have meaningful conversations on what future funding needed to look like.

Finance staff from both Perth & Kinross Council and NHS Tayside supported the IJB, as well as dedicated staff in the IJB itself. Three very experienced members of staff have left the finance team in the past 18 months, resulting in a loss of valuable knowledge of social care delivery. The team has returned to almost full capacity. The partnership accountant is providing additional senior financial management capacity to the chief finance officer and the partnership has been unable to recruit temporary backfill. Health and social care finance staff have co-located together at the partnership's offices in Perth which provides strong working relationships and collaboration.

Relationships between the partnership and its parent bodies of Perth & Kinross Council and NHS Tayside had strengthened in recent months. Since the creation of the partnership in 2016/17, relationships have been tested in relation to budget setting. The council held the underspend in an earmarked reserve to meet statutory obligations. A significant amount of time and effort had been invested to improve relationships between the finance teams as well as at executive level. The conversations around funding and expectations are now more open. This has

allowed a more constructive relationship to develop than what had existed previously.

Arrangements for managing risk
The partnership had a strategic risk register and the risk management processes were still being developed. Both the processes and thresholds for escalating risk had recently been clarified and this had been viewed as a positive development. The strategic risk register had identified risks, including workforce recruitment and retention, financial sustainability and leadership. For some risks, the register had identified that current control measures were having no or limited impact in reducing risk. As a result, further treatment actions were required. We acknowledge that there is some consistency between the risks identified in our report and those on the partnership's risk register, together with the treatment actions required to address areas for improvement.

An example of a treatment action was the need to consolidate and complete the framework for care programme boards to mitigate the risk of a lack of clear leadership and direction. A further example would be a recruitment marketing, workforce plan and a joint working agreement which were based on clear models of care and identified as a treatment action to mitigate the risk of being able to both recruit and retain staff. However, some of the areas for development we identified were absent from the partnership's approach to mitigating risk. Including these areas would ensure effective prioritisation together with the alignment of management capacity and effort with strategic priorities. As well as implementing all of the outstanding areas for development, we noted an absence of effective programme and project management together with ways of evaluating these.

The risk register also identified the risk of unclear governance and lack of a performance management framework as 'moderate'. However, the actions to treat this risk were focused on care and clinical governance structures and there were no actions to improve performance management.

Many of the treatment actions set out in the risk register had no time frame against them. It was positive that treatment actions for the areas with highest residual risk all had target time frames. Almost all of these actions (including the two examples included above) were due before the end of March 2019, but good progress towards their implementation was not evident. Very high risks identified in the draft risk register in November 2018 had not yet been mitigated.

Contract management, procurement and market facilitation
The partnership was able to deliver their commissioning intentions through effective approaches to procurement and contract management. This was demonstrated through the retender of care at home services. The new tender sought to increase the sustainability of supply in rural areas by adopting a strategy of commissioning a small number of larger providers. The potential benefits of this approach were in terms of economies of scale. Successful providers would have a larger and more

predictable demand on which to base workforce development. The retendering process was achieved through effective working relationships between the partnership's commissioning manager and Perth & Kinross Council's procurement manager. The partnership worked positively to involve external stakeholders in the retendering process. Providers were invited to comment on the new service specification and service users were directly involved in the evaluation of tenders. It was noted that the process was not underpinned by the use of directions by the IJB.

The contract management and monitoring process had recently been reviewed. This provided a clear and proportionate framework for managing and monitoring contracts. Third and independent sector providers confirmed that they had formed excellent supportive relationships with the contract monitoring team and locality managers.

New contract monitoring performance indicators had been introduced for all care groups. This was a suite of indicators to measure quantitative data which was submitted quarterly. There were no arrangements to capture information on outcomes.

Providers and the partnership worked together to co-produce solutions to shared challenges. However, these were rarely progressed to implementation because of budget pressures and lack of capacity within the partnership. An example of this was the development of the care at home pricing model as part of the process to implement the Scottish Living Wage. Similarly, the floating support tender for housing-related support had a single specification despite providers expressing concern that this would make it more difficult for small providers to complete. There was a risk that this previous experience would discourage providers from co-producing solutions in the future.

The partnership had started to develop a market position statement and care providers confirmed that they had been invited to participate in this process. There had been some delay in progressing this. The current draft required considerable development in terms of the information that it provided. The partnership had no plans to undertake activities to restructure the market, for example by promoting innovation or to intervene by future retendering.

Contractual arrangements for services for people requiring complex care had not been reviewed for some time and focused on supporting people in individual tenancies. Supported living and complex care provision for working age adults were purchased by block contracts[10] with an option to spot purchase[11] additional hours when required. There was a plan to review and consider spot purchases. Prices for these purchases were variable. The partnership was seeking to use the National

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[10] A block contract guarantees a given volume of business to a service provider, usually over a set period of time, and in advance of the service being delivered.
[11] Spot purchasing refers to when the services are purchased as and when needed and the service provider has no guarantee of the volume of service that will be purchased in a time period.

Framework Agreement for support provision that Scotland Excel[12] is developing to improve purchasing arrangements, but this had been delayed.

Vacancies in long term supported living services were filled quickly but there was a growing recognition from managers within the partnership that core and cluster[13] models needed to be developed to reduce reliance on high-cost individual care packages. In view of the increasing budget pressures from people with complex needs and the likely lead-in time for new developments, the partnership had missed opportunities to make earlier progress to redesign services.

Specialist support providers stated that the partnership was missing opportunities to redesign services to have more sustainable costs through core and cluster models. While they understood that there had been a growth in demand for behavioural support, they suggested that the staffing levels and costs could be managed more effectively through core and cluster developments, rather than relying on large-scale care packages to support people in individual tenancies.

The commissioning and contracts team had worked hard to review service level agreements with small third sector organisations. It was positive that this review would seek to increase the alignment between third sector funding and the partnership's strategic priorities. Third sector providers confirmed that the team had also been successful in developing tailored service specifications and outcome measures to capture the outcomes delivered by diverse services. This was following the Threading the Needle project, where the commissioning and contracts team had worked with Evaluation Support Scotland to develop outcome measures to measure the impact of third sector organisations.

Vision and aims
The partnership's strategic commissioning plan (2016–2019) had a clearly articulated and comprehensive vision and aims. These were underpinned by five key priority themes. However, these were not consistently referenced in other key planning documents.

The vision and aims were reflected in the council's corporate plan and the local outcomes improvement plan. The new chief executive of the council was developing an approach called the 'Perth and Kinross offer', which would focus on shifting the balance of control and responsibility between public services and the community, with an emphasis on co-creation and community empowerment. This approach complemented the partnership's vision. This consistency and alignment of the vision and aims across partner agencies was positive.

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[12] Scotland Excel offers a range of procurement, training and consultancy services which deliver savings, efficiency and capability.
[13] Core and cluster model refers to shared accommodation in which people have their own private bedroom or other single person accommodation unit, but share communal facilities such as kitchens and bathrooms.

There was variance in the extent to which other strategies, action plans and key documents reflected the vision, aims and key themes. The 2016–2019 technology enabled care strategy reflected both the vision and aims. The participation and engagement strategy and communications strategy both included the partnership's vision. The draft organisational development strategy reflected the key themes but not the vision. The third sector health and social care strategic forum action plan and the terms of reference for the four strategic programme boards did not reflect either the vision or key themes. This lack of consistency in reflecting the partnership's vision and aims limited the overall coherence of planning and strategic activity across the partnership.

The strategic commissioning plan identified some principles to underpin the partnership's approach. However, these were not consistently referenced by either the partnership or other stakeholders. The partnership had not agreed a recognisable set of values that was evident throughout its planning and operational activity.

Locality plans were developed by locality managers and their teams, with the involvement of other stakeholders. Encouragingly, the locality action plans were based around the five key priority themes. However, they did not explicitly reflect the partnership's vision statement.

Communicating the vision
Roadshows had been carried out in all three localities to communicate the vision and aims of the partnership. This vision was well known: 72% of respondents to our staff survey agreed that they were aware of the partnership's vision for health and social care services. Leaders, senior managers, locality managers and frontline staff understood and demonstrated commitment to the vision. In at least one locality, there had been joint sessions for staff to develop their local vision for integrated services. However, not all staff groups had subscribed to the vision, or the model of integrated working. In some acute settings, the cultural shift had been slow. Competing priorities from NHS Tayside and Perth & Kinross Council staff had negatively impacted on the development of integrated working in Perth Royal Infirmary. However, the partnership's engagement with clinicians on the Perth Royal Infirmary site impacted positively on existing behaviours and fostered a collaborative approach.

Integrated approaches
Although collaborative working was strong, particularly in the localities the partnership was at an early stage of integrating the workforce. The IJB had responsibility for commissioning and planning, and the responsibility for delivery of services remained with the employing NHS Tayside and the council. A parallel management structure was evident at all levels below the chief officer and chief finance officer, with the exception of finance posts. Despite this, the chief officer directly managed the heads of health and adult social care who had operational

responsibilities. This resulted in some confusion about where the ultimate responsibility for operational delivery of adult services was located.

The partnership had established its three localities on an aligned health and social care model, rather than an integrated approach. Each locality had a health manager and a social work manager, who had differing spans of control. The NHS manager managed considerably more staff in the locality than the social work manager did, whilst the social work manager had responsibility for other staff in the wider partnership area. This meant that the level of focus on locality work differed between health and social work managers.

There was a clear commitment to supporting the development of a shared culture and understanding through close partnership working at locality level. The aspiration was that a positive and collaborative approach would lead to a smooth transition to integrated service delivery. Locality managers and professional leads demonstrated a clear commitment to developing cultures and behaviours that supported collaborative working. For example, joint development sessions to embed a shared culture had illustrated a commitment to collaborative working. Significant progress had been made and frontline staff and locality managers confirmed that joint working in aligned locality care teams was positive. Similarly, occupational therapists from health and social care were positive about working together. However, there were no integrated management arrangements.

Senior partnership staff believed they had the right balance between integrated working and respecting professional roles. However, there was evidence of a desire within the locality teams and occupational therapy to further integrate and to develop new skills and explore new roles. Staff and managers consistently reported that staff were keen to integrate even further. There was frustration that senior management had not responded to requests from staff to integrate management and budgets.

Workforce planning
The development of workforce planning had been slow. Some service areas in the partnership were operating in contingency arrangements and there was difficulty recruiting and retaining staff.

Having the right workforce was recognised as fundamental to the future effectiveness of the health and social care services in the partnership. Workforce recruitment and retention was acknowledged to be particularly challenging in some professional areas (care homes and homecare, mental health services, GPs and registered nurses) and in the more rural geographical areas. Workforce issues impacted on the partnership's ability to deliver services in some areas, which resulted in contingency arrangements being used, for example in the mental health inpatient units and partnership wards in the acute hospital.

Some work had been undertaken to understand future workforce needs in terms of skills and capacity. Activities to support recruitment of the workforce in NHS Tayside,

Perth & Kinross Council and third sectors included recruitment events for care at home providers and entering into discussion with local colleges in order to recruit home care staff. However, there was little evidence of a strategic approach beyond the commitment in the community partnership's local outcomes improvement plan (2017–2027) to develop a skills academy for care by 2021.

Despite a stated intention to develop an integrated workforce plan, the partnership had not yet achieved this. A draft joint workforce and organisational development strategy was approved by the IJB in spring 2016, but workforce plans did not follow this. There was a lack of clarity amongst staff about the status of joint workforce planning. Less than half (47%) of respondents to our staff survey agreed that they were aware of the workforce planning arrangements in place to support the integration of health and social care. The partnership still had separate workforce plans for NHS Tayside and Perth & Kinross Council. Although a formal legal agreement to facilitate further integration and joint management structures[14] had been drafted, it was still to be formally signed off by NHS Tayside. From a strategic perspective, a continued absence of focus on the potential benefits of greater structural integration represented a missed opportunity. Integrated approaches have the potential to make better use of the available workforce, which is one of the partnership's key challenges.

The allied health professions directorate had developed interface guidance on the relationship between operational management and professional support. The principles were in use but the guidance to support the implementation was still in draft. There was potential for this to be used more widely than this staff group which was a positive development. However, work still needed to be taken forward in relation to differential terms and conditions.

Locality management
Locality managers held a highly respected leadership role for frontline staff. They were a role model for integration and encouraged multi-agency working. Most staff (76%) who responded to our survey agreed that they were encouraged to work collaboratively to support meaningful integrated working and good practice. Frontline staff told us they felt listened to by their managers and felt that they could make a contribution at locality level and within their teams. Almost two-thirds (62%) of those responding to our staff survey agreed that they felt valued by their managers. There was a commitment to service delivery in the localities and a desire to meet the needs of the local population. However, only 32% of respondents felt that the quality of services for adults had improved since the integration of health and social care.

In 2016, the partnership had restructured adult care services in the localities from specialist teams into two core teams: one providing early intervention and prevention services and the other dealing with long term and complex care needs. This was

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[14] This is when an NHS staff member is managed by a manager is who is employed by the Council or vice versa.

now well embedded. Service managers were able to describe a number of projects and initiatives they had under way to provide early intervention and prevention in their locality, for example the social prescribing project which is an important component of the partnership's overall strategy. However, the partnership had not evaluated its approach to early intervention and needed to review the effectiveness of their arrangements.

People working in localities identified a lack of strategic oversight and a disconnect between the overarching strategic plans and priorities, and those for delivery of services at the frontline. . This was partly supported by the results of our staff survey, with 54% of respondents familiar with the partnership's local priorities. Staff expressed frustration at this disconnect and a desire for a clear strategic direction to be established by senior leaders.

Leadership
The perception of staff was that senior leaders had been distant and had not set a strategic direction for service delivery. Change was poorly communicated and a historically challenging relationship between the partnership and NHS Tayside had impacted negatively.

The partnership had new senior leadership. The chief executive of Perth & Kinross Council had only been in post for six months, and the chief executive of NHS Tayside for just three months. At the time of our inspection, the existing chief officer was about to leave post and a new chief officer had been appointed. The NHS Tayside and Perth & Kinross Council chief executives and a number of senior managers and leaders told us that the progress of health and social care integration in Perth and Kinross had been slow. Both new chief executives expressed a commitment to the integration agenda and were keen to take a leadership role to drive the vision and culture of integration. Whilst recognising that they had different perspectives and priorities in some areas, they had already established regular and meaningful dialogue to support the progress of integration.

In our staff survey returns, less than half of the responses to questions relating to leadership were positive. Only one third of respondents agreed that senior managers communicated well with frontline staff. Fewer than half (46%) agreed that leaders were visible or that they created a trusting, positive, sharing and open organisational structure. Team leaders and frontline managers were seen as approachable and engaged. However, senior managers were often seen as distant from the day to day work, with limited understanding of the pressures on frontline staff. Additionally, they were perceived as imposing change without consultation or understanding the impact of the change. This view was also expressed by other stakeholders.

Senior managers felt challenged by heavy workloads and limitations on their capacity to do all the work they needed to. On the whole, they acknowledged that they could be more visible to staff. Some managers were actively working to improve communication with staff and other stakeholders.

Historically, NHS staff had often been absent from key meetings and there had been a lack of allocation of the appropriate number of NHS Tayside non-executive IJB members. This had limited the partnership's ability to make progress in a number of areas. These included budget and workforce planning, data sharing and development of shared performance frameworks and progressing shared partnership priorities. A positive change in this relationship between Perth & Kinross Council and NHS Tayside was evident. There was a commitment to improving the budget-setting process. In 2019/20, it was significantly smoother and more collaborative than in previous years. Frontline staff also perceived an improvement in shared priorities and a culture of collaborative working.

The partnership had been delegated hosted services which demanded a lot of time and leadership capacity and diverted attention from the integration agenda. As mentioned earlier in this report, actions were under way to address this.

The production of the new strategic commissioning plan had been delayed to allow the new leadership to be fully involved and consult on priorities with wider stakeholders. The IJB members had been concerned about their lack of engagement in the draft of the plan and establishment of strategic priorities. This delay could allow them to be actively engaged. These were early positive signs for the quality of the new leadership team in the Perth & Kinross partnership, but the management team had not been in post long enough for the impact to be evaluated.

Leadership of planning and strategic direction
The partnership's strategic commissioning plan (2016–2019) was broad ranging and ambitious. As discussed earlier in this report, it was not well supported by plans for implementation and did not identify clear priorities to support activity at local level or planning for particular service user groups.

Senior managers contributed to the oversight and implementation of the integration agenda through the Executive Management Team (EMT) and the Integrated Management Team (IMT) meetings. The partnership provided a description of the EMT and IMT roles. However, there was a consistent lack of understanding and clarity amongst staff and managers about the purpose of the respective teams. The efficacy of the EMT and IMT was hindered by this lack of clarity and understanding about the role and remit. Some of the managers attended both meetings, including the heads of health and social work. There was a lack of confidence about the membership of each team being correct. The IMT was challenged with balancing aspiration with limited resources and maintaining capacity to deliver operational responsibilities.

The partnership had a number of planning, commissioning and management forums to support its work. Not everyone understood the role and purpose of the different groups and meetings. The linkages and communication routes between groups were not clear. This meant that senior managers and leaders spent a lot of time in meetings that did not always operate as effectively or efficiently as they might have

done if the planning, management and governance forums had been developed in a more deliberate way. It also meant that the partnership did not have a coherent or systematic approach to strategic planning and commissioning or to the management and monitoring of integration and transformation.

There was a commitment in the partnership that the new strategic programme boards would assist with strategic direction in localities and provide the basis for meaningful performance reporting. The development of the programme boards had the potential to strengthen strategic planning and commissioning activity for the identified programmes of care. However, there was no evidence about how the priorities of the programme boards would link to the priorities of the localities; or how their strategic priorities would come from either the strategic commissioning plan, the strategic planning group or the IJB. It was too early to demonstrate the impact.

Integration Joint Board
Poor communication, trust and information sharing between the partnership and the board was evident. There was also a lack of consultation or engagement on the strategic direction and strategic plan development for the partnership. The sharing of financial information was positive and demonstrated improvement. The members lacked training and development opportunities to have the knowledge and confidence required to fulfil their role and provide effective governance. As a result of these factors, the IJB was not fulfilling its role.

IJB members and senior managers had not received training and guidance on the use of directions to ensure that the IJB's commissioning intentions were effectively implemented by NHS Tayside and the council. As a result, the members did not issue directions. The IJB is the central point from which effective integration of resources and services was driven in a partnership with parallel management structures and budgetary processes. This requires the IJB to be able to confidently direct NHS Tayside and Perth & Kinross Council to implement its strategy, including investment and disinvestment. Legal advice had been sought on the use of directions. There was a lack of clarity in the partnership about the rationale behind this.

As mentioned earlier in this report, the partnership did not have a comprehensive performance or progress monitoring framework for leaders or the IJB to track progress against the strategic commissioning plan. It was a recent development that the IJB audit and performance committee was to receive regular performance reports. This followed a refocus of the committee which had previously focused almost solely on audit. Prior to this, the committee received its annual report and one delayed discharge report. The first report was submitted to the committee by the OPUSC Programme Board. This was a positive development, although both IJB and OPUSC Programme Board members agreed that more work needed to be done to agree the format and content of the report for the longer term. Prior to the recent introduction of performance reports, the IJB did not have sufficient performance data

to understand and scrutinise the partnership's performance, and measure progress against its strategic priorities. This limited the IJB's ability to fulfil its role in setting strategic direction and in overseeing implementation of strategies and plans.

The IJB was at an early stage in developing its capacity to lead on strategy and direction for the partnership. It had experienced a high rate of membership turnover, with 34 voting members since its inception in 2016. The involvement of NHS Tayside members had been particularly inconsistent. The associate nurse director was temporarily filling a non-executive vacancy, but had not attended meetings. The IJB had a full quota of four elected members. Encouragingly, the voting members on the IJB were motivated and enthusiastic, and keen to fulfil their role in direction and scrutiny of the partnership.

Insufficient priority had been given to developing the IJB. The frequency and content of training for IJB members was not sufficient to enable them to fulfil their role as an autonomous decision-making board. New IJB members received a one-day induction which covered a range of complex and new topics. Bespoke training had occasionally been offered, such as finance training, to support the members to contribute to the financial plan and the financial recovery plan. This was appreciated by the members, who were positive about the overall approach of financial planning and their level of understanding. The members welcomed the visits to service areas and the comprehensive information that accompanied these. There was an appetite to do more service visits. However, there remained a lack of confidence among IJB members about the remit and scope of their role and in their knowledge of how the IJB should operate. There was a need for a comprehensive rolling programme for training to ensure the members understood all areas of performance data, service delivery and partnership performance. The partnership recognised the need to develop information and training to support IJB members, but timescales had slipped from June 2018.

There was a disconnect between the perspective of the IJB members and partnership staff in relation to the sharing of information. IJB members expressed considerable frustration that they were not being included in the review of the strategic plan at an early stage. Senior managers advised that while a draft plan had not been presented, IJB members had been fully updated on progress. Additionally, they had been engaged in its building blocks in terms of the formation of the strategic programme boards and financial planning. There was a history of poor communication and information sharing between the partnership and the IJB members. The sharing of financial information was positive and demonstrated improvement. The role of public partner and carer representatives was not being appropriately supported or valued. These issues needed to be addressed for the IJB to operate effectively.

The disconnect between the perspectives of IJB members and senior managers within the partnership was a cause for concern. IJB members need to have

ownership of the partnership's strategic commissioning plan. There was a similar disconnect between IJB members and senior managers about the IJB's creation of a clinical and care governance sub-committee resulting in ineffective communication between senior staff and IJB members on key issues.

Clinical care and professional governance
Clinical and care governance within the partnership was a key priority. Aligned rather than integrated working arrangements had resulted in a number of governance groups. This resulted in duplication and overlap. The partnership recognised this and was in the process of reviewing arrangements.

Clinical and care governance arrangements were in place for all of the partnership's activities, including community health services and social work. The partnership had a number of groups and forums that oversaw clinical and care professional governance. However, the main governance forum, chaired by the chief social work officer and associate medical director, was integrated and oversaw work considered by other forums. This group reported into an NHS pan-Tayside clinical quality forum. Within the partnership, NHS Tayside and Perth and Kinross single agency groups fed into the joint care and professional governance forum. Both NHS Tayside and Perth & Kinross Council had single agency groups feeding into the joint forum. NHS Tayside clinical governance groups had also recently been established in the three localities and there was an intention to establish a clinical governance group for mental health. The number of governance groups was time consuming and inefficient for staff who had to attend several of them. This also reflected a continuing identification with NHS Tayside and Perth & Kinross Council rather than with the partnership.

The new programme boards had been established with no clear direction on how some of the older groups fit into the structure or how the programme boards link to the clinical and care governance structure. The development of the programme boards should have created an opportunity to rationalise the number of groups.

The partnership recognised that its clinical and care governance arrangements were complex and not sufficiently integrated. Senior managers were concerned about making changes to these processes until they were clear that it was safe to do so. This was a transitional arrangement, although there was no evidence of whether the arrangements were sustainable until a more integrated approach was introduced.

The partnership was in a period of transition and was planning to develop a more streamlined and integrated model. The new model was to include an integrated care and clinical governance framework based on the Health and Social Care Standards. Although there was no clear time frame for this piece of work, it was positive and aligned with the early aspirations of the new leadership team and professional leads.

The IJB had initiated a new clinical governance committee to scrutinise clinical care and governance arrangements. It was not clear how the new committee would link to

existing clinical and care governance arrangements. There was also a lack of understanding and clarity about the role of this group and some managers expressed reservations that it would have an operational rather than a strategic focus.

4. 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 in line with the national average when measured against a range of nationally published datasets. The partnership's performance focus had been on capacity and flow around the acute setting. Improvements in this area were evident as a result.

Nonetheless, the partnership lacked strategic leadership of performance and did not have a robust performance framework. This limited its ability to measure progress against wider strategic priorities or the aims of the strategic commissioning plan. There was no mechanism for regular scrutiny of performance in relation to service delivery across the partnership. This included the IJB audit and performance committee which had not received performance information prior to February 2019.

The partnership's performance monitoring did not build on the experiences of those receiving care or their carers. The partnership's limited use of data did not help to inform planning and commissioning decisions. Locality staff also felt hindered by a lack of performance data to identify service gaps and drive appropriate improvements.

Evaluation: Weak

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 made progress in implementing a number of actions from its strategic commissioning plan (2016–2019) but had not maintained a balanced and effective approach to implementing all of its priorities. To some extent this reflected the impact of the capacity required to redesign inpatient mental health and learning disability inpatient services. At the same time, progress was limited by the lack of a systematic and effective approach to the development and implementation of the plan. The partnership was in the process of developing a new strategic commissioning plan. It had implemented revised strategic planning arrangements to ensure improvements from its first strategic commissioning plan (2016–2019) were achieved. It was too early to assess whether these revised arrangements would be

effective. Overall, this meant that the partnership's strengths in this area, just outweighed its weaknesses.

The partnership's first strategic commissioning plan (2016–2019) set out clear priorities. These were underpinned by a wide range of ambitious actions across the services and activities for which the partnership had responsibility. Although the partnership had made significant progress in implementing a number of actions, a balanced and effective approach to implementing all its priorities had not been maintained. Progress had been made in relation to existing operational pressures, such as delayed discharge and unscheduled care, but priorities such as workforce and complex care were progressing slowly, without a developed strategy.

The management capacity taken up by the redesign of inpatient mental health and learning disability services had a negative impact on the partnership's ability to make progress on all of its priorities. At the same time, the partnership lacked a systematic approach to monitoring and evaluating the implementation of all its plans. It had not sufficiently considered whether its plans were achievable and realistic. Plans were not underpinned by effective programme and project management or subject to regular review and re-prioritisation, taking into account the capacity available to deliver them. The partnership was developing a new strategic commissioning plan. It has implemented new arrangements to improve its development and implementation but it is too early to determine if these have been successful. Financial planning has also improved, together with collaborative working between senior management and finance.

There were effective arrangements in place for the commissioning, procurement and monitoring of services purchased from external providers. The partnership had worked hard to establish its localities. Localities had driven the development of early intervention and prevention, but clear processes to ensure alignment with strategic priorities were absent. Self-evaluation and quality assurance had not been prioritised. There was a commitment to involving external stakeholders, but this had been implemented inconsistently.

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

The partnership had a clear vision and aims, underpinned by strategic themes. The partnership's vision was largely aligned with the strategic vision of partner agencies. It was widely recognised and understood by partnership staff.

Locality teams were led by effective managers who were well respected by frontline staff. However, there was a disconnect between senior managers in the wider

partnership and staff in the localities, where there was a lack of strategic direction from senior managers, and leaders were perceived as distant. Staff and managers were not confident about workforce planning intentions, despite difficulty in adequately staffing all service areas. Staff worked in a collaborative way but expressed a desire to progress to an integrated workforce, and frustration at the delay in this.

As a consequence of the aligned, rather than integrated structure, there were a number of different clinical and care governance and management groups. This contributed to a lack of clarity about the role of the groups, duplication of work, a lack of communication between groups and inefficient use of senior staff time.

The IJB was not equipped to fulfil its role. Poor communication, sharing of information and training had impacted negatively on the development of the members. The IJB was not setting the strategic direction for the partnership or fulfilling its governance role.

The new leadership team had expressed a commitment to driving integration in a positive direction, but had not yet had time to translate this commitment into action. It was too early to evaluate the impact that the new leadership team would make.

Evaluation: Weak

Evaluation summary

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

5. Areas for development

1	The partnership should improve its approaches to performance measurement and management. A performance framework should be developed using appropriate data and information about outcomes. It should be used to benchmark and report to facilitate the identification of service gaps and to drive improvement.
2	The partnership should improve its strategic planning and commissioning processes to ensure that: • effective programme and project management supports implementation of all plans and priorities, taking into account the scale of the task, its capacity, finance and the timescale needed to achieve it • plans demonstrate SMART[15] principles, and • existing strategies and planning groups are reviewed to ensure that the partnership's capacity is used effectively to deliver its strategic priorities.
3	The partnership should put in place a systematic approach to monitoring and reviewing the implementation of its strategic commissioning plan and any other plans and strategies which support its implementation. This should include: • robust prioritisation of balancing immediate pressures with longer term strategic actions which can avoid or reduce future risks • a systematic approach to reviewing and updating its strategic needs assessment • periodically considering whether plans and actions need to be re-prioritised to take account of new and emerging challenges and opportunities, and • reallocating capacity from lower priority areas where necessary, or securing additional resources.
4	The partnership should ensure that it places greater priority on evaluating the impact of its plans and strategies, including: • putting in place a systematic approach to involve stakeholders, and • effectively evaluating specific developments and initiatives to determine their impact on improving outcomes and to inform future strategy.
5	The partnership should ensure that workforce planning is maintained as a key priority in all its activities and encompasses the workforce requirements of NHS Tayside, Perth & Kinross Council and third and independent sector providers.

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[15] Specific, Measurable, Achievable, Realistic, Time-related

6	The partnership should build on existing good relationships with care providers and housing services to identify where there is potential to co-produce solutions to strategic challenges. This should include co-producing a market facilitation plan.
7	The partnership should review its participation, engagement and communication strategies, and monitor the impact and effectiveness of its communication and engagement activity.
8	The partnership should review its structures and processes for management, strategic planning and governance to ensure the structure is fit for purpose. The purpose and remit of each part of the structure should be clearly set out and communicated to the wider stakeholders.
9	The partnership should invest in the development and support of the IJB members. This will include improved communication, training, consultation and engagement. As well as enhanced information sharing to allow the IJB to fulfil its governance role.

6. Conclusion

Scottish Ministers have asked the Care Inspectorate and Healthcare Improvement Scotland to assess the progress made by HSCPs 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, and
- establish a vision, values and aims across the partnership, and the leadership of strategy and direction.

In Perth and Kinross, we found important weaknesses in some key areas, which significantly outweighed the strengths that we identified.

There had been improvement in relationships between partners and financial planning. In those performance areas where the partnership focused its attention, such as hospital discharge, a positive impact was evidenced through performance information. Localities were vibrant and staff worked closely together to provide services collaboratively.

However, overall, there was a lack of leadership and strategic oversight which resulted in poor planning, direction and monitoring of services following the setup of the integration authority. Some key strategic priorities were not given sufficient attention and the partnership had not been realistic about its capacity to implement its plans. Structures and processes had not been developed or redesigned to ensure efficiency and effectiveness.

The partnership has new leaders in post who express commitment to the integration agenda and have already taken steps that reflect this commitment. This is evident in the continued building of better relationships and in improved financial planning. The partnership must sustain this as it will provide a positive foundation for improvement in the future.

It is important that the partnership progresses the identified areas for improvement to allow it to:
- build on its revised approach to strategic commissioning
- progress the transformation of its governance and planning structures
- develop its workforce planning, and
- put in place an integrated performance management structure.

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 Perth & Kinross 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 1,845 staff. Of those, 524 (28%) responded. We also carried out fieldwork activity over seven days, during which we interviewed a number of people who hold a range of responsibilities across the partnership. The partnership offered observation of the IJB and the audit and performance committee, which inspectors attended.

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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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.